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

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

PROGRAM COMPLIANCE COMMITTEE MEETING
Wednesday, March 9, 2022
2nd Floor Conference Room
1:00 p.m. – 3:00 p.m.

AGENDA

I. **Call to Order**

II. **Moment of Silence**

III. **Roll Call**

IV. **Approval of the Agenda**

V. **Follow-Up Items from Previous Meeting** - ***None***

VI. **Approval of the Minutes –** February 9, 2022

VII. **Report(s)**
- A. Chief Medical Officer
- B. Corporate Compliance - ***None***

VIII. **Quarterly Reports**
- A. Access Call Center – ***Deferred to April 13, 2022***
- B. Children's Initiatives
- C. Clinical Practice Improvement
- D. Customer Service
- E. Integrated Health Care

IX. **Strategic Plan Pillar** - Customer

X. **Quality Review(s)**
- A. QAPIP Evaluation FY 2021
- B. QAPIP Plan FY 2022

XI. **"Putting Children First" Initiative *(Presentation)***

XII. **Chief Clinical Officer's Report**

XIII. Unfinished Business

A. **BA #22-16 (Revised)** – Substance Use Disorder (SUD) Prevention Funding – DWIHN's Provider Network

XIV. New Business

(Staff Recommendations)

A. **BA #22-46** – Behavioral Health Home – ***Providers listed in Board Action***

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

PROGRAM COMPLIANCE COMMITTEE

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

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

AGENDA TOPICS

II. Moment of Silence

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

III. Roll Call

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

IV. Approval of the Agenda

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

V. Follow-Up Items from Previous Meetings

DISCUSSION/ CONCLUSIONS

There were no follow-up items from previous meetings to review.

VI. Approval of Meeting Minutes

DISCUSSION/ CONCLUSIONS

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

VII. Reports

DISCUSSION/ CONCLUSIONS

A. **Chief Medical Officer** – ***Deferred to March 9, 2022***

B. **Corporate Compliance Report** – Nichole Hunter of the Allen Law Group is filling in as the Corporate Compliance Director until a replacement has been named. Ms. Hunter submitted and gave highlights of the Corporate Compliance update. Ms. Hunter reported:

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

Dr. Carter opened the floor for discussion. Discussion ensued. The Vice-Chair has noted that the Corporate Compliance report has been received and placed on file.

VIII. Quarterly Reports

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

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

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

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

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

DWIHN continues to train first responders; its providers, drug court staff/inmates/jail staff and the community on how to reverse an opioid overdose. The medical examiners provisional data suggest that drug overdose deaths declined by 9.3% between April 2020 to April 2021 in Wayne County. Dr. Carter opened the floor for discussion. Discussion ensued.

The Vice-Chair noted that the Managed Care Operations', Residential Services' and Substance Use Disorder's quarterly reports have been received and placed on file.

IX. Strategic Plan Pillar - Access

DISCUSSION/ CONCLUSIONS

Jacquelyn Davis, Clinical Officer submitted and gave an update on the Strategic Plan Access Pillar report. Ms. Davis reported:

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

Dr. Carter opened the floor for discussion. Discussion ensued. The Vice-Chair noted that the Strategic Plan Access Pillar has been received and placed on file.

X. Quality Review(s) -

DISCUSSION/

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

CONCLUSIONS

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

XI. Chief Clinical Officer's (CCO) Report

DISCUSSION/ CONCLUSIONS

Melissa Moody, Chief Clinical Officer submitted and gave highlights of her Chief Clinical Officer's report. Mrs. Moody reported:

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

comprehensive array of integrated healthcare services. This is a 22% increase in enrollment since October 2021. There are currently seven (7) Health Home Partners providing OHH services in Region 7.

Dr. Carter opened the floor for discussion. Discussion ensued. The Vie-Chair noted that the Chief Clinical Officer's report has been received and placed on file.

XII. Unfinished Business

DISCUSSION/ CONCLUSIONS

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

XIII. New Business: Staff Recommendation(s)

DISCUSSION/ CONCLUSIONS

A. **BA #22-47** – Mental Health First Aid (MHFA)/Question, Persuade, Refer (QPR) – *Vendors' list included in board action* – Staff requesting board approval to enter into a contract with various vendors for the continuation of the MHFA and QPR. Dr. Carter opened the floor for discussion. There was no discussion.

B. **BA #22-49** – Tri-County Strong Crisis Counseling Program (CCP) – *Vendors' list included in board action* – Staff requesting board approval to enter into a contract with nine (9) various vendors for an amount not to exceed $3,725,575.00 to implement a virtual and face-to-face crisis counseling program designed to serve victims of flooding in the tri-county area. Dr. Carter opened the floor for discussion. There was no discussion.

C. **BA #22-53** – Sleeping Bags/Coats – The Empowerment Plan - Staff requesting board approval for the use of $88,100.00 in PA 2 funding for 700 sleeping bags/coats for our Co-Occurring homeless consumers. This will allow providers to provide active outreach and support individuals who are experiencing homelessness and substance use disorder throughout Wayne County. Dr. Carter opened the floor for discussion. There was no discussion.

D. **BA #22-54** – Jail Plus – DWIHN's Provider Network– The Wayne County Department of Health, Human and Veteran's Services (HHVS), Clinical Services Division, Adult Community Corrections is requesting board approval of a sub-recipient Intergovernmental Agreement (IGA) between the County of Wayne and DWIHN to add value to our contracted services not funded via the Community Corrections' grant, including access to its' network of providers for intensive wrap-around service, utilization of its' Access Management System for immediate client placement. Judy Davis, Director of Substance Use Disorder informed the committee that the amount for Black Family Development should be $82,500.00 instead of $85,000.00 and the amount for Detroit Recovery Project should be $113,500.00 instead of $116,000.00. These corrections will be made before going to Full Board for approval. **(Action)** Dr. Carter opened the floor for discussion. There was no discussion.

E. **BA #22-55** - American Rescue Plan Act (ARPA) – DWIHN's Provider Network – The Michigan Department of Health and Human Services (MDHHS) awarded the SUD Department $1,129,060.00 from the ARPA grant with an additional $125,000.00 for administrative cost and unmet needs. The funding will provide prevention, intervention, treatment and recovery support continuum services to include various evidence-based services and supports for individuals, families and communities. Dr. Carter opened the floor for discussion. There was no discussion.

The Vice-Chair bundled the board actions and called for a motion on BA #22-47; BA #22-49; BA #22-53; and BA #22-54 (including corrections for Black Family Development ($82,500.00 instead of $85,000.00) and for Detroit Recovery Project ($113,500.00 instead of $116,000.00)) and BA #22-55. **Motion:** It was moved by Mr. Phillips and supported by Mr. Glenn to move BA #22-47; BA #22-49; BA #22-53; BA#22-54 (including corrections for Black Family Development ($82,500.00 instead of $85,000.00) and for Detroit Recovery Project ($113,500.00 instead of $116,000.00)) and BA #22-55 to Full Board for approval. Dr. Carter opened the floor for further discussion. There was no further discussion. **Motion carried.**

XIV. Good and Welfare/Public Comment

DISCUSSION/ CONCLUSIONS

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

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

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

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

Program Compliance Committee Meeting
Chief Medical Officer's Report
Shama Faheem, MD
March 2022

Behavioral Health Outreach:

- DWIHN has continued outreach efforts for behavioral health services, with special focus on Children services this year.
  - Medical Director Biweekly Newsletter highlighting recent data on children's mental health during pandemic
  - Medical Director's monthly AsktheDoc advocacy videos addressing important mental health and COVID related questions.
    - ❖ Ask the Doc Digital with DWIHN Chief Medical Officer, Dr. Shama Faheem EP.1: https://www.youtube.com/watch?v=zgf5uS84ou8
    - ❖ Ask the Doc Digital with DWIHN Chief Medical Officer, Dr. Shama Faheem EP.2: https://www.youtube.com/watch?v=oB2f9LfCIME
- Our Customer Service Department has also continued advocacy and outreach for mental health as well as COVID vaccination through Constituent Voice Department's What's Coming Up Videos:
  - ❖ Medical Director participated with Constituent's Voice to create a brief video discussing COVID-19 vaccination as well the situation around school shooting and threats and its psychological impacts https://www.youtube.com/watch?v=e-hJ3B3TOC4
  - ❖ Children's Initiative Director participated with DWIHN Constituent's Voice to create a brief video explaining children services and suicide prevention: https://www.youtube.com/watch?v=0JW6nMIIviE.

- Tri-county collaboration addressing threats and violence at school: The 3 counties have been discussing joint branding of services and joint mental health awareness month event. The Michigan State Police (MSP), the Michigan Department of Education (MDE), and the Michigan Department of Health and Human Services (MDHHS) are jointly working on development of threat assessment guidelines to assist Michigan communities as they develop and implement their approaches to threat assessment. An introductory seminar was held on 2/28/22. In the meantime, we had discussions with our other county partners around opportunities of getting trained on it and subsequently offering those threat assessment trainings to staff within community mental health systems as well as schools, depending on their engagement and interest.

Performance Bonus Incentive Pool (PBIP)-Integrated Health Department):

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

- ❖ Total Performance Incentive Earned: 91.39% of available amount (FY 20= 74.46%)
  - PIHP/MHP Joint Metrics: Score 71/100 or 71% (FY 20= 49%)
  - PIHP Only Metrics: Score 200/200 or100% (FY 20 = 100%)

Performance Improvement Projects:

We have been closely monitoring multiple performance improvement projects and HEDIS measures. Our current intervention strategies include education to provider network, regular memos highlighting out-of-compliance cases, however, we are also currently implementing a HEDIS certified platform which will display individual CRSP provider data for their review to allow them opportunities for early intervention and improved outcomes.

Given low HEDIS scores on some children's HEDIS measures last year, our Children's Department has developed PIPs for ADHD medications and antipsychotic medications monitoring developing interventions to address the numbers.

We collaborated with the State to join them in their "We treat Hep C" initiative and have created a Performance improvement project around increased screening for Hep C in the high-risk Substance use disorder population. Provider education sessions have begun and we are working on steps towards baseline data collection.

Quality:

DWIHN has continued to show upward trend for majority of our performance indicators. Performance incentives have been attached to them and are starting to go live so we are expecting to see further improvement. Master level clinicians' shortages continue to be a reported barrier by several of our providers and have continued to be a contributing factor for Indicator 2A, that is, completion of a biopsychosocial within 14 days of a non-emergency request for services.

MDHHS will be conducting a review of our waiver and SUD services starting mid-March and Quality team is working to meet the pre-review requirements. BHDDA completed part of their review of Critical incidents report and time frames and recognized and appreciated Region 7's improved performance in FY 21where 6 incidents were out of the compliance time frame versus 28 in FY 20. Our goal is zero out of compliance incidents in FY 22.

Workforce Development Department Outreach, and Justice Involved Efforts Synopsis:

Reach Us Detroit (RUD) 24/7 Virtual Therapy Line continues to be offered to residents of Wayne County that are 14 and up. An increase in calls requesting support for behavioral health risk assessments of youth that were suspended from school due to making verbal threats occurred. RUS completed behavioral health screenings and assessments on those referrals. Additional referrals from law firms have been made to support the mental health of youth pending expulsion. Non-Wayne County individuals were referred to local resources.

Detroit Police Department/DWIHN Pilot Partnership - *To ensure that reporting is accurate, data for this project will be presented for the previous month.*

CNS and Team Wellness continued to support law enforcement through our co-response partnership with the Detroit Police Department. During the month of January Co-Responders made a total of 183 encounters and connected 51 individuals to a service. They had 11 suicide calls, the CIT team was able to intervene and provide the appropriate interventions to prevent harm to the consumers. There was a total of 3 overdose calls for the month. The CIT team was able to coordinate with both the EMS and Nurses at the hospital where the consumer was conveyed due to medical issues. A total of 43 resource cards were provided and reviewed with consumers for assistance with mental health, substance use, and homelessness.

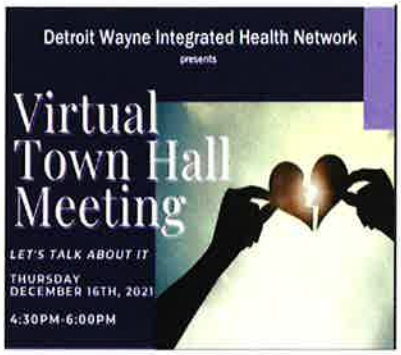
Detroit Wayne Integrated Health Network
CHILDREN'S INITIATIVE DEPARTMENT
EXECUTIVE SUMMARY REPORT

Quarter 1 (Oct 2021 – Dec 2021)

Pillar 1	Pillar 2	Pillar 3	Pillar 4
Clinical Services & Consultation	Stability & Sustainability	Outreach & Engagement	Collaboration & Partnership

DWIHN Community Town Hall

DWIHN Children's Initiative Department (CID) facilitated a **Town Hall: Let's Talk About It** on 12/16/2021 that included a Guest Speaker (Dr. James Henry – Professor at Western Michigan University, Co-Founder / Director of Children's Trauma Assessment Center) and a panel of 9 participants to discuss mental health, school safety / violence, grief / loss, and trauma. Overall, there were about 55 attendees including WXYZ Ch7 news station as well.



Other participants included the following:

- **Eric Doeh (CEO / Closing Remarks) –** CEO / President (DWIHN)
- **Dr. Faheem (Opening Remarks) –** Chief Medical Officer (DWIHN)
- **Cassandra Phipps (Moderator) –** Director of Children's Initiative (DWIHN)
- **Andrea Smith -** Director of Workforce Training and Program Development (DWIHN)
- **Rev. Dr. Carla Spight Mackey -** Faith Based Initiative, Clinical Specialist Performance Improvement (DWIHN)
- **Daniel West -** Director of Crisis Services (DWIHN)
- **Danyelle Orr-McNeil -** Parent Support Partner (Assured Family Services)
- **Karl D'Abreu -** National Council of Alcohol and Drug Dependence CADD, Life Support Services
- **Dr. Markita Hall -** Executive Director of Educational Services (Wayne RESA)
- **Scott Thomas -** English Communications Teacher
- **Tyanna McClain -** Regional Youth Coordinator (The Children's Center)

Detroit Wayne Integrated Health Network
School Success Initiative

The **School Success Initiative (SSI)** uses evidence based practices to deliver prevention based services to children, utilizing a 3-tier universal health screening.

- **Tier 1** - prevention and stigma reduction services
- **Tier 2** - evidence based behavioral health supports
- **Tier 3** – referred for community mental health services

Census: A total of 12,021 students actively received SSI services from among 11 Children Providers. There was a total of 1,869 screenings and 262 discharges. SSI Therapists are in a total of 72 schools in which 25 schools are in Detroit and 47 schools are in Out-Wayne County.

Quarter 1 (Oct-Dec 2021)						
Provider	# of Student Presentations	# of Student Received SDQ Screenings	Tier 1	Tier 2	Tier 3	Total # of Students Received SSI Services
ACCESS	944	488	944	0	2	**1434**
ACC	1	3	4	0	10	**17**
BDFI	1290	34	2958	119	12	**3123**
CCS	386	109	443	74	58	**684**
CNS	1068	29	1071	8	19	**1127**
DC	798	288	798	238	46	**1370**
Hegira	0	507	0	1	22	**530**
SWCS	2698	47	2748	31	37	**2863**
Starfish	0	252	175	28	49	**504**
TCC	75	8	75	0	0	**83**
TGC	0	104	85	97	0	**286**
Total # of Students	**7260**	**1869**	**9301**	**596**	**255**	**12021**

School Success Initiative Projects:

SSI Redesign: Presentation was presented at the November Board Meeting and the 3 Goals have been accomplished: 1) Coordination with Teen Health Centers, 2) Increased Accessibility of Services, and 3). Implemented Standardization of Services.

MHWIN / Redcap: Continue to coordinate with Access and IT Departments:

- Create the calendar to schedule intake appointments (Resolved)
- Allow Providers to see the status of the SSI Tier 3 Referrals (Discontinued - This feature was unable to be added to MHWIN; however, Providers are coordinating with the Access Department for the status of referrals),
- Update the enrollment section to include the option for a member to decline services (Resolved)
- Compare data in Redcap to quarterly narrative reports for consistency of data collection (Ongoing – Currently making updates in Redcap to add additional features)

Michigan Model of Health (MMH): Coordinated with Wayne RESA to gain information for purchasing the Pre K curriculum and SSI Providers to attend the training in February 2022.
School Based Health Centers: DWIHN met with School Based Health Centers to coordinate status, progress, and discuss school needs.

System of Care Report to the Community

On December 2, 2021, the **12th Annual Report to the Community "We Are Stronger Together"** took place via Zoom; in which there were 103 stakeholders attended. Cassandra Phipps, Director of Children's Initiatives presented an overview of Connections' System of Care accomplishments for Fiscal Year 2020-2021. The keynote speaker was Crystal Shaw, Vice President at Hope Against Trafficking.

Youth United

Youth United is a youth--led initiative that promotes youth voice and youth partnerships in Wayne County System of Care (SOC) using positive youth development values and philosophy.

Advisory/Advocacy (Central Region)	• Youth MOVE Detroit drafted a flyer to promote participation at the Youth MOVE Detroit Council meetings which is posted on various social media platforms. They continue to post youth related resources and events to engage youth participation using social media as well. To date, there are 174 followers on Youth MOVE Detroit's Instagram; which increased by 13 followers from the previous quarter. There are 542 followers Youth MOVE Detroit's Facebook; which increased by 5 followers from the previous quarter. • December 16, 2021, there was a Meet and Greet at The Children's Center. The theme was "Winter Wonderland". There were 17 participants who engaged in a series of interactive games including decorating ornaments.
Leadership/Training (East Region)	• There was a focus group with Black Family Development, Inc.'s Youth Assistance Program on December 2, 2021. There were eight 8 participants who discussed current youth related issues and possible solutions. Based on results of the youth involvement survey results, substance use, bullying, depression, and gun violence were some of the topics they recommended addressing in future activities/trainings/events for youth. • On December 9, 2021, Youth United facilitated a presentation titled, "Accountability in the Workplace". There were 8 participants. The training focused on the definition of accountability and benefits of accountability in the workplace.

Anti-Stigma/Social Marketing (Northwest Region)	• December 13, 2021, there was a Breaking Down Stigma training with the Youth United team via Zoom; in which were 9 participants. Discussion focused on defining stigma regarding and mental health matters.

Special Projects

Access Department / IT Department: Infant Mental Health Screening: CID coordinated with DWIHN Access and IT Department to develop a screening process for individuals ages 0 to 6 for the Infant Mental Health Program to contact the Access Department to determine eligibility for services rather than going directly to the Children Provider. A meeting was held with IMH Providers to discuss and received additional feedback to incorporate in the new changes. **Foster Care Screening**: CID coordinated with Access and IT Departments to update the screening process for members in Foster Care. Meeting was held with DHHS to present the referral process proposal for completing screenings for children in Foster Care as well as receiving Trauma Screening Checklists from DHS Workers.

City of Detroit Office of Disability Affairs: December 2021 showcased an interview with Children's Initiative Director concerning challenges children and families encounter regarding the pandemic, the vaccine, and trauma.

Detroit Public School Community District Nurse Training: CID facilitated a 2 day training to 125 nurses with DPSCD on Behavioral Health including information about community mental health services, diagnosis, psychotropic medications, trauma, coping skills, secondary traumatic stress, and self care.

Dearborn Schools Parent Training: Coordinated with Utilization Management Department (Jim Kelly) to train Parents on transitional services and supports for students turning age 26 with serious intellectual developmental disabilities in Nov 2021.

Clinical Services

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

Disability Designation	# of Children Providers	Q1
SED	15	6891
I/DD	11	4075
Total Individuals Served		**10966**

Intensive Clinical Services:

Home Based: Home Based services is an intensive strength based model provided to the family at home, school, and or the community. The goal is to empower families, improve community involvement, and prevent out of home placements.

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

Wrap Around: Wrap Around is a team-driven and family-led process involving the family, child, natural supports, agencies and community services. Individual services and supports build on strengths to meet the needs of children and families across life domains, promoting success, safety and permanence in home, school and community.

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

Waiver Services:

SED Waiver: Enhanced community based services to children/youth in Foster Care or who have been adopted through the child welfare system, who are at risk of psychiatric hospitalization, utilizing the Wraparound Model, which is a team-driven process involving the family, child, natural supports, agencies and community services.

Children's Waiver: The Children's Waiver Program (CWP) makes it possible for Medicaid to fund home and community-based services for children who are under age 18. To be eligible for the CWP, the child must have a documented developmental disability and need medical or behavioral supports and services at home.

Quarter 1 (October 2021 – December 2021)	SED Waiver	Children Waiver
New Referrals / Screens	28	2
Active Cases	56	45
Renewals	8	12
Discharges	6	2

Trainings

Training	Training Name / Attendees
Children's Mental Health Lecture Series	• Restorative Justice 101 (46 attendees) • Social Injustice and Culturally Competent Care: Addressing the Intersection of Culture and Social Injustice in Black/African American Communities (37 attendees)
Quarterly Leadership Training Series	• Overview of The Coach Approach Model as a Trauma-Sensitive Method of Supervision and Engagement (27 attendees)
Substance Use Training	• "Working with Adolescents: Redefining Co-Occurring as Substance Use and Trauma" (46 attendees)
DHHS Staff Training	• Accessing Community Mental Health Services (46 attendees)

CPI Quarterly executive summary report

Evidence Based Supported Employment/Individual Placement and Support

DWIHN Evidence Based Supported Employment (EBSE) program manager provided general oversight, monitoring as well as technical assistance to EBSE providers who helped members served with behavioral health and substance use co-occurring disorders find meaningful work in the competitive labor market in the community and follow their path of self-sufficiency and recovery. DWIHN's program manager continued to monitor the merger of Northeast Guidance Center and Central Network Services as well as the newly announced merger of Community Care Services with Hegira Inc, to ensure services and supports received by members served continue uninterrupted. DWIHN's program manager will continue to assist providers who are impacted by workforce challenges to identify recruitment and retention strategies.

Monthly EBSE supervisor and employment specialist check-in meetings were held with providers to address fidelity standards and identify strategies for process improvement.

Some EBSE providers continued to provide in-person community-based services despite pandemic concerns. Others continued to work with their members remotely based on member preferences as well as perform job development with potential employers via telephone or the internet due to safety concerns.

There was a total of (197) referrals, (174) admissions, (101) competitively employed in the community in a variety of industries, such as retail, manufacturing, health care and food service with an average hourly wage of ($14.00). Twenty-two (22) members successfully transitioned from EBSE services as their employment goals were met.

Follow up from PCC November 2021: Returning Citizens Competitively Employed
FY 21-22 (1st Qtr.)

1) ACCESS-(3)
2) Central City Integrated Health (1)
3) Community Care Services-(0)
4) Development Centers-(0)
5) Lincoln Behavioral Services-(1)
6) Northeast Integrated Health/CNS Healthcare-(0)
7) Southwest Counseling Solutions- (3)
8) Team Wellness Center-(21)
9) The Guidance Center-(1)

Total: (30) successfully employed in the community

Other

Initiated development of new DWIHN policy for Conflict-Free Case Management for network provider use, and completed updates to DWIHN's Assessment Policy, Proven Behavioral Health Clinical Technology Inclusion and Application Guideline, Integrated Bio-Psychosocial Assessment Procedure to ensure NCQA and HSAG guidelines were met as well as other regulatory requirements. Assisted with review of the IPOS template used by CRSPs to ensure alignment with DWIHN's standardized IPOS core elements as well as DWIHN's IPOS audit tool to ensure the standards set forth by HSAG and MDHHS were met. Also, reviewed and followed up with responsible CRSP to ensure a plan is initiated to manage members who were identified in a recent DWIHN quarterly report as having multiple hospital admissions within 30 days for psychiatric care. Provided additional updates to DWIHN's Integrated Bio-Psychosocial
Continued to assist with review and updates to DWIHN's workforce core training requirements for adults and children, including supplemental trainings. Recommendations for the development of credentialing procedures specific to clinical specialty were established, including compliance standards for practitioner completion of core trainings.

Assertive Community Treatment (ACT)

CPI monitored ACT program admissions and discharges of Lincoln Behavioral Services, Community Care Services, and Northeast Integrated Health, including the appropriateness of the level of care determinations. Provided technical assistance to Hegira, Team Wellness Center, and North East Integrated Health Network to ensure program eligibility requirements were met.

During the 1st quarter, CPI manager facilitated a follow up monthly meeting with all of our pilot program providers for Med Drop, which are Community Care Services, Lincoln Behavior Services, Northeast Integrated Health network/CNS, All Well Being Services, Hegira, Development Centers, and DWIHN internal Clinical Officer. Topics discussed were ways to increase admissions rates, talking points, and recommendations for providers with regards to presenting the program to members. All providers also discussed any strengths and or weakness with implementing the program in their agency. Topics discussed were also any concerns or issues with the new modifier code changes.

In October, November and December CPI participated in IPLT where topics discussed were the revision and updates of the policies and assessments. CPI also facilitated an update meeting with Genoa Pharmacy/ Med Drop to obtain an update on DWHIN 8 Pilot Providers that are participating.

November 2021

CPI manager participated in procedure code work group meeting, where the updated modifiers and codes were discussed. The procedure work group are currently working on inputting codes and new modifiers in providers contracts so that there will not be an issue with billing.

CPI met with Med Drop for a monthly follow up meeting, where it was noted that 37 Current Active Clients CCS=14 LBS = 16 CNS/NIH = 5 DCI=2 as of Nov 1st 2021.

CPI manager attended the Hospital Liaison Meeting facilitated by COPE an DWIHN Crisis department. Topics discussed were, COPE/ SUD concerns, State Liaison updates and law enforcement liaison updates. CPI manager also attended the internal Hospital Recidivism workgroup that is facilitated by the quality department.

The CPI manager also facilitated the monthly ACT forum, where topics such as performing the PAR (Face to Face or via Telehealth) training which special guest Sojourner Jones from the Crisis department at DWIHN to discuss AOT orders and ACT members and potential ACT members, code modifier changes, MDHHS provider manual updates, ATR training tool training, and CPI monitoring of the 2-hour timeframe of completing the PARS.

CPI manager attended COPE biweekly huddle meeting, topics discussed were issues with ACT teams completing the PARS within the 2-hour time frame and concerns with PHQ-9 imbedded into the PAR.

December 2021

CPI manager met with Med Drop for a monthly follow up meeting, where it was noted that there are 35 Current Active Clients. CCS=12, LBS=16, NIH=5 DCI=2 as of December 1, 2021. Also, for the month of December the CPI manager attended the Hospital Liaison Meeting facilitated by COPE and the DWIHN Crisis department. Topics discussed by the CPI manager were members in AFC specialized homes and the ACT fidelity review incentive were discussed.

Other activities completed by the CPI manager include:

- Participated in audit of IPOS internal meeting.
- Participated in OIC internal meeting.
- Participated in PHQ-9 data meeting with DWIHN IT.
- Facilitated a follow up monthly meeting with all pilot program providers for Med Drop, which are Community Care Services, Lincoln Behavior Services, Northeast Integrated Health network/CNS, Hegira, Development Centers. Topics discussed were ways to increase admissions rates, talking points, hospital recidivism list and recommendations for providers with regards to presenting the program to members.

Med Drop Quarter One Members Enrolled

For quarter one, there were, 35 Current Active Clients. Community Care Service has a total of 14 members, Lincoln Behavior Service has a total of 14 member and Northeast Integrated Health Network has a total of 4 members and Development Center has 2 members at the end of December.
Med drop has been expanded to the following providers and will be receiving referrals the end of September. The following providers are, Hegira, The Guidance Center, Development Center, Team Wellness, and All Well Being Service.

Med Drop System Outcome from October 1 through December 31st
79% reduction in the number of psychiatric hospital admissions for clients while participating in the Med Drop Program, compared to the number of psychiatric hospital admissions for the Med Drop clients in the 12 months prior to entering the Med Drop Program.

77% reduction in psychiatric hospital days for clients while participating in Med Drop Program, compared to the number of psychiatric hospital days used by the Med Drop clients in the 12 months prior to entering the Med Drop Program.

100% reduction in jail admissions for clients while participating in the Med Drop Program compared to the number of jail admissions for the Med Drop clients in the 12 months prior to entering the Med Drop

Program. The pre-admission program data is the client's self-report at the time of the program orientation sessions.

100% reduction in jail days for clients while participating in the Med Drop Program compared to the number of jail days for the Med Drop clients in the 12 months prior to entering the Med Drop Program. The pre-admission program data is the client's self-report at the time of the program orientation sessions.

Detroit Wayne Integrated Health Network

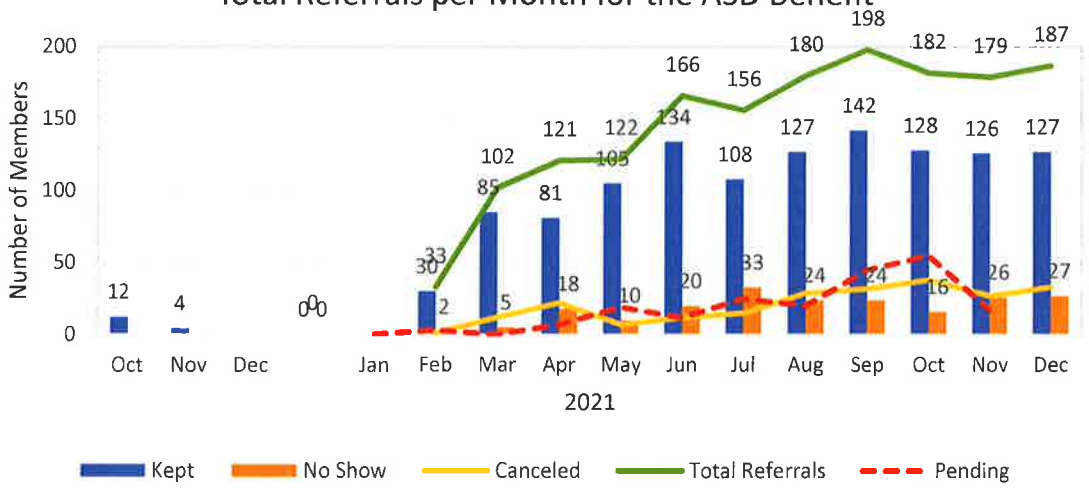
Autism Spectrum Disorder Benefit

1st Quarter Fiscal Year 2021/2022

This report will review the general metrics for the benefit and provide an overview of activities and opportunities addressed during the quarter.

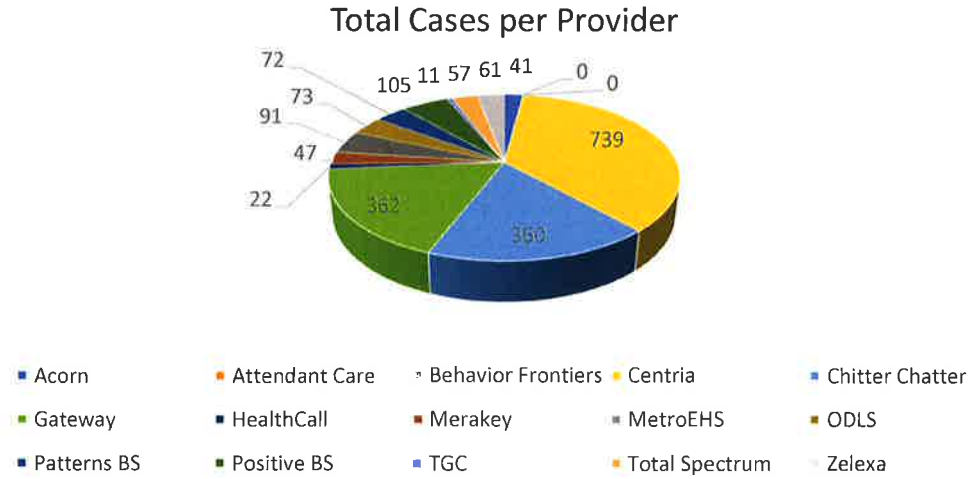
Referral Summary

Referral data for the first quarter shows an average of 127 diagnostic evaluations kept monthly



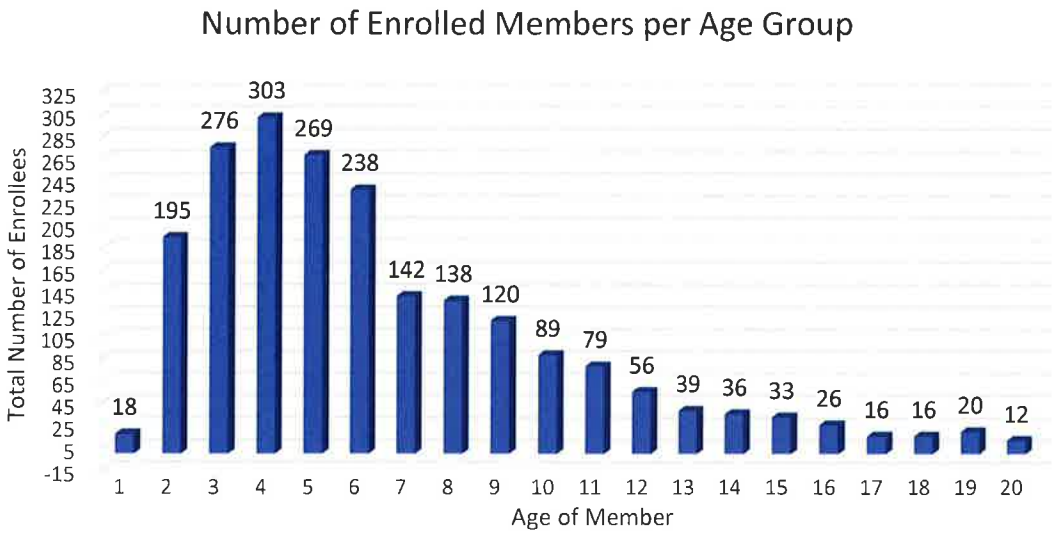
ABA Provider Network Summary

DWIHN ASD Benefit continues to grow each quarter. There are currently 2120 open cases receiving services with the largest concentration of members enrolled with Centria Healthcare and second largest tied between Chitter Chatter and Gateway Pediatric.



Member Summary

Research has shown that by addressing delays early on, especially between birth and 3 years of age, children have better outcomes. DWIHN's ASD Benefit provides early intervention services for infants and toddlers with the largest concentration of enrollees between the ages of 3 and 6 years.



Network Updates

- The awarded providers from the RFP focused on demographic need are providing services to the network.
- An additional Independent Evaluator was provisionally added to the DWIHN network to which significantly improved time from service request to diagnostic appointment from 4 weeks to within the week.
- Centria Healthcare relocated from 14328 Northline Road Southgate, MI 48195 to 22601 Allen Road Woodhaven, MI 48183. This new location will improve member access to the southern section of Wayne County which does not have any other ABA providers in network.

PROGRAM COMPLIANCE COMMITTEE MEETING
CUSTOMER SERVICE REPORT
1st QUARTER 2022
March 9, 2022

I. Customer Strategic Plan Pillar: 92% completion.

II. DWIHN Customer Service Unit Call Center Activity: Reception/Welcome Center/Switchboard (3,653^) Abandonment Rate (0.5%) and Customer Center Call Center (1,616) Abandonment (13.4%^) The Abandonment rate standard is (< 5%).

III. DWIHN Welcome Center (Reception Area) Walk-ins: Includes Customer Service, Family Support Subsidy, Recipient Rights and other. There were 14 Customer Service walk-ins reported for the first quarter of 2022.

IV. Family Support Subsidy Activity: Calls (1,452) Increase. Applications rec'd (227 decrease) Applications Submitted to State (270) Increase.

V. Grievances Activity: Number of Grievances filed (17^). Grievances by Categories involved: (26) top 4 areas: Delivery of Service, Interpersonal, Customer Service and Access to Staff.

VI. Appeals Activity: Advance Notices: (3,974) and Adequate Notices (809).

Local Appeals Activity Calls received: (103) increase.

Appeals Filed with Customer Service: (9^).

State Fair Hearings Request (0) decrease.

MI Health Link Appeals and State Fair Hearings (0).

VII. QI & Performance Monitoring Activity: Responded to HAP, Molina, AmeriHealth and Meridian Health ICO audits and POC's. Conducted Customer Service Orientations to new Access Center Staff. Updated Member materials i.e. Member Handbook. Conducted orientation and training to the two newly hired Customer Service Performance Monitors.

VIII. Member Engagement Activity: Coordinated monthly CV meetings. Conducted outreach activities and training on topics such as: Ambassadors, Financial Stability, Supported Decision-Making. Collaborated with the National Disability Institute to host a three-day financial stability roundtable regarding communities of color, people who are low-income, and those having disabilities. Continued to conduct a series of meetings with Clubhouse & Drop-in Centers regarding re-accreditation. Published Member Quarterly Newsletter "Person's Point of View".

XI. Member Experience Activity: Continued to work on various survey activity i.e. Peer Employment, National Core Indicator, Experience of Care and Health Outcomes Survey, and Provider Satisfaction

Submitted by: Michele Vasconcellos, Director, Customer Service 3/1/2022

Executive Summary

Integrated Health Care 1st Quarter Report 2021-2022

Program Compliance Committee meeting – March 9th, 2021

Collaboration with Health Department

The State of Michigan and the Health Department has identified Hepatitis C in the SUD population as a new focus and DWIHN will be collaborating on this.

Health Plan Pilots (3)

IHC staff continued to participate in integration meetings with Health Plan 1 and Health Plan 2 to further develop care coordination activities between DWIHN and the Medicaid Health Plans.

Regarding a shared electronic platform, DWIHN, Health Plan 1, and their Care Coordination provider continues to utilize the Care Coordination module offered by Vital Data Technology, LLC (VDT) as a shared electronic platform to assist in risk stratification of shared members, development of shared care plans, and documentation of care coordination activities. Files including data from DWIHN and Total Health Care were sent to VDT. Weekly Implementation Status meetings were initiated and continue to be held. The program went live on June 1st 2021 and 6 individuals have received joint care from DWIHN and Health Plan 1. Care Coordination is completed every two weeks on members. Health Plan 1 was bought by another Health Plan in October and DWIHN is in discussions on how this initiative can be expanded.

DWIHN and Health Plan 2 Care Coordinator and Manager staff continued to hold monthly care coordination meetings to review a sample of shared members who experienced a psychiatric admission during the previous month. The goal of the care coordination activities is to exchange information and address any identified gaps in care. Health Plan 2 has agreed to use the shared platform and are interested in having a further discussion on how this will aid in more proactive coordination of treatment.

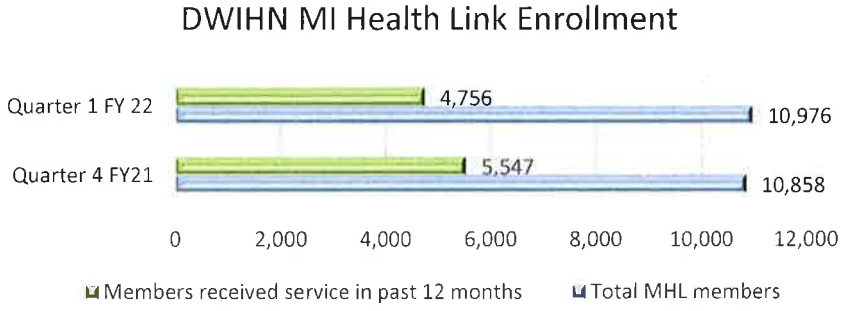
IHC staff was in communication with Health Plan 3 staff throughout the First Quarter and Health Plan 3 is reviewing the proposal for a joint pilot project internally. A meeting occurred between DWIHN and Health Plan 3 staff in March and Health Plan 3 has not decided on a joint project

Medicaid Health Plans

In line with the MDHHS/PIHP contract, IHC staff continues to perform Care Coordination Data Sharing on a monthly basis with each of the 8 Medicaid Health Plans (MHP) serving Wayne County for mutually served individuals who met risk stratification criteria, which includes multiple hospitalizations and Emergency Department visits for both physical and behavioral health, and multiple chronic physical health conditions. There were 146 cases reviewed during the quarter.

MI Health Link Demonstration

The number of DWIHN members who are enrolled in MI Health Link, and the number of those members who received a behavioral health service within the previous 12 months decreased from Quarter 4 FY21 to Quarter 1 FY22.



During this quarter, 68 Behavioral health care referrals were completed and submitted to the ICO, Care Coordination was provided to 146 MI Health Link members to support engagement in Behavioral Health services, and Transitions of Care coordination was provided for 146 MI Health Link members who were discharged from a psychiatric hospitalization during the quarter. IHC staff also completed LOCUS assessments for 47 MI Health Link members and participated in 8 Integrated Care Team meetings with the ICOs during the quarter.

Complex Case Management

IHC continues to offer and provide Complex Case Management services to DWIHN members as part of DWIHN's NCQA accreditation. There were 56 CCM active cases within the quarter. This is the largest number since the beginning of the program. Twelve (12) new Complex Case Management cases were opened during the quarter and 15 Complex Case Management cases were closed during the quarter. Of the 15 closed cases 8 of the cases were closed as a result of the members meeting their identified Plan of Care goals. Information regarding Complex Case Management was also sent to staff at 35 different provider organizations, including hospitals, clinically responsible service providers, and a residential provider. Care Coordination services were provided to an additional 50 members during the quarter who either declined or did not meet eligibility for CCM services. Going forward the Clinical Specialist will focus on educating provider organizations at the team level and at the Outpatient Provider Meeting monthly.

OBRA/PASRR

IHC continued the monitoring and oversight of DWIHN's provider of Omnibus Budget Reconciliation Act/Pre-Admission Screen Annual Resident Review (OBRA/PASRR) services. The average percentage rate of pended assessments during the first quarter is 18.6% which is much lower than the previous quarter of 32%. NSO has hired another supervisor to help with the oversight of staff and reading completed OBRA assessments for errors. NSO hired a consultant from the State of Michigan to assist in decreasing pends, which seems to be successful.

The provider's rate of congruence between their and MDHHS determinations of mental health services needs for members in the 1th quarter 95%. The provider completed PASRR screenings and reviews for 290 members in the first quarter which is a decrease from the last quarter of 316 members.

Detroit Wayne Integrated Health Network

Integrated Health Care Department

First Quarter Report FY 2022

Program Compliance Committee – March 9, 2022

Collaboration with Wayne County and Detroit Health Departments

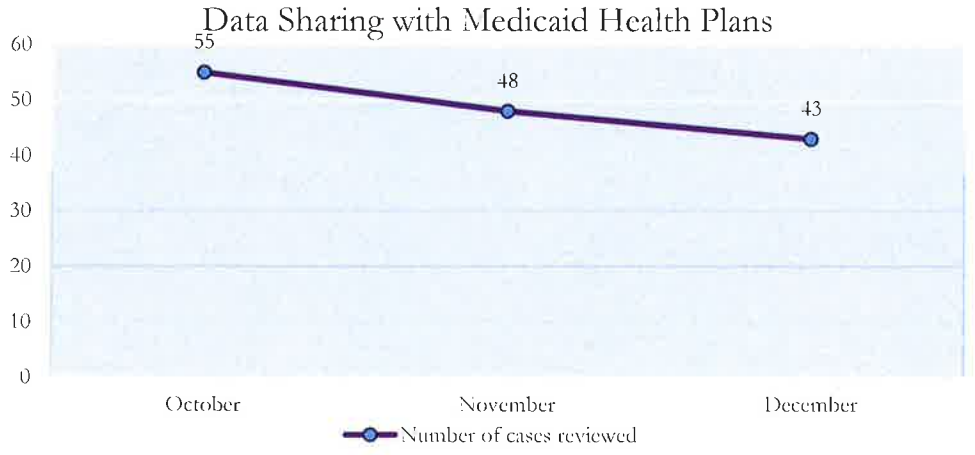
During the third quarter of FY 21 the State of Michigan and the Health Department announced their plan to promote testing and treatment within the SUD population for Hepatitis C. DWIHN is working with SUD providers on this initiative to increase Hepatitis C treatment and testing provided to members.

Community and Member Education

During this Quarter staff did not have any community educations

Care Coordination with Medicaid Health Plans

As part of DWIHN's implementation of the MDHHS Performance Metric to Implement Joint Care Management processes between the PIHP and Medicaid Health Plans, IHC staff continued to perform Care Coordination Data Sharing on a monthly basis with each of the 8 Medicaid Health Plans (MHP) serving Wayne County for mutually served individuals who met risk stratification criteria, which includes multiple hospitalizations and ED visits for both physical and behavioral health, and multiple chronic physical health conditions. Care Coordination data sharing involves developing and updating Joint Care Plans between DWIHN and the Medicaid Health Plans. IHC staff continued to collaborate with the Medicaid Health Plans regarding increasing the number of members reviewed during the meetings. The monthly average of cases reviewed during the first quarter of FY 22 was 48.



Integrated Health Pilot Projects

IHC staff continued to participate in integration meetings with Health Plan 1 and Health Plan 2 to further develop care coordination activities between DWIHN and the Medicaid Health Plans.

Regarding a shared electronic platform, DWIHN, Health Plan 1, and their Care Coordination provider continues to utilize the Care Coordination module offered by Vital Data Technology, LLC (VDT) as a shared electronic platform to assist in risk stratification of shared members, development of shared care plans, and documentation of care coordination activities. Files including data from DWIHN and Total Health Care were sent to VDT. Weekly Implementation Status meetings were initiated and continue to be held. The program went live on June 1st 2021 and 6 individuals have received joint care from DWIHN and Health Plan 1. Care Coordination is completed every two weeks on members. Health Plan 1 was bought by another Health Plan in October and DWIHN is in discussions on how this initiative can be expanded.

DWIHN and Health Plan 2 Care Coordinator and Manager staff continued to hold monthly care coordination meetings to review a sample of shared members who experienced a psychiatric admission during the previous month. The goal of the care coordination activities is to exchange information and address any identified gaps in care. Health Plan 2 has agreed to use the shared platform and are interested in having a further discussion on how this will aid in more proactive coordination of treatment.

IHC staff was in communication with Health Plan 3 staff throughout the First Quarter and Health Plan 3 is reviewing the proposal for a joint pilot project internally. A meeting occurred between DWIHN and Health Plan 3 staff in March and Health Plan 3 has not decided on a joint project.

Quality Improvement Plans

The IHC department continued to manage five Quality Improvement Plans (QIPs) that are in alignment with NCQA requirements. The focus of the QIPs includes the following: *7 and 30 day Follow Up After Hospitalization for Mental Illness, Adherence to Antipsychotics Medications for Individuals with Schizophrenia, Diabetes Screening for members prescribed atypical antipsychotic medications*, and *Hepatitis C testing and treatment.*

During this quarter all five QIP were presented to the IPLT meeting due to they will be restarted. DWIHN has had two different measuring tools for outcome tracking of these measures and the validity of outcomes cannot be compared. DWIHN will use the VDT HEDIS Scorecard moving forward to track outcomes.

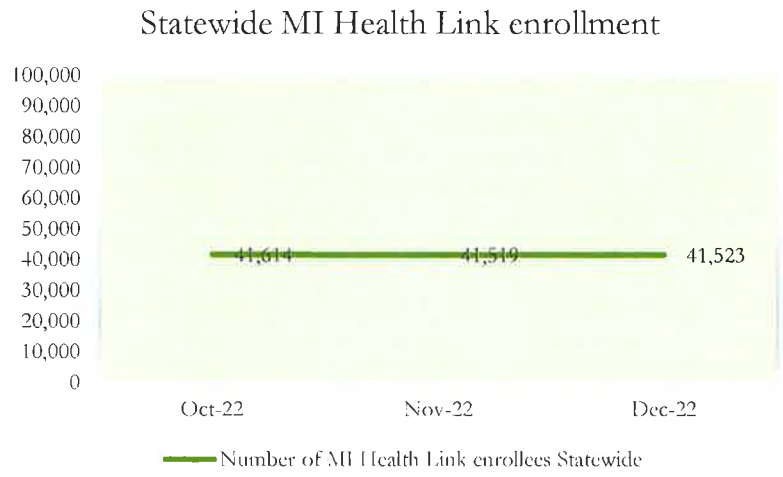
IHC staff continued collaborations with the Customer Services department regarding identifying barriers to members participating in their Follow-Up After Hospitalization appointments and the Quality Improvement department regarding monitoring CSRP providers performance on the measure. IHC staff met with Access Department to discuss better ways to engage Mi Health Link members into services. IHC staff also made outreach telephone calls to 184 members during the quarter to remind them of their follow-up after hospitalization appointment.

MI Health Link Demonstration

IHC staff continued to attend and participate in multiple meetings regarding the MI Health Link demonstration, including the following: monthly ICO/PIHO Joint Operations Meeting with MDHHS, monthly ICO/PIHP Systems Sub-Workgroup, monthly ICO/PIHP Quality Sub-Workgroup, monthly meetings with each ICO, and quarterly Member Advisory Group meeting with each ICO.

Statewide Enrollment

The total number of persons enrolled in the MI Health Link demonstration statewide has decreased since October-41,614 to 41,523 in December.



DWIHN Enrollment

10,976 persons with MI Health Link are currently enrolled with DWIHN. Of those persons, 4756 received services from DWIHN within the past 12 months. This is a decrease from the member of members enrolled in services and a decrease in number of members served as of last quarter. This is due to individuals choosing plans after the passive enrollment in the 4th quarter of 2021.

Disability Designations for Members with MI Health Link

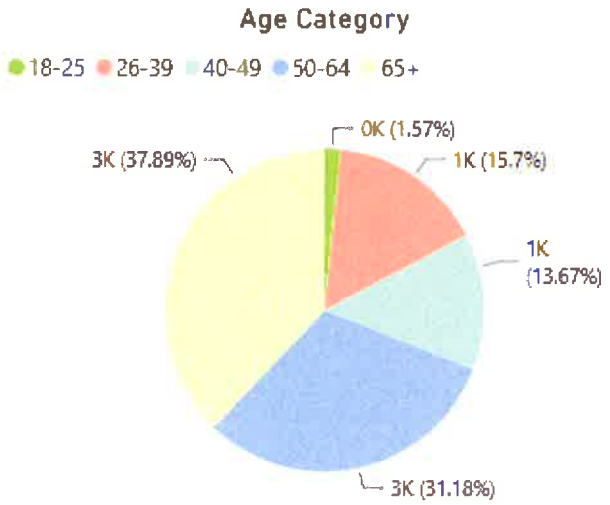
DWIHN provided services to 4756 MI Health Link members in the last 12 months. Approximately 80% of the members had a Mild to Moderate Mental Illness or Serious Mental Illness designation. 16.4% had an Intellectual/Developmental Disability. 284 active members with MI Health Link currently have a Mild to Moderate disability designation. 158 active members with MI Health Link currently have a SUD disability designation.

Co-Occurring Diagnosis

96.6% of MI Health Link members served in the last 12 months did not have Co-Occurring Mental Illness and Intellectual/Developmental Disability diagnosis. 20% of MI Health Link members had Co-Occurring Mental Illness or Intellectual/Developmental Disability diagnosis.

Age Category

Given that members must be eligible for both Medicaid and Medicare to enroll in MI Health Link, it is not unexpected that over 68.89% members are age 50 and above. 37.89% of MI Health Link members were within the age category of 65+ years. 31% of MI Health Link members served within the last 12 months were within the age category of 50-64 years. 14% of MI Health Link members were within the age category of 40-49 years. 15.7% of MI Health Link members were within the age category of 26-39 years. 1.57% of MI Health Link members were within the age category of 18-25 years.



Living Arrangement

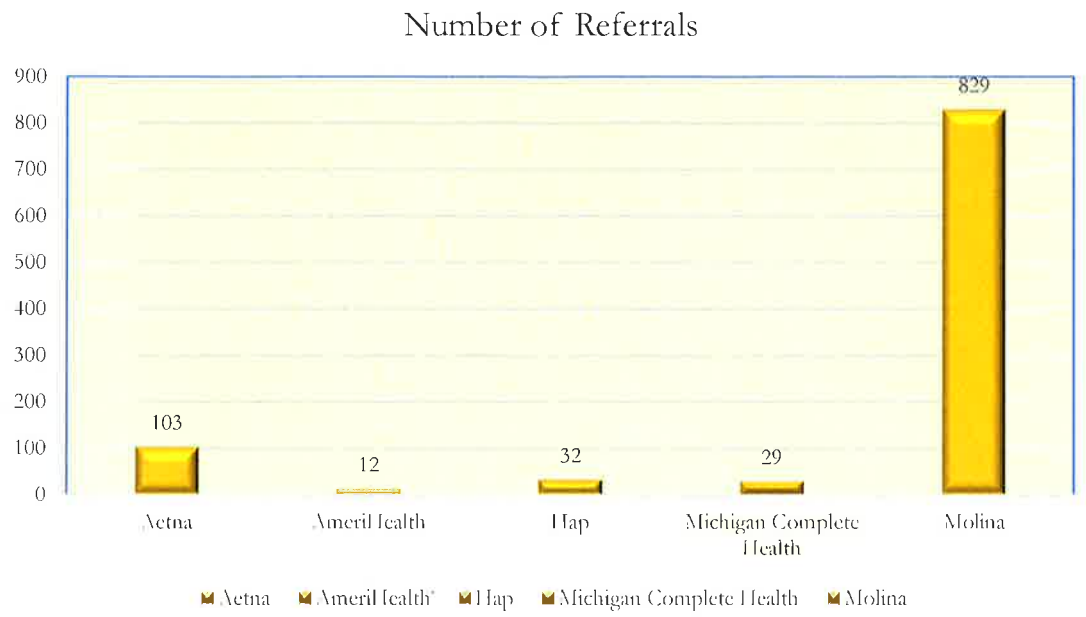
The majority of MI Health Link members served within the last four months reside in a Private Residence.

Habilitation Waiver

Currently, 28 MI Health Link members are enrolled in the Habilitation waiver, which is decrease from 47 members last quarter.

MI Health Link Referrals

DWIHN processed 973 referrals from the ICOs for behavioral health services during the last quarter. Of those referrals, behavioral health care was coordinated with the ICO for 146 of the members, 435 were voided and 470 were pended.



MI Health Link Care Coordination

DWIHN continues to send weekly and monthly reports to each of the five ICO's. The reports include information regarding *Critical Events*, *Member and Provider Grievances and Appeals*, *Transitions of Care*, *Referrals*, *Utilization Management*, and *Credentialing*. IHC staff performed Care Coordination for 74 MI Health Link members to support engagement in Behavioral Health services and provided Transitions of Care Coordination for 146 MI Health Link members who were discharged from a psychiatric hospitalization during the quarter. IHC staff completed LOCUS assessments for 117 MI Health Link members during the quarter. IHC staff also participated in 6 Integrated Care Team meetings with the ICOs during the quarter, regarding 5-10 members per meeting.

MI Health Link Audits

In the first quarter DWIHN went through multiple audits:

During the first quarter DWIHN received communication from ICO MCH Meridian who is requesting policy and procedure updates to be submitted in a delegation audit for CY 2021 by November 15, 2021. DWIHN submitted policies and procedures for review by ICO awaiting determination of audit.

IHC Department assisted Quality Department with submission of Delegation Audit tool and supporting documents to ICO Aetna for review during this report period.

ICO Amerihealth is still awaiting the BAA agreement being handled by DWIHN Legal Department.

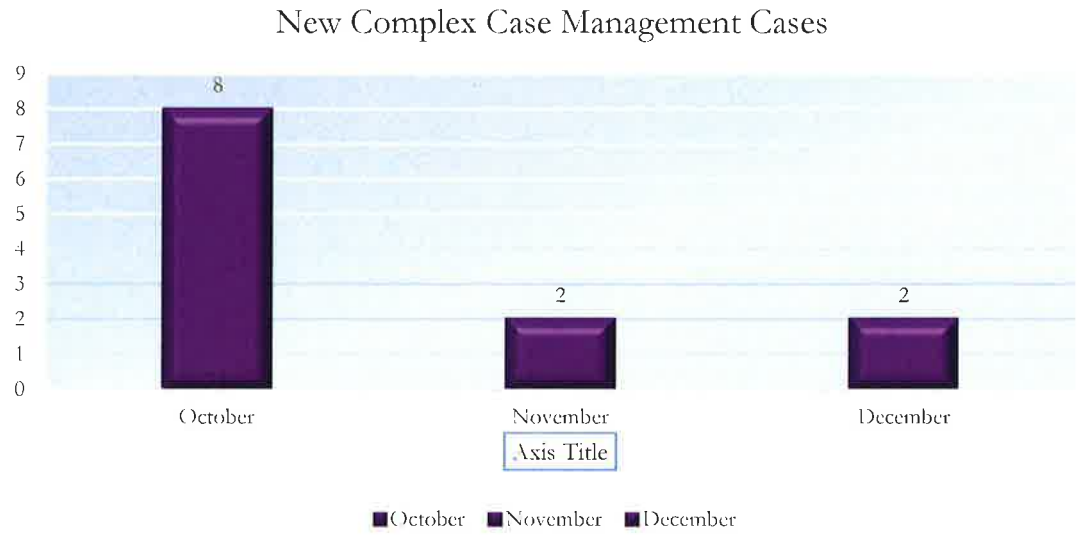
IHC department held several internal and external meeting for new processes for MHL State Hospital Inpatient operational process. This is a new process for DWIHN in which several departments are collaborating to complete processes to execute oversight from

Cost Settling with the ICOs

Medicare rules allow for claims for services to be submitted up to one year after a service is provided. Therefore, cost settlement is not able to begin until at least one year after the time period of the demonstration. DWIHN is not cost settling at this time with any ICO's.

Complex Case Management

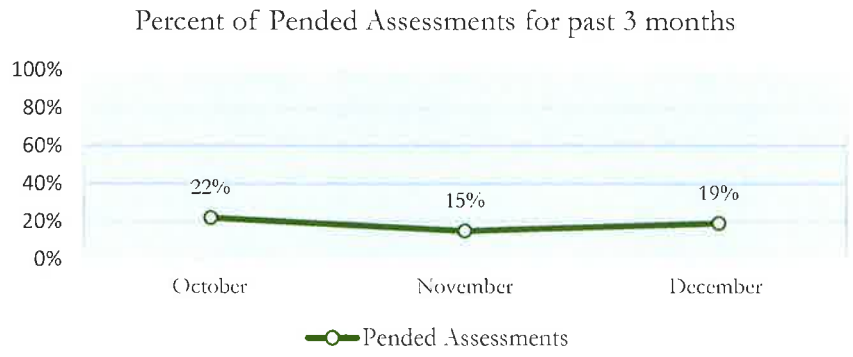
IHC continues to offer and provide Complex Case Management services to DWIHN members as part of DWIHN's NCQA accreditation. There were 56 CCM active cases within the quarter, this is the largest number since the beginning of the program. Twelve (12) new Complex Case Management cases were opened during the quarter and 15 Complex Case Management cases were closed during the quarter. Eight (8) cases were closed as a result of the members meeting their identified Plan of Care goals and six (6) members were unable to locate. Information regarding Complex Case Management services was offered to and declined by 50 additional individuals during the quarter. Information regarding Complex Case Management was also sent to staff at 35 different provider organizations, including hospitals, clinically responsible service providers, and a residential provider.



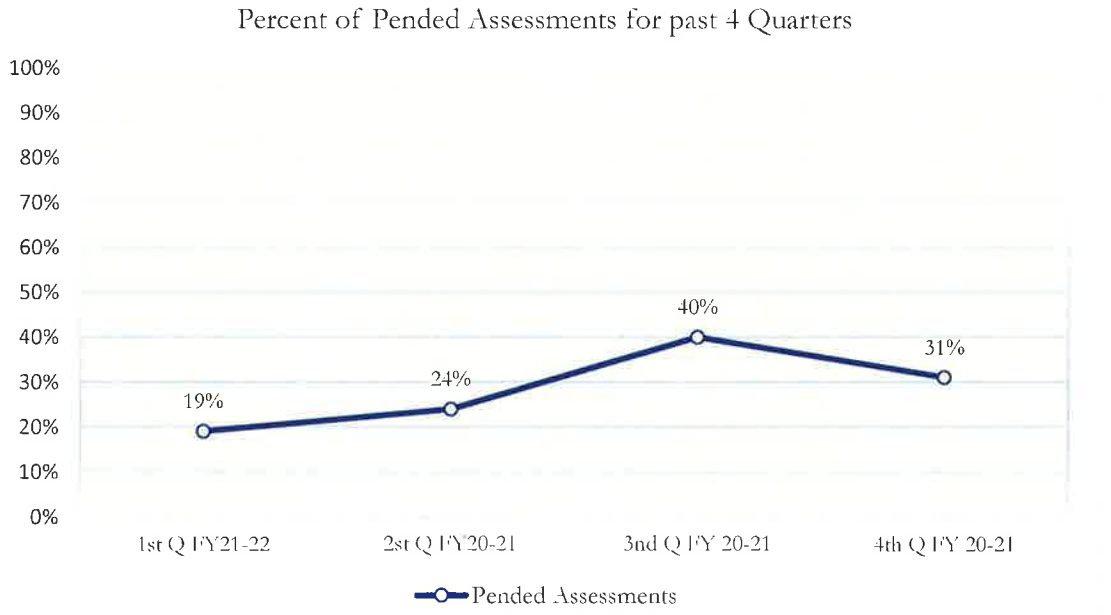
Omnibus Budget Reconciliation Act/Pre-Admission Screen Annual Resident Review (OBRA/PASRR) Services

The Clinical Specialist OBRA/PASRR continued to monitor the MDHHS OBRA/PASARR assessment que on an ongoing basis to review assessments that have been submitted by the OBRA/PASARR provider, Neighborhood Services Organization (NSO), to MDHHS. The Clinical Specialist also participated in the monthly meetings with NSO and quarterly meeting with MDHHS during the quarter.

The percentage of pended assessments decreased from the end of the previous quarter to this quarter, October (22%), November (15%) December (19%). DWIHN met with NSO to discuss how to prevent this from increasing. NSO has hired a consultant who used to work for the State of Michigan in the PASRR program to help with training on the OBRA assessment.



Overall, the average percentage of OBRA/PASARR assessments that were pended this quarter was lower than the three quarters.



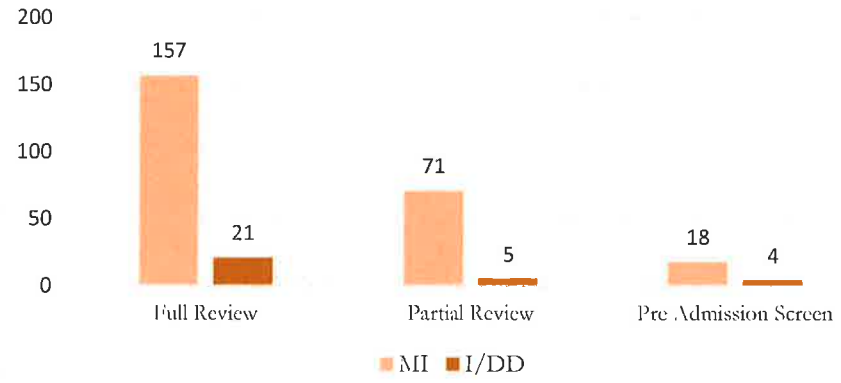
Thirteen members were placed out of an Extended Care Facility this quarter.

During the 1st quarter of the Fiscal Year, NSO's OBRA trainer conducted 86 trainings involving 138 staff. Training topics included PASARR process and information, Abuse/Neglect, Resident's Rights, Alzheimer's Disease, Eloping, Bereavement, Communication, Resident to Resident Altercations, and Behavioral Management.

The congruency was 95% for this quarter.

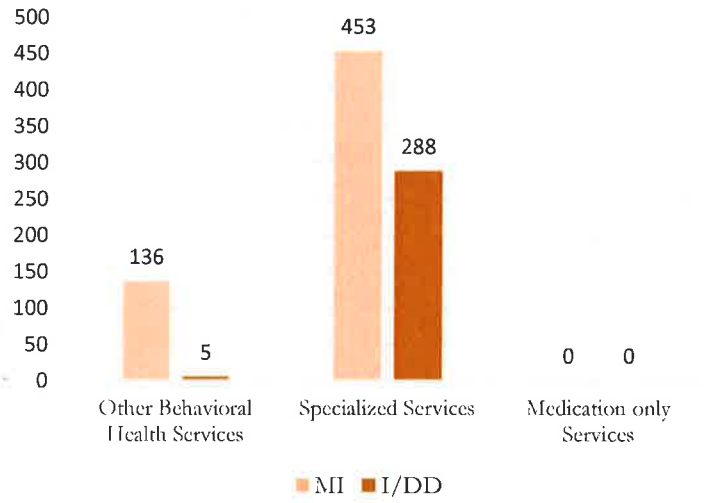
During the quarter, NSO completed screenings and reviews 290 members.

Completion of Screenings and Reviews for the 1th Quarter



Thus far this Fiscal Year, NSO has provided Clinical services to 982 members. See chart below for breakdown of services.

Individuals seen for Clinical services during this Fiscal Year



March 9, 2022

Strategic Plan – CUSTOMER PILLAR

Program Compliance Committee Status Report

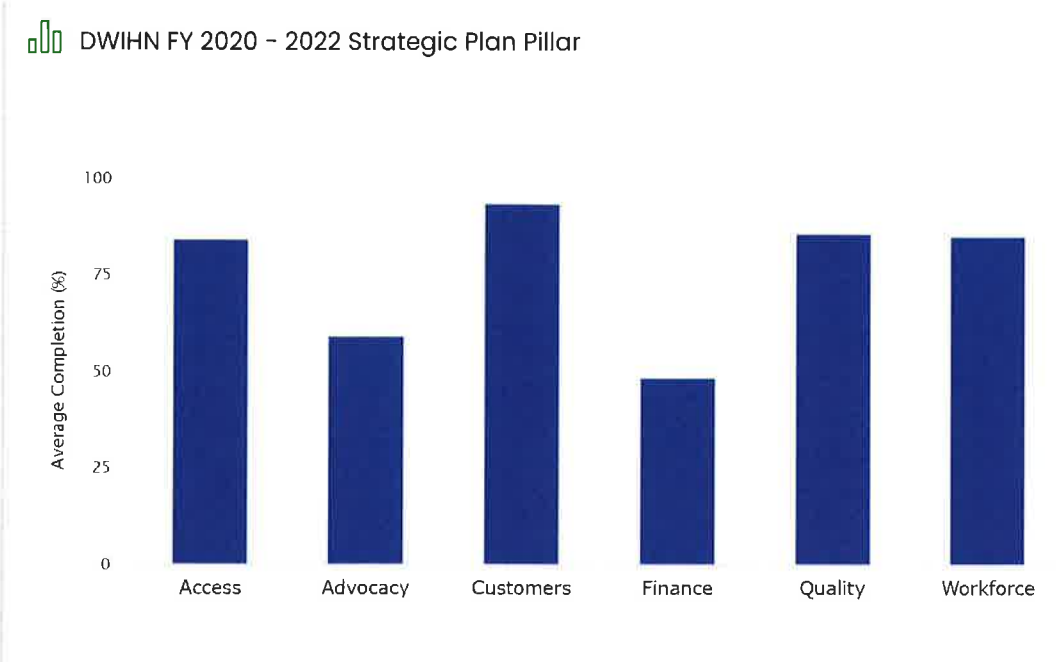
Table of Contents

To our board members:

Our commitment to social responsibility includes a dedication to transparency, collaboration and stakeholder engagement as a core component of our business and sustainability strategy, our monthly reporting process, and our activities within the county.

Our Strategic Planning Status Report is our report to our board members. It tells how we are performing against key indicators that measure our performance against the Access, Customer and Quality Pillars and impact in the areas that matter most to our stakeholders.

Pillar Dashboard Summary



There are three (3) pillars that are under the governance of the Program Compliance Committee: Access, Customer and Quality.

Summary of Pillar Status

Access Pillar is presented under the leadership of Jacquelyn Davis, Clinical Officer. Overall, we are at 84% completion on this pillar. There are four (4) goals under this pillar. They currently range from 75% - 98% completion.

Title	Completion
Create infrastructure to support a holistic care delivery system (full array) by 31st Dec 2022	**75%**
Create Integrated Continuum of Care for Youth by 30th Sep 2022	**86%**
Establish an effective crisis response system by 30th Sep 2022	**78%**
Implement Justice Involved Continuum of Care by 30th Sep 2022	**98%**

Quality Pillar is presented under the leadership of April Siebert, Director of Quality. Overall, we are at 86% completion on this pillar. There are four (4) organizational goals. They range from 70% to 100% completion for the high-level goals.

Title	Completion
Ensure consistent Quality by 30th Sep 2022	70%
Ensure the ability to share/access health information across systems to coordinate care by 31st Dec 2021	100%
Implement Holistic Care Model: 100% by 31st Dec 2021	94%
Improve population health outcomes by 30th Sep 2022	80%

Customer Pillar is presented under the leadership of Michele Vasconcellos, Director of Customer Service. Overall, we are at 94% completion on this pillar. There are three (3) goals under this pillar. They range from 85% - 100% completion.

Customers 94%

Title	Completion
Build infrastructure to support the implementation of Self Determined/PCP/Shared Decision Making: 100% by 1st Dec 2020	100%
Enhance the Provider experience by 30th Sep 2022	85%
Ensure Inclusion and Choice for members by 30th Sep 2021	97%
Improve person's experience of care and health outcomes by 30th Sep 2022	93%

A detail report of this pillar will follow.

Customer Pillar

Detailed Dashboard

Program Compliance Committee Meeting

March 9, 2022

CUSTOMER PILLAR 2 LEVEL GOALS

03/02/2022

14
GOALS

93%
GOAL COMPLETION

Draft | Not started | Behind | On Track | Nearly There | Overdue | Complete | → Direct Alignment | ⇢ Indirect Alignment

DWIHN FY 2020 - 2022 STRATEGIC PLAN PLAN

CUSTOMERS

Goal	Owner	Tracking T...	Task				Update	System U...	Current Co...
Enhance the Provider experience		Child Goal Average					**June White:** The provider/practitioner survey was distributed late September 2020. It was analyzed in January 2021. A full report was presented to PCC and QISC, there is room for improvement of the survey in which an Adhoc meeting was held in January 22 to discuss next step and ways to improve. *01/25/2021*	No activity recorded	**85%** **85.12 /** 1% ahead
→ **Ensure 80% Provider satisfaction: 100%**	June White | Director of Network Management	Child Goal Average	**Analyzed Survy Completed the review of the 2020 survey, identified areas of improvement, next steps discussed at meeting held on 1/22/2021**	Due: 01/01/2021	June White	☑	NEW **Allison Smith:** FY 2021 Provider Satisfaction Survey will be going out in September (Practitioner and Provider Organizations). *08/06/2021*	NEW **Allison Smith** on 08/06/2021: Progress: 0% ▶ **83.4%**	**82%** **82.35 / 100%** 21% behind

Goal	Owner	Tracking T...	Task	Update	System U...	Current Co...
→ **Improve level of support by conducting regularly scheduled system training across network: 100%**	Manny Singla | CNO/CIO	Manual Slider		**Manny Singla:** A new care coordination platform is going to be piloted with providers along with HEDIS quality measures to ensure we are providing care in a holistic fashion and using a outcomes and data driven approach *01/28/2021*	NEW **Nasr Doss** on 08/04/2021: Progress: 84% ▶ **85%**	**85%** **85 / 100%** 15% behind
→ **Provide tools and support to ensure providers have more meaningful experience: 100%**	Manny Singla | CNO/CIO	Manual Slider		NEW **Nasr Doss:** A lot of enhancements have been implemented to MHWIN to ensure providers have more meaningful experience, the disenrollment module is one of them that assist providers in following the re-engagement policy on a timely manner. 3 Pilot providers concluded a testing of the module and full implementation is scheduled for the month of Aug 2021. *08/04/2021*	NEW **Nasr Doss** on 08/04/2021: Progress: 85% ▶ **88%**	**88%** **88 / 100%** 12% behind
Ensure Inclusion and Choice for members	Lucinda Brown | Self Determination Network Provider Program Administrator	Child Goal Average		NEW **Brooke Blackwell:** Held a Town Hall Listening Session with State Representative Mary Whiteford to discuss her bill that would amend the Mental Health Code to create a Behavioral Health Oversight Council within the Michigan Department of Health and Human Services to advise in developing and executing public behavioral health policies, programs, and services. It would also authorize MDHHS to contract with an Administrative Services Organization (ASO), which would assume certain responsibilities from MDHHS and its designated community mental health entities. *10/29/2021*	**Allison Smith** on 02/04/2021: Progress: 100% ▶ **92.25%**	**97%** **96.5 /** 3% behind
→ **Build infrastructure to support the implementation of Self Determined/PCP/Sha Decision Making: 100%**	Lucinda Brown | Self Determination Network Provider Program Administrator	Manual Slider	**Conduct SD trainings to external groups** Due: 11/30/2020 **Contact Guidance Center** **Team Wellness** **STEP** **Postponed**	☑ **Lucinda Brown:** DWIHN has completed the infrastructure to support anyone who receives services to Self-Direct their services. *01/25/2021*	**Lucinda Brown** on 01/25/2021: ✓ Completed Task **Get on agenda**	**100%** **100 / 100%**

Sign Agreements electronically in MHWIN **Have agreements in a signable format in MHWIN** **-This area is not a priority. Written agreements are complete for people to sign externally.**	Due: 08/31/2020	-	☑
Letters to Guardians/Staffing Agents/ Network **Letters were sent to Eric and Stacie for review on 5/28**	Due: 05/29/2020	Self Determination Provider Network Administrator (Unappointed)	☑
Update the SD Policy	Due: 11/30/2019	-	☑
Develop a SD brochure for marketing **Talk to Communications Dept to develop**	Due: 09/30/2019	-	☑
Detail the procedure **Develop, get approved by Dana and Eric, test with CV**	Due: 09/30/2019	-	☑
Conduct SD trainings to external groups **Contact MORC, AWB, & Lincoln Behav**	Due: 08/31/2019	-	☑
Develop stadardized agreements **Develop, get approved by Dana and Eric, test with CV**	Due: 08/31/2019	-	☑
Get List of Support Coordination Agencies for future trainings **CRSP list was developed**	Due: 08/31/2019	-	☑
Develop a Powerpoint for training **Develop to train individuals**	Due: 08/31/2019	-	☑
Set up training for CRSP who have people transitionaing to DWIHN	-	-	☑
Implement changes recommended by CV	-	-	☑
Meet with CV to get feedback on documents	-	-	☑
Meet with Kim regarding Choice Voucher	-	-	☑
Identify department staff needed **Develop needs analysis report**	-	-	☑
Develop process of payment procedures **Develop process if there are payment/claims issues, Need initial info form for FI for new ppl**	-	Self Determination Provider Network Administrator (Unappointed)	☑
Get on agenda to present to SD Workgroup	-	-	☑
Get on agenda to present to Constituent Voices	-	-	☑

to present to internal departments

Current Co...

			Get on agenda to present to internal departments **-MCO** **-Quality** **-Residential** **-Customer Service** **-UM** **-CM**	-	-	☑	
			Originally started but postponed **Complete a simple visual for people who receive services for SD** **Individual who receives services stated something visual that breaks the steps down would be helpful due to limited ability to long read words.**	-	-	☑	
			Meet with Fiscals, have PAS share EVV	-	-	☑	
→ **Develop components to support the Self Determination by enabling individualized budget, agreements in the MHWIN system along with standardized IPOS: 100%**	Lucinda Brown | Self Determination Network Provider Program Administrator	Manual Slider				**Lucinda Brown:** The individual budget is now available in production mode within MHWIN. *01/25/2021*	**Lucinda Brown** on 01/25/2021: Progress: 95% ▶ **100%**
→ **Increase the competencies around Self Determination, Shared Decision Making and Person Centered Planning: 100%**	Andrea Smith | Director of Workforce Development	Manual Slider				**NEW Lucinda Brown:** Beginning June 23, 2021, the Self-Determination Team holds weekly Welcome Sessions every Wednesday to provide education, information, and answer any questions regarding Self-Directing Services. MDHHS will be offering a Self-Determination Conference next month which will be shared with our provider network. *07/28/2021*	**NEW Lucinda Brown** on 07/28/2021: Progress: 69% ▶ **86%**
→ **Offer Self-Determination and Self-Directed Arrangements across all populations served.: 100%**	Lucinda Brown | Self Determination Network Provider Program Administrator	Manual Slider				**Lucinda Brown:** The final component (budgets) for self-directing services was completed this past quarter in MHWIN. DWIHN now has the infrastructure to assist any member to Self-Direct their services. *01/25/2021*	**Lucinda Brown** on 01/25/2021: Progress: 90% ▶ **100%**

Current Co...

100%
100 / 100%
-

86%
86 / 100%
14% behind

100%
100 / 100%
-

Goal	Owner	Tracking T...	Task				Update	System U...	Current Co...
Improve person's experience of care and health outcomes		Child Goal Average						**Allison Smith** on 02/18/2021: Progress: 90% ▶ **64.42%**	93% 92.5 / 6.34k% behind
→ **Deliver information about Provider SItes and Practitioners in appropriate formats: 100%**	Michele Vasconcellos | Director of Customer Service	Manual Slider					NEW **Donna Coulter:** More than 130 Provider Satisfaction Surveys were collected. *10/18/2021*	NEW **Manny Singla** on 06/18/2021: Progress: 90% ▶ **100%**	100% 100 / 100% -
→ **Ensure 80% member satisfaction: 100%**	Michele Vasconcellos | Director of Customer Service	Child Goal Average					NEW **Donna Coulter:** Member Experience team continues to coordinate the annual ECHO Survey with WSU. Children's Survey members have exceeded more than 300 responses, through mail and telephone calls. The Adult Survey surveys were also administered during this period. *10/18/2021*	**Allison Smith** on 02/05/2021: Progress: 25% ▶ **100%**	100% 100 / 100% -
→ **Ensure Access to Recipient Rights**	Polly McCalister | Director of Recipient Rights	Child Goal Average	**Determine number of children served Magnolia Scott if possible will locate data on children served and report**	Due: 06/10/2022	Polly McCalister	☐		**Allison Smith** on 02/04/2021: Progress: 100% ▶ **46.5%**	100% 100 / -
→ **Ensure individuals are placed in the least restrictive environment**	Dan West | Director of Crisis Services	Child Goal Average					NEW **Jacquelyn Davis:** DWIHN has added 12 Diversion beds to the network and there are 2 pending. The Residential Unit has secured 18 Out of home Respite beds for Adults. *08/05/2021*	**Allison Smith** on 02/03/2021: Progress: 0% ▶ **36.11%**	70% 70 / 5% behind

Mental Health Care-

"Putting Children First"

Overview

- The Detroit Wayne Integrated Health Network continues to focus on putting children first and ensuring that the community knows DWIHN offers a comprehensive System of Care for children, families and parents.

Specialty Populations

With "Putting Children First," there will be more focus on special populations:

- Children ages 0 to 6
- Young adults transitioning into adulthood – ages 18 to 21
- Foster Care
- Juvenile Justice
- Pediatric Integrated Health Care
- Schools
- Diversity / Inclusion / Equity

Goals

1. ACCESS
2. PREVENTION
3. CRISIS INTERVENTION
4. TREATMENT

Goal #1: Access

Increase access to services for children and youth

Branding

- Updating the Children's Initiative website / resources / flyers
- Revamping the children CONNECTIONS logo
- Training departments on children services
- Utilizing social media platforms

Outreach

- Gathering feedback and ideas from the community
- Facilitating Town Halls, Conferences, Workshops

Census

- Develop reports to track the current census and trends of members

Screening

- Streamlining the screening process for children ages 0 to 6, ages 17 to 21, foster care
- Access screenings trained on the CAFAS

(objective tool to determine eligibility for services)

Goal #2: Prevention

Provide early prevention opportunities for children and youth

Pediatric Health Care

- Gathering a list of Pediatricians within Wayne County to partner with and train on CMH services
- Creating a Pediatric Health Care Work Group
- Focus on various screenings (Ex: depression, ADHD, Autism)
- More collaboration with the MC3 project

Technology

- Explore opportunities to connect children with technology (Ex: STEM kits)

Schools

- Outreach to train schools on children mental health needs

Tri-County Initiative

- Partnership with Macomb and Oakland Counties to offer resources to the community

(Ex: Universal school safety trainings, Town halls, Conferences)

Goal #3: Crisis Intervention

Ensure crisis services are available to children when needed

Care Center

- Development of the Care Center at the Milwaukee building to provide Crisis Assessments

Expansion of Crisis Services

- Hospital Liaisons to focus on children in Emergency Departments and track length of stay
- Partnership with Juvenile Justice departments with the county jail and Wayne State University to support mental health needs

Crisis Training

- Create a children crisis flyer
- Train the community, clinical professionals, and families on crisis prevention and intervention techniques

Goal #4: Treatment

Provide quality services to children and youth

Expansion of Services

- Partner with children providers to gather a list of all children services and resources available to the community

Quality of Services

- Track the utilization of children services and evidenced based practices to identify trends and measure outcomes
- Track improvement of HEDIS measures for children receiving ADHD and Antipsychotic medications

Workforce

- Tracking trends of capacity shortages for clinical staff
- Partner with children providers to assist with advocacy efforts to improve the availability of clinical staff
- Partner with children providers to offer specific trainings relating to self care, secondary traumatic stress, and burnout.

Partnerships

DWIHN Departments:

- Access, Autism, Children's Initiative, Communications, Crisis, Clinical Practice Improvement, Customer Service, Executive Leadership, Faith Based Initiative, Integrated Health, IT, Quality, Substance Use, Utilization Management, Workforce Development

New Partnerships:

- Detroit Institute for Children – Special Needs Conference (April 2022)

Pending Partnerships:

- Motor City STEAM – Stem Kits
- Detroit CHEMprenuerist
- Detroit Police Department (Sex Crimes Unit) – "I'm Telling Campaign"

Questions

Thank You

CHIEF CLINICAL OFFICER EXECUTIVE SUMMARY
PROGRAM COMPLIANCE COMMITTEE
March 9, 2022

COVID-19 RESPONSE PLAN:

DWIHN's 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	COVID-19 Positive
December 2021	617	32
January 2022	468	19
February 2022	579	3

Inpatient Hospital Admission Authorization data as of 2/1/2022.

COVID-19 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.

Crisis Stabilization Service Provider	Services	February 2022- # Served
Community Outreach for Psychiatric Emergencies (COPE)	Intensive Crisis Stabilization Services (MDHHS Approved)	205 (9% increase)
Team Wellness Center (TWC)	Intensive Crisis Stabilization Services (MDHHS Approved)	181 (3% increase)

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.

Provider	# Served- February 2022
Quality Behavioral Health (QBH)	0 (7)
Detroit Rescue Mission Ministries (DRMM)	4 (6)
Abundant	1 (6)

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).

CHIEF CLINICAL OFFICER EXECUTIVE SUMMARY
PROGRAM COMPLIANCE COMMITTEE
March 9, 2022

Provider	Services	# Beds	February 2022- # Served
Detroit Family Homes	Licensed Residential Home- Adults	4	4 (6)
Kinloch	Licensed Residential Home- Adults	3	0 (4)
Detroit Family Home- Boston	Licensed Residential Home- Adults	6	0 (4)

RESIDENTIAL DEPARTMENT- COVID-19 Impact:

	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022 (Oct 1, 2021- current)	Feb. 2022
Total # Covid-19- Members	169	76	99	**4 (Jan-60)**
Related Deaths	*34*	*7*	*3*	***1 (2-Jan)***
Total# Covid-19 Staff	71	59	58	**1**
Related Deaths	*3*	*0*	*1*	***0***

VACCINATIONS- RESIDENTIAL MEMBERS:

	# of Members Fully Vaccinated	Vaccine Booster Jan. 2022	Vaccine Booster Feb. 2022
Licensed			
City of Detroit	649 (88.7%)	113 (17.4%)	**221 (34%)**
Western Wayne	1,243 (91.3%)	496 (39.9%)	**502 (40.3%)**
Unlicensed			
City of Detroit	93 (61.1%)	51 (54.8%)	**92 (98.9%)**
Western Wayne	678 (68.2%)	79 (11.6%)	**456 (67.2%)**

*The was no change in the rate of vaccinations in February 2022.

COVID-19 MICHIGAN DATA:

Michigan COVID-19 Cases: March 2, 2022 update: The total number of confirmed COVID-19 cases in Michigan is 2,058,856 with 32,050 confirmed deaths. Wayne County reported 245,725 confirmed Covid cases and 3,928 deaths. The City of Detroit reported 122,340 confirmed Covid-19 cases with 3,224 deaths. (Source: www.michigan.gov/Coronavirus)

Michigan COVID-19 Vaccination Updates:

Area	First dose- Initiation	Fully Vaccinated
State of Michigan	66.1%	59.8%
Wayne County	73.6%	67%
City of Detroit	48.7%	40.9%

Health Home Initiatives:

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

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

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

Substance Use Services (SUD):

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

Women's Pregnant and Post-Partum Pilot Program: DWIHN recently received additional funding to provide integrated services that support family-based services for pregnant and postpartum women (and their minor children) with a primary diagnosis of SUD, including Opioid Use disorders. This includes outreach, screening & assessment, Peer Recovery supports, case management, and evidence-based practices. DWIHN is currently working with two identified providers on implementation of this program.

CHIEF CLINICAL OFFICER'S REPORT
Program Compliance Committee Meeting
Wednesday, March 9, 2022

CHILDREN'S INITIATIVES – Director, Cassandra Phipps

February 2022

Pillar 1 Clinical Services & Consultation	**Pillar 2** Stability & Sustainability	**Pillar 3** Outreach & Engagement	**Pillar 4** Collaboration & Partnership

Mental Health Care: Putting Children First

President and CEO, Eric Doeh presented the vision for the new initiative Mental Health Care: Putting Children First. Children's Initiative Department (CID) assisted with developing a work group to gain feedback on ideas and action steps. The initial planning meeting was held 2/16/2022 with participation from various departments. As a result, 4 goals were established to focus on special populations pertaining to children.

GOALS	SPECIALTY POPULATION
Goal 1: Access • Branding / Outreach / Census / Screenings **Goal 2: Prevention** • Pediatric Care / Technology / Schools / Tri County **Goal 3: Crisis Intervention** • Care Center / Expansion of Crisis Services / Crisis Training **Goal 4: Treatment** • Expansion of Services / Quality of Services / Workforce	• Kids age 0 to 6 • Young Adults transitioning to adulthood age 17 to 21 • Juvenile Justice • Foster Care • Pediatric Integrated Health Care • Schools • Cultural Competency: Refugees / Other ethnicities / LGBTQ

School Success Initiative (SSI)

Provider Meetings: Monthly Provider meeting was held this month on 2/10/2022. Executive Officer Ramona Robertson from Child's Hope presented on Prevention of Abuse / Neglect campaign for April 2022. Discussed the benefit of creating a universal school safety training to train schools on how to identify risks and warning signs of homicidally and suicidality as well as interventions. **Michigan Model of Health (MMH):** SSI Therapists attended the MMH training in Feb 2022 via Wayne RESA for the Pre-K model. **MHWIN/Redcap:** Met internally to discuss updates to Redcap to include the Risk Factors, Evidenced Based Practices, and other features to improve data collection for SSI program. Plan to make the updates 3/4/2022. All of the updates in MHWIN has been finalized for Tier 3 referrals. **Electronic SDQ:** Discussed updating the current SDQ Form into a typable PDF that would be more efficient and user friendly for students, parents, and teachers to complete. **SSI Handbook:** Presented to SSI Providers to review and provide feedback for the next meeting. **Behavioral Health Learning Collaborative (BHLC):** Meeting was held 2/9/2022 and discussed initiative to integrate behavioral health into schools, school safety response plans.

Other Initiatives

Access Department: Children's Initiative Department is partnering with Access Department to streamline the screening process for children in foster care, children ages 0 to 6 in the Infant Mental Health (IMH) program, and young adults ages 18 to 21.

Improvement Practice Leadership Team (IPLT): SOGIE: CID presented a proposal to IPLT to incorporate SOGIE language (Sexual Orientation Gender Identity Expression) into the biopsychosocial assessment and screenings. Next steps are to collaborate with Ruth Ellis to gather data on outcomes of SOGIE language, fidelity of SOGIE, and provide a list of training opportunities of how to consider SOGIE language when working with members for services. **HEDIS:** CID presented to IPLT a performance improvement plan for the NCQA requirements for ADHD medications and antipsychotic medications. The goal is for 50% of members to see a primary care doctor within 30 days of receiving ADHD medication and continually as needed. In addition, the goal is for 50% of members to see a primary care doctor for children ages 1 to 11 and 12 to 17 receiving antipsychotic medications. **Waiver Services:** CID is coordinating with Contracts Department to identify providers to provide ancillary services for members receiving SED Waiver and Children's Waiver services.

Outreach

I Am a Priority: On 2/8/2022 Children's Initiative Director explained Children Services to non-profit I Am a Priority who is starting a mentoring program for teenage girls. Youth United (YU): Partnered with Development Center for canned food drive for Black History month. **What's Coming Up Video:** Children's Initiative Director participated with DWIHN Customer Service Department and Constituent's Voice to create a brief video explaining children services and suicide prevention, https://www.youtube.com/watch?v=0JW6nMIlviE. **Navigating Community Mental Health Training:** CID trained almost 150 various professionals on the process to access mental health services. **Detroit Institute for Children:** CID and Communications Department met with agency regarding the request for DWIHN to participate in the Special Needs Conference in April 2022. As a result, Children's Initiative Director will present on accessing CMH services and participate during the panel discussion.

Collaboratives

System of Care: Cross System Management (CSM): Meeting was held this month. Presented the Spotlight Awards to recipients. Discussed SPA 1915, the new MDHHS process for B3 services. Addressed progress and barriers with the Pediatric Integrated Health Care work group. Decision to restart the workgroup with the focus of outreach, educating about referral process for CMH services, and addressing HEDIS measures. Also discussed how providers are handling requests from schools to provide return to school letters. **Children System of Transformation (CST):** Meeting was held this month and discussed the change of the new DWIHN children initiative "Putting Children First", progress and barriers with capacity concerns among providers, school safety letters requests from schools, utilization of case management services. SPA 1915, the new MDHHS process for B3 services.

Trainings: Peer to Peer Clinical Training: "Talk, Protect and Report". It will be was an evidence-informed training for individuals to become strong and effective advocates to protect children, including information on how to talk about sexual health with children and one another, how to protect children from abuse and how to report abuse and suspicious behavior. **Access Department Training on CAFAS:** Access Department was trained on how to administer CAFAS to determine eligibility for CMH services during screenings. Plan to incorporate the CAFAS into MHWIN. **PECFAS Booster Training** (12 attendees), **CAFAS Booster Training** (9 attendees). Children's Initiative

Director attended the following trainings this month: MDHHS Annual Winter Conference: Putting People First, Strengthening Families, Behavioral Threat Assessment and Management Training (BTAM), and Bridging the Gap for youth and young adults.

CLINICAL PRACTICE IMPROVEMENT – Clinical Officer, Ebony Reynolds

Evidence Based Supported Employment Clinical Specialist Feb 2022 Activity
For the month of Feb some of DWIHN-EBSE providers continue to deliver services remotely due to the pandemic and in-person if so desired by members served or the employer. However, some are utilizing a hybrid approach to service delivery. Member employment success stories were provided to DWIHN's communication department to share with the community highlighting the recovery journey of member's served and the significance of employment in supporting their journey. Also, MDHHS, Michigan Rehabilitation Services (MRS) and Bureau of Services for Blind Persons (BSBP) are meeting with PIHPs and/or CMHPs to increase collaboration as well as improve the quality of our supported employment outcomes.

Assertive Community Treatment (ACT)
Monitored ACT admissions and dis-enrollments reported by Hegira and Team Wellness Center to ensure appropriate guidelines are met when updating member clinical record in MHWIN.

CPI Policy/Procedure Review
Continued to review and provide updates to the Assessment Policy, Integrated Biopsychosocial Procedure and Conflict-Free Case Management Policy to ensure NCQA quality indicators and HSAG review recommendations are addressed.

CRSP IPOS Audit/ Hospital Recidivism Report Review
Continued to assist with review of standardized IPOS to ensure CRSPs alignment with DWIHN's standardized IPOS core elements and that HSAG's review recommendations are addressed in DWIHN's IPOS audit tool. In addition, improvement plans from CRSPs were reviewed to ensure a plan is initiated to manage members who were identified as having multiple hospital admissions within 30 days for psychiatric care as well as strategies developed to assist CRSPs with the elimination/reduction of incidents of member multiple inpatient readmissions for psychiatric care.

Project - WC Jail - IST - Probate Court - Returning Citizens Clinical Specialist Feb 2022 Activity

- From January 29 February 25 there was 99 releases from the jail. Of the 99, 43 were linked to the assigned provider; were placed in other correctional facilities or hospitalization; some were not eligible for CMH services and not entered in MHWIN.

Project - Jail Diversion/ ACT Reviews/AOT Orders

- From January - February there was 51 AOT orders. Of the 51, 8 were on a continuing hospitalization order; 6 were ineligible and not entered into MHWIN; 10 were linked to the Access Center for a provider assignment; and 27 had the provider notified of the order.
- From January 28 – February 25 there were 7 returning citizens.

Assertive Community Treatment/ Med Drop Clinical Specialist Feb 2022 Activity
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.

During the month of February, CPI manager met with Genoa Health and Team Wellness on ways to start implementation of Med Drop. Expansion to members with AOT orders was included in the discussion along with the discussion of having medical teams present Med Drop during medical appointments.

For the month of February CPI manager participated in procedure code work group meeting, where the updated modifiers and codes were discussed. Readmission IBPS follow up and training discussion, participated in OIC meeting, standardized IPOS where topics discussed are HSAG HCBS standard elements and HSAG compliance cap review (Standard vs coordination and continuity of care).

CPI manager also participated in the IBPS rollout training, finalization of IPOS plan for PCE, abbreviated IBPS readmission training, and combining hospital recidivism smartsheet in the month of February.

CPI manager met with Med Drop for a monthly follow up meeting, where it was noted that there are 34 Current Active Clients CCS-13, LBS-15, NIH-3, DCI-3 as of January 4, 2022. For February 2022 there were 36 Current Active Clients CCS-13, LBS-15, CNS-3, DCI-4, AWBS-1.

Also, for the month of February the CPI manager attended the COPE follow up meetings facilitated by COPE and the DWIHN Crisis department.

Other activities completed by the CPI manager include:

- Participated in cascade updates with internal staff.
- Participated in OIC internal meeting.
- Participated in COPE BIWEEKLY follow up meetings.
- Participated in Med drop Expansion meeting (internal)
- Facilitated monthly meetings with Genoa Health coordinator.
- Facilitated a follow up monthly meeting with all pilot program providers for Med Drop, which are Community Care Services, Lincoln Behavior Services, Northeast Integrated Health network/CNS, Hegira, Team Wellness and Development Centers. Topics discussed were ways to increase admissions rates, talking points, AOT population and recommendations for providers with regards to presenting the program to members.

CRISIS SERVICES – Director, Daniel West

Below is the monthly data for the Crisis Services Department for February, 2022 for adults and children.

CHILDREN'S CRISIS SERVICES

Month	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	Crisis Stab Cases
January	309	267	60	19%	235	76%	133
February	257	234	64	25%	182	71%	102

- Requests for Service (RFS) for children increased by 17% compared to January. The diversion rate decreased slightly from the month of January.
- There were 102 133 intensive crisis stabilization service (ICSS) cases for the month of February, a 30% decrease from January. Of the 102 cases there were 35 initial screenings.
- There was a total of 41 cases served by The Children's Center Crisis Care Center in February, 11 cases more than last month. On 2/7, there was a reported water main break causing remote work, and walk-ins resumed 2/8.

COPE

Month	RFS	Unique consumer	Inpatient admits	% Admitted	# Diverted	% Diverted	# Inpt due to no CRU
January	912	835	595	65%	296	32%	4
February	907	853	591	65%	292	32%	4

- The number of requests for service (RFS) for adults remained similar to January, decreasing slightly from 912 to 907. The number of diversions remained the same at 32%.
- The Crisis Stabilization Unit (CSU) at COPE served 205 cases in this month, a 10% increase from January at 185.
- The Mobile Crisis Stabilization Team provided services to 88 members in January, down from 93 in January.

CRISIS RESIDENTIAL/HEGIRA

- The number of available beds is 16.

Referral Source	Total Referrals	Accepted Referrals	Denials
ACT	0	0	Level of Care change – 4 Not medically stable due to SUD – 0 Not medically stable due to physical health – 1 Violent/aggressive behavior – 0 Immediate danger to self – 0 No follow-up from SW/Hospital – 2 Member choice-1 CRU bed unavailable-1 Total - 9
COPE	32	29	
DWIHN Res.	4	4	
Step Down (Inpatient)	18	12	
Total	54	45	

CRISIS CONTINUUM

- For the month of January, Team Wellness Crisis Stabilization Unit (CSU) provided services to 186 individuals, a slight increase from the month of January.

PROTOCALL

Month/Year	# Incoming Calls	# Calls Answered	% answer w/in 30 secs	Avg. Speed of answer	Abandonment rate
January	828	719	51.9%	85s	11.9

- Call data for the month of February was not available for this month's report.
- Protocall continues to struggle with staffing concerns, and are currently training several staff in an attempt to address performance issues. Protocall experienced a 25% increase in calls, but a decrease in the percentage of calls answered within 30 seconds, and an increase in abandonment rate.

COMMUNITY LAW ENFORCEMENT LIAISON ACTIVITY REPORT

- The number of ATRs for the month of February increased by 6.71% (302 completed for this month as compared to 283 in January).
- Community Law Enforcement Liaison engaged 45 individuals this month.

- 100% have repeat hospitalizations without follow up by the CRSP. CRSP and MDOC agents were alerted and engaged in discharge planning. 40% have Team Wellness as a CRSP.
- 26% have as history of SUD.
- 26% were on court orders.
- 1% needed residential placement.

- 9 Citizens returned and were connected to DWIHN services upon release from MDOC.
- DWIHN received 82 Assisted Outpatient Treatment (AOT) orders from Probate Court this month and respective CRSPs are notified to incorporate these orders in treatment planning.
- There were 18 ACT consumers referred to COPE: 78% went inpatient, 17% went Outpatient, and 1% were admitted to CRU. No pre-placement or partial day hospitalization was sought during this reporting period. It should be noted 29% of ACT PARs were completed by COPE.

Community hospital liaison report not available at this time

MOBILE OUTREACH SERVICES

Number of Mobile Events Attended	13
Number of Meaningful Engagements	56
Number of Subsequent Contacts	15
Number of Screenings in the system	3

CUSTOMER SERVICE – Director, Michele Vasconcellos

Administration/Call Center Operations/ Family Support Subsidy/Medical Records

- DWIHN's Customer Service division handled a total of 1,910 calls in the month of February. Front Desk 802 with an ABD rate of 0.8%; Call Center 1108 with an ABD rate of 8.4%. The ABD rates are out of compliance with contributing factors of phone related issues for the CSRs and there were occasions when calls were going to the Access Center due to the Front Desk staff and the CSRs were assisting other callers.
- Family Subsidy requests continue to be remotely addressed and processed without interruption.
- Processed and mailed out" Choice" letters to members as a result of provider closures or discontinuance of services.
- Continued to meet to discuss Medical Record retention and Therefore initiative.
- Addressed Special follow-up cases from the state.

Customer Service Performance Monitoring/ Grievance & Appeals

- Disenrollment Training 2/23 including IT Deputy Chief Information Officer and CS Department (ACC and AWBS).
- Participated in UM, Quality Ops, ICO monthly meetings.
- Participated in Quarterly CS Provider meeting as well as Quarterly JOC Meeting with Molina
- Met with IT and MCO regarding the online directory requested revisions.
- Met with Wayne County Mediation Dispute Resolution Center regarding mediation status.
- Medicaid template updates made to PCE regarding HSAG.
- MI Health Link letters are completed and in PCE.
- Participated in multiple provider closure meetings and mailed member choice letters as required.

- Completed 7 PIHP member extension calls for UM Department.
- Completed a total of over 1300 plus dis-enrollments to date for members without an assigned CRSP
- Completed 2 Desk Audits for ABDs
- Collaborated with MCO re: 3 grievances (Gateway and Community Care Services)
- Requested response from Lincoln Behavioral Service regarding levied plan of correction.
- Presented at Outpatient and Residential Provider Meeting (2/18/22)
- Provided technical assistance to multiple providers (Life Center, AHS, Goodwill, CNS)
- Met with CSRs and Front Desk Staff re: call transfer, job barriers, etiquette, etc.
- MDHHS Grievance and Appeals Template completed and submitted
- Collaborated with CMO, Director of Crisis Services regarding second opinion procedure
- Therefore Project has 5 boxes of documents scanned and entered into the system.
- Alerted to member becoming plaintiff in MI Kids Now lawsuit
- Two CS Performance Monitor Audits were completed: CCIH and BFDI
- EOB Discussion and Training meeting for distribution.
- Member Materials were distributed to CRSP providers
- Provider Directory (hardcopy) was updated

NCQA/HSAG

- Staff continued to work on HSAG POC upon recommendations from aforementioned agency. Met with Quality to review status.
- Met with Quality to discuss upcoming audit for Grievances and Appeals and to address the updated status for Standard 1 POC.
- Meetings scheduled for standards and file review. Meeting pending.

Member Engagement/ Experience

- Reported on the final results of the Annual ECHO survey results for adults and children during the Customer Service Quarterly Meeting
- Coordinated the Developmental Disabilities Awareness Month series planned for each Thursday during the month of March
- Selected a vendor to develop the DWIHN mobile application for community engagement after evaluating and scoring four responses
- Continued to host monthly member (e.g., EVOLVE) and advisory group meetings (Constituents' Voice general assembly, Leadership etc.)
- Coached providers with two adult foster homes on basic computer features
- Collected data on peer specialist workforce and liaisons
- Collaborated with the National Disability Institute to host a three-day financial stability roundtable regarding communities of color, people who are low-income, and those having disabilities.
- Continued to conduct a series of meetings with Clubhouse & Drop-in Centers regarding re-accreditation
- Published the Winter Member Quarterly Newsletter "Person's Point of View"
- Collected the National Core Indicator background profiles and consents
- Collaborated with Wayne State University to collect the Experience of Care and Health Outcomes survey data
- Coordinated collection of provider satisfaction survey data for organizations and practitioners

INTEGRATED HEALTH – Director, Vicky Politowski
Please See Attached Report

MANAGED CARE OPERATIONS – Director, June White
Please See Attached Report

RESIDENTIAL SERVICES – Director, Shirley Hirsch
Please See Attached Report

SUBSTANCE USE DISORDER – Director, Judy Davis
Please See Attached Report

UTILIZATION MANAGEMENT – Director, Jennifer Jennings
Please See Attached Report

Autism Spectrum Disorder Benefit

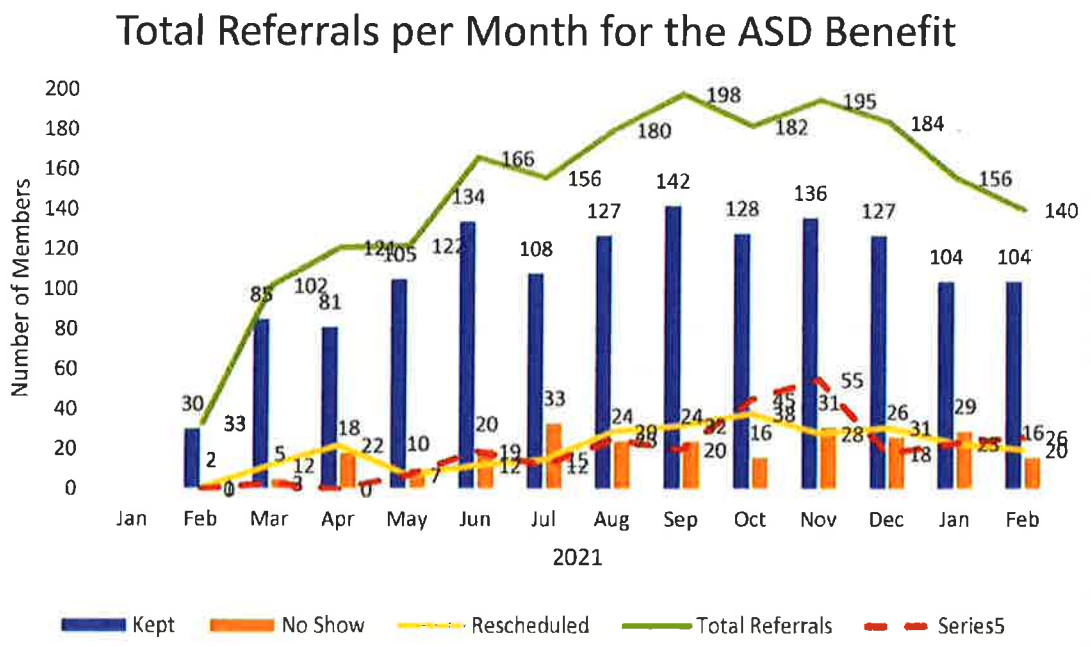
February 2022 Monthly Report

Enrolled in ASD Benefit

Total open cases for the month of February 2022 is 2,229 which is an increase of 109 members enrolled into the ASD benefit.

Summary of Diagnostic Evaluations

Total comprehensive diagnostic evaluation scheduled by the Access Center was 140 and of those scheduled 104 appointments were kept resulting in 12 members not being eligible (non-spectrum) for the Autism benefit and 26 members approved but undecided.



Provider Updates

- IPLT approved sunsetting measure related to the number of Behavior Analysts in the provider network as DWIHN exceeds this quality measure. New measurement will focus on the number of Behavior Technicians providing services to improve timeliness to ABA services.
- Utilization Management has updated CPT codes 97151 to code 96112 and 96113 based on MDHHS updates that went into effect 10/1/21. The new CPT code to authorize and bill for initial and ongoing eligibility assessments for the ASD benefit will go into effect on 3/1/22.
- The ASD benefit staff provided internal trainings on the physician referral process.
- DWIHN hosted two informational meetings via Zoom on the referral process for Wayne county Medicaid eligible beneficiaries seeking access for the Autism benefit at DWIHN.
- The ASD benefit staff reached out to physician and pediatricians in the Wayne County to coordinate training on the referral process.

Integrated Health Care Department

Monthly Report

March 1, 2022

Collaboration with Health Department

The Health Department will be focusing on Hepatitis C, DWIHN is preparing for this initiative. DWIHN met with the State in October to discuss data collection and how to roll this initiative out to the Behavioral Health and SUD providers in Wayne County. IHC has developed a quality improvement plan and has added fields to the Integrated Biopsychosocial that is completed by CRSP clinicians to include Hep C treatment questions. IHC met with the SUD providers on January 26th to discuss the initiative. IHC has created a power point presentation for Hep C treatment that will be presented to providers.

Quality Improvement Plans

The IHC department manages five Quality Improvement Plans (QIPs) that are in alignment with NCQA requirements. The focus of the QIPs includes the following: 7 and 30 day Follow Up After Hospitalization for Mental Illness, Adherence to Antipsychotic Medication, Diabetes Screening for members prescribed atypical antipsychotic medications, and Hepatitis C treatment. Currently implementing a HEDIS certified platform which will display individual CRSP provider data to allow early intervention and opportunity to improve outcomes. The HEDIS certified platform will also include measures for Opioid Health Home and Behavior Health Home. The HEDIS Quality Scorecard was present to the CRSP Quality Directors on January 26th, 2022. The HEDIS Quality Scorecard will be present to all CRSP's in March. DWIHN and Vital Data continue to work on the HEDIS platforms that show the data for these QIP for providers is correct.

Population Health Management and Data Analytics Tool

DWIHN and Health Plan and Health Plan designee staff continue to meet at least weekly to prepare for implementation of the two platforms, one for providers to view member encounter information and performance on HEDIS measures, and the other for DWIHN and Health Plan designee to utilize to coordinate care for shared members and for DWIHN to view HEDIS measure performance. VDT continues to make corrections and revisions to both platforms based on feedback from DWIHN and Health Plan and Health Plan designee staff. The platform went live on June 1st. To date DWIHN and Health Plan designee staff are meeting on a twice monthly basis to complete coordination of members who are new and in Tier 2 and 3. To date there are 3040 shared members, 1,823 are in Tier 0/1, 1175 in Tier 2 and 42 in Tier 3.

VDT and DWIHN met on 11/29/2021 how to implement the OHH, BHH and CCBHC measures needed. DWIH has approved the proposal from VDT and will begin work on these added measures.

Data Share with Medicaid Health Plans

In accordance with MDHHS Performance Metric to Implement Joint Care Management, between the PIHP and Medicaid Health Plans, IHC staff performs Data Sharing with each of the 8 Medicaid Health Plans (MHP) serving Wayne County. Mutually served individuals who meet risk stratification criteria, which includes multiple hospitalizations and ED visits for both physical and behavioral health, and multiple chronic physical health conditions are identified for Case Conference. Data Sharing was completed for **37** individuals in February. Joint Care Plans between DWIHN and the Medicaid Health Plans were developed and/or updated, and outreach completed to members and providers to address gaps in care.

Integrated Health Pilot Projects

DWIHN has identified 3 Health Plans for Integrated HealthCare Pilot Projects.

Health Plan 1:
Collaboration continues between DWIHN and **Health Plan 1** staff with implementation of shared electronic platform with VDT to facilitate information exchange and document care coordination activities. The shared platform went Live June 1st and to date there are **42** members in the program. Health Plan 1 and DWIHN meet bimonthly to discuss individuals in Tier 2 and 3, in the month of February, **6** individuals were discussed. Platform review continues, recommended changes/additions are in process with projected go live of HEDIS measures and scorecards platform (ProviderLink) and Care Coordination platform (PlanLink) in March. Health Plan 1 was incorporated into another health plan and DWIHN is waiting on a new contract from that health plan to be sent.

Health Plan 2:
Care Coordination with **Health Plan 2** was initiated in September 2020, these meetings occur monthly. There were **7** cases discussed in the month of February for the Pilot program. The plan requests the number of cases to be discussed during Case Review. The BCC workgroup met on 2/22/2022 to discuss goals and HEDIS measures to be tracked. Currently the workgroup is waiting data to be able to set baselines. Health Plan 2 has decided that the shared platform has a benefit and this is being discussed

Health Plan 3:
Health Plan 3's In February the IHC department was included in a project with Health Plan 3, that is looking at hospitalization data on admits to the emergency department. Health Plan 3 would like to coordinate with DWIHN to see how data sharing can be completed for individuals in the ED.

MI Health Link Demonstration

IHC department under the MI Health Link Program received total of 325 request for level II in the month of January 2021 from the following ICO organizations below: Pending = not processed yet, Voided = Member was unable to reach, referred in error, or declined assessment, or declined BH services, Active= Level II was sent to ICO.

ICO	Active	Pending	Voided	Totally by ICO
Aetna	16	17	12	45
Amerihealth	3	0	11	14
HAP	5	6	4	13
Meridian	8	3	11	22
Molina	74	83	135	292
TOTAL	**106**	**109**	**173**	**388**

Voided referrals reasons are as follows:

	Member Declined Assessment	Member Declined Services	Member not available before deadline	Referrals in error	Unable to reach
Aetna	0	8	1	0	3
Amerihealth	0	7	0	3	1
HAP	0	3	1	0	4
Meridian	0	4	0	0	7
Molina	2	59	6	22	46
Total	**2**	**81**	**8**	**25**	**61**

Comparison Data for Voided Referrals:

	Number of Voided Referrals	Member Declined Assessment	Member Declined Services	Member not available before deadline	Referrals in error	Unable to reach
March 2021	182	1	85	13	34	49

April 2021	230	2	113	3	44	68
May 2021	173	0	82	1	27	66
June 2021	156	2	79	5	30	42
July 2021	195	2	102	0	20	69
August 2021	178	0	78	2	31	67
September 2021	184	0	88	4	39	53
October 2021	172	5	85	5	24	53
November 2021	152	11	94	2	9	36
December 2021	186	11	125	5	7	38
January 2022	180	3	120	5	7	45
February	**177**	**2**	**81**	**8**	**25**	**61**

*Increase in number of Member declined servcies, process and interventions to be reviewed.

ICO Meridian is still unable to receive level II responses through the Care Bridge, referrals are logged in MH WIN and manually processed by sending to Meridian through secure email. documents have not been received to share internally with DWIHN.

During this reporting period IHC department has started to share outcome data sheet regarding TOC and FUH follow-up, of the **66** reviewed in February, 21 returned to hospital post 30 days.

Transition of care services were provided for **45** persons who were discharged from the hospital to a lesser level of care, community outpatient, or additional level of service Behavioral Health or Physical Health.

There were **36** LOCUS assessments completed for the MI HealthLink Demonstration received from Network Providers who service Nursing Home Facilities for Mild-Moderate population.

Care Coordination Activities for the ICO enrollees—**32** individuals who have been identified to have a gap in services. This is a combined effort between IHC staff and the ICOs.

ICO Plan Name	Number of cases requested by ICO	Number of cases DWIHN recommended for Care Coordination for the month	Number of cases DWIHN recommended for Care Coordination for next month	Number of cases to refer to Complex Case Management	Number of case reviewed Total

HAP	0	16	10	0	16
AET	44	0	12	0	44
Amerihealth	3	4	2	0	14
MCH	0	3	0	0	3

Plan Name	DWIHN Reviewed Cases for Recommendation	New Cases (not from prior90 days)	Number of Cases from the Prior Month	Closed Cases w/Goals Met	Successful Closed = w/ goals met & 2+ partial goals met	Unsuccessful Close = No Goals met unable to reach	Total Number Active of cases within CC360 = New Cases + Prior Cases	Total number of cases touched.
Priority	6	0	0	0	0	0	6	6
BCC	1	0	0	0	0	0	1	1
Aetna	7	0	0	0	0	0	7	7
HAP	5	0	0	0	0	0	5	5
McLaren	3	0	0	0	0	0	3	3
Meridian	5	0	0	0	0	0	5	5
Molina	5	0	0	0	0	0	5	5
UHC	5	0	0	0	0	0	5	5

Special Care Coordination Project

Plan Name	Number of cases requested by Medicaid Health Plan	Number of cases DWIHN recommended for Care Coordination for the month	Number of cases DWIHN recommended for Care Coordination for next month	Number of cases to refer to Complex Case Management	Number of case reviewed Total
Health Plan 2	0	5	2	0	7

Health Plan 1	1	1	0	0	1

FUA: Report and workflow process has been established meetings have taken place with SUD department workflow will be submitted to SUD and IHC staff first week in January 2022. During this reporting period DWIHN has reviewed **34** cases of which **15** cases **44%** of the cases have been sent to the respective MHPs as these cases are not open to DWIHN. **19** cases **55%** were open to DWIHN providers were notified and members were called. Of those cases **none** confirmed connecting with outpatient providers.

There was a total of 15 FUA Members sent to MHPs (not open to DWIHN)

Medicaid Health Plan (total)	**15**
Priority	**4**
BCC	**9**
Aetna	**0**
HAP	**0**
McLaren	**0**
Meridian	**2**
Molina	**0**
UHC	**0**

There was a total of 19 FUA members that were open to DWIHN that contact was attempted but did not maintain f/u appointment.

Medicaid Health Plan (total)	**19**
Priority	**0**
BCC	**3**
Aetna	**3**
HAP	**4**
McLaren	**3**
Meridian	**0**
Molina	**4**
UHC	**2**

Compliance Meetings for MHL Program

DWIHN has met with all ICOs and marketing material for CY2022 has been approved. Builds for the following areas are still under review for testing UM, Claims, Appeals & Grievances during this reporting period. SARAG reports for 2022 have been tested and approved with collaboration of the IT department, reports were delayed in the Feb 15 submission due to system updates by DWIHN.

IHC has assisted with the completion and submission of the MHL attestations with compliance department from ICO Amerihealth, ICO Aetna, ICO HAP and ICO Meridian.

DWIHN during this reporting month IHC received communication from ICO Amerihealth who is requesting policy, procedure and files to be submitted in a delegation audit for CY 2021 by January 31, 2022. Submission completed by 2/1/2022. ICO has received all submissions timely outstanding items are BAA (2020) and Access Center CAP. DWIHN completed annual compliance attestation.

DWIHN during this reporting month IHC received communication from ICO Aetna requesting the review of BAA for 2021. DWIHN completed annual compliance attestation.

DWIHN during this reporting month IHC completed annual compliance attestation for ICO Meridian.
During this reporting period IHC, corrected all outstanding encounter errors from ICO Encounter reports

Complex Case Management

Complex Case Management Services require the individual to agree to receive services, have Physical and Behavioral Health concerns and experiencing gaps in care. The enrollee must also agree to receive services for a minimum of 60 days.

For the month of February, there are currently **9** active cases, **3** new case opened, **7** case closures, and no pending cases. Four **(4)** cases were closed due to meeting their treatment goals, and **3** was unable to reach.

Care Coordination services were provided to **15** additional members in February who either declined or did not meet eligibility for CCM services. Follow up after hospitalization was competed with **43** consumers to help identify needs.

Complex Case Management staff have been working to identify additional referral opportunities. Twenty (**20**) presentations were provided for DWIHN CRSPs and at Provider Meetings: CLS, Team Wellness, Lincoln Behavioral Services, Development Center, Guidance Center, Wayne Center, Social Security Administration, Michigan Guardian Services, Roderick

Bingham Guardian, Beginning Step, Havenwyck, St. Mary's Hospital, Henry Ford Kingswood, Henry Ford Wyandotte, Pontiac General, Samaritan, Beaumont Taylor, Hawthorne.

EMS Friendly Faces:

From the EMS list, 56 members received outreach attempts to engage in Complex Case Management due to high ER utilization. CRSPS were also contacted to inform of high utilization status. **35** members had assigned a CRSP, in which **25** Case Managers/Supports Coordinators were reached. None were engaged into Complex Case Management as majority of members were unable to reach.

Peer Health Coach Grant:

DWIHN has contracted with four Certified Peer Health Coaches who will be stationed at Central City working with individuals who have multiple medical conditions along with behavior health. All four Peer Health Coaches were onboarded and started May 24th.

The Peer Health Coaches are working to reconnect non-adherent clients to therapy. Teaching other peers motivational intervention techniques. Identifying clients diagnosed to have hypertension that may be interested in participating in a hypertension study that will reconnect them to their PCP.

707 of the 1,665 Members on the DWIHN Disenrollment List for CCIH.

Of those members:

418 (59%) have had letters sent from either PHC/CM/Therapist

114 (16%) have or had scheduled appointments since 12/7/2021

63 (9%) are open files but need closed in eCRS

64 (9%) have closed files already in eCRS

28 (4%) are file not open yet/didn't complete intake

51 (7%) have CRSP issues, which include wrong designations and no CRSP found

27 (4%) are deceased and are included in either open files to be closed or already closed files

19 (3%) do not have an IPOS, which may be misrepresented

15 (2%) have a LOCUS Level of 1 or 2, which are not designated in open files to be closed

13 (2%) have a designation of AFC Home

4 (1%) are incarcerated

1 (.1%) who has a LOCUS Level 6

Members who have received face-to-face engagement for the month of February, 27 members were surveyed below are the results for the Peer Health Coaching Participant Questionnaires

1. What would you say your overall health was/is before PHC?

Poor- 0

Fair- 0

Good - 27

Very Good - 0

2. How aware are you of risk factors and ability to manage existing health issues before PHC?

Poor -0

Fair- 23

Good - 4

Very Good - 0

3. Awareness of risk factors and ability to manage existing health issues after PHC?

Poor- 0

Fair - 23

Good - 4

Very Good - 0

8 Satisfaction Surveys were obtained

1. Did the PHC help you understand the importance of follow up care?

Yes- 8

No -

Not Sure -

2. Did the PHC assist and support you to get the care you needed?

Yes - 8

No –

Not Sure – 0

3. Was the PHC attentive and help you work through problems?

Yes - 8

No -

Not Sure -

4. Did the PHC treat you with courtesy and respect?

Yes - 8

No -

Not Sure-

5. How satisfied were you with your PHC?

Very - 8

Some What -

Not Sure -

Monthly Report

Managed Care Operations

February 2022

MCO DEVELOPMENT MISSION:

The department monitors over 400+ providers under 9 Provider Network Managers and 1 HUD specialist Manager. All staff are committed to serving and reaching out to our providers monthly and quarterly to ensure providers know we are here to assist in answering any questions and directing them to the appropriate department for assistance. Questions come in daily through email or calls surrounding staff shortage concerns, adding sites, authorization questions, claims questions as well as possible closing sites, in which we assist in answering.

MHWIN system cleanup of records/Online Directory:

For this month the team continue to work on cleaning up records in MHWIN. There were several gaps identified and addressed

a. Cleaned up Staff records in MHWIN, that need NPI #'s
b. Added ADA site accommodation(s) fields in MHWIN with hours of operations for MDHHS requirements.
c. Reviewed the SAP database for accuracy that was submitted to the State.
d. Met with our IT Dept in an effort to make the directory more compliant with State requirements

Internal /External-Training Meetings Held:

a. Met with 5 CRSP providers regarding the 14-day intake calendar slots where providers are experiencing staff shortages in the intake department for new intakes
b. Held the first internal meeting to discuss network adequacy and provider gaps in services
c. Reviewed all changes to the Provider Manual for 2022, will be finalized end of Feb 2022.
d. Weekly meeting with Continuum of Care Board (COC), to discuss HUD/Homeless projects.

PIHP Email Resolutions and Phone Provider Hotline:

For the month of January, we received/answered 67 emails and 16 phone messages from providers with concerns related to claims billing, credentialing issues, Provider change notifications, Procedure Code changes, Single Case agreements, and changes with the FY 2022 State Code/Modifier changes.

New Providers/ Merger/Closures Changes to the Network /Provider Challenges:

Providers continue to struggle with staff shortages to maintain staff in homes as well as staff in general among all of our providers resulting from the pandemic.
DW also continues to meet with providers to find solutions that will better all during these times.

The network has had several home consolidations or closures under the unlicensed settings, which is a result of the members personal health or staff challenges providers have had causing them to merge or close the settings.

Provider Closure/Mergers FY 21-22					
Description	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	YTD Totals
Licensed-Residential Homes	2	2			4
Unlicensed /Private Home Services (SIL's)	3	9	1		13
Clubhouse services	1				1
Outpatient services, SUD services	4	6	1		11
Provider Organization Merger(s)	1				1
Total	11	17	2		30

Even though, we see constant changes in the network we have maintained a number of providers in our pool that can be potential providers ranging from private clinicians, therapy services, outpatient and residential providers. It they are approved through our credentialing process and approved by the board we can easily shift with any changes within the network.

Housing Resource and Street Outreach to the Homeless:

As reported by the Housing Urban Development (HUD) Annual Homeless Assessment Report, the report found that the number of sheltered people in families with children declined considerably between 2020 and 2021, while the number of sheltered individuals remained relatively flat. Between 2020 and 2021, the number of veterans experiencing sheltered homelessness decreased by 10 percent. On a single night in 2021, 15,763 people under the age of 25 experienced sheltered homelessness on their own as "unaccompanied youth." The number of sheltered individuals with chronic patterns of homelessness increased by 20 percent between 2020 and 2021. As we partner with our providers to assist the homeless with housing and reaching individuals on street to -date we continue to see improvement one month at time.

This report is based on a Calendar quarter not a Fiscal year.

Southwest Counseling Solutions - Housing Resource Center FY 22 Contract Amount: **$1,089,715**		
	1st Quarter	Year-To-Date
# of Persons Served	**3054**	**3054**
# of Persons Screened for Mainstream Services	**2498**	**2498**
# of Persons who received Housing Assistance	**556**	**556**

Neighborhood Service Organization (Detroit Healthy Housing Center) FY 22 Contract Amount: **$902,050**		
	1st Quarter	Year-To-Date
# of Persons Served	**134**	**134**
# of Persons Receiving Emergency Shelter Services	**134**	**134**
# of Persons referred to Permanent Housing	**115**	**115**

Neighborhood Service Organization (Housing First – Clinical Case Management) FY 22 Contract Amount: **$25,000**		
	1st Quarter	Year-To-Date
# of Persons Served	**25**	**25**
# of Persons who applied for Permanent Supportive Housing	**14**	**14**

# of Persons who Exited to Permanent Housing	**2**	**2**
# of Persons enrolled in Medicaid, Primary Health Care, or Community Mental Health Programs	**2**	**2**

Neighborhood Service Organization (PATH - Street Outreach) FY 22 Contract Amount: **$169,493**		
	1st Quarter	Year-To-Date
# of Persons Served	**109**	**109**
# of Persons Enrolled in PATH	**35**	**35**
# of Persons Connected to SOAR	**78**	**78**
# of Persons Enrolled who Exited to Permanent Housing	**18**	**18**

Wayne Metropolitan Community Action Agency (PATH - Street Outreach) FY 22 Contract Amount: **$75,000**		
	1st Quarter	Year-To-Date
# of Persons Served	**47**	**47**
# of Persons Enrolled in PATH	**16**	**16**
# of Persons Connected to SOAR	**0**	**0**
# of Persons Enrolled who Exited to Permanent Housing	**7**	**7**

CNS Healthcare (Covenant House Program) FY 22 Contract Amount: **$132,872.25**		
	1st Quarter	Year-To-Date
# of Persons Served	**56**	**56**
# of Persons who assessed and referred to the appropriate level of care	**42**	**42**
# of Persons experiencing mental health crisis that received crisis intervention services.	**14**	**14**

Central City Integrated Health (CoC PSH Program - Match) FY 22 Contract Amount: **$114,754**		
	1st Quarter	Year-To-Date
# of Individuals Served	**49**	**49**
# of Households Served	**35**	**35**

Central City Integrated Health (Leasing Project - Match) FY 22 Contract Amount: **$50,291**		
	1st Quarter	Year-To-Date
# of Individuals Served	**38**	**38**
# of Households Served	**32**	**32**

Quarterly Goals still in progress:

Quarterly goals set for FY 2022.

• The Risk Matrix- The Risk Matric is a web-based software system that our providers can use to coordinate care, manage operations, view cost of services paid and better serve our members. The matrix allows DWHIN to be able to monitor the provider's performance and gain a base line of care services for our members. We are able to track and monitor cost and related services that will assist in finding improvement opportunities in our current care model.
• The Provider Manual- is a tool/ guide for the provider. This manual is an extension of the provider contract/agreement that include requirements for doing business with DWIHN. Together the manual, our policies and the contract give the provider a full picture of the requirements and procedures to participate in our network. The purpose and intent of the Provider Manual is to strengthen our current and future network providers.
• Network Adequacy form/procedure. This internal process will assist in structing our network in a way where we can view our provider services at a glance for better monitoring over our network through this procedure. We will start evaluating the network in the first quarter of the FY 2022.
• Online Directory- Provider/Practitioner. We are working with internal depts (Customer Service/Credentialing unit) to enhance our online contracted provider and practitioner directory to include the type of services along with the disability designations served by the provider or practitioner making the directory more user friendly and informative for the members as well as internal use.
• Provider Orientation Meetings – twice a year (March/September 2022, the purpose of this meeting is to assist the network in navigating through out system as we have some many new departments that have been developed over the year.
• Quarterly Provider Network Mangers "One on One' with providers- has been going very well we have met with 155 providers out of 358 since the start of the meetings in January 2022. This is a 43% completion rate.

Annual Provider/Practitioner Survey:

The Provider/Practitioner survey is a way for DWIHN to retrieve feedback from providers and practitioners on how well DWIHN does as a manager of care, this survey also helps us identify any gaps in process or procedures as well as reveal any areas for improvements. The Annual Provider/Practitioner Survey closed at the end October. A full analysis of the survey is still under review for presentation in 2022.

Provider Meetings Held:

a. The future CRSP provider meeting will be held on March 7, 2022
b. The next Residential/Outpatient Provider meeting will be held on April 1, and every 6 weeks thereafter.

Submitted by June White 2/28/22

Detroit Wayne
Integrated Health Network
Residential Services Department

Department Monthly Report: **February 2022**

Residential Referrals

January 20221 ***Pending Assignments***	***17***
# of Assigned Referrals for February 2022	**254**
Total Cases	271

Referral Source Breakdown

Assessments Requested for Members currently in Specialized Settings	7
Crisis Residential	10
CRSP	72
Emergency Departments	10
Inpatient Hospitals	153
Nursing Homes	11
Pre-placement (C.O.P.E.)	3
SD-to-Specialized Residential Services	0
Youth Aging Out (DHHS)	5
Detroit Veteran Affairs Medical Center	3
Total Received Referrals	**271**

Referrals per Disability Designation

AMI Referrals	177
IDD Referrals	94

Residential Staff Assessment Productivity

Assessments Completed (SALs)	78
Assessment/Referral Cancelled or Rescinded	35
Cases Assigned for Brokering Only	21

Residential Referral Tracking

- Inpatient Penetration Rate – ***0.68%***
- HAB Waiver Requests – ***3***

State Hospital Referrals

Pending Discharge: January 2022	***11***
# of Referrals Accepted for February 2022	**2**
Total Cases	13

Members Accepted In to Specialized Placement; Pending Discharge Agreement	6
Residential Assessments to be Completed	2
Referrals Currently in Brokering Process	5

Residential Service Authorizations

Total Processed Authorization Requests	**1,087**
Authorizations APPROVED (in less than 14 days)	**751**
Requests Returned to CRSP	336

30-Day/Emergency Member Discharge Notifications – AMI/IDD

Carry-over Discharge from January 2022	***9***
Total Member Notifications Received: February 2022	21
Total Member Discharge Notifications	**30**

30-Day Notices from Licensed Facilities	19
Emergency Discharges	9
Rescinded Requests/Self-Discharges	**2***

- ***(2) 30-day discharges*** were rescinded by the residential providers after case review determined the members can remain in their specialized placement with additional supports from their designated CRSP.

COVID-19

# of Positive Cases Reported (2/1 – 2/28): 4

Per Designation	AMI	IDD
Males	0	2
Females	1	1

# of Deaths Reported (2/1 – 2/28): 1

Per Designation	AMI	IDD
Males	0	1
Females	0	0

COVID-19 Quarantine Facility Utilization

Quarantine Facility Name	February 2022 # Members Serviced
Detroit Family Home-Southfield	4
Kinloch Home (Redford)	0
Detroit Family Home-Boston (Detroit) *No Longer Quarantine Site, eff. 2/15/22*	0
February 2022 TOTALS:	**4**

COVID-19 Vaccine Booster Reporting

- Report attached for review

Residential Communications

The department has begun quantifying communications received and responded to during the month February 2022; by telephone calls/voicemails, faxes, and/or emails.:

Voicemails: February 2022	**188**
Blank Messages/Fax Machine Calls/No Contact Info from Caller	61
Calls/Voicemails Responded to with **24/48 Hours**	108
Forwarded to Assigned Residential Staff	10
Forwarded to other DWIHN Departments	5
Responses Requiring Director/Manager Review	4

Emails: February 2022 ResidentialReferral@dwihn.org	**312**
Emails Responded to with **24/48 Hours**	238
Forwarded to Assigned Residential Staff	25
Forwarded to other DWIHN Departments	17
Responses Requiring Director/Manager Review	32

Residential Facility Closures

The following residential facility closures were processed during February 1-28, 2022 to relocate all members to alternate specialized placements.:

# of Facility Closure Notifications	14
Received in February 2022: On-Going/In Process	4
Requests ON-HOLD/PENDING	2
Completion of Facility Closures	8

Parkgrove Home – 25943
CRSP Notification Received: 1/5/22
Confirmed Closure Date: 2/26/22
CRSP notification received reporting residential provider is closing facility due to lack of staffing. Residential Care Coordination team successfully completed relocating 4 of the 5 members to alternate facilities contracted with DWIHN. (One) member returned to their family home.
Current Status: **CLOSED**

Castle Home – 25083
Provider Notification Received: 1/18/22
Confirmed Closure Date: 2/16/22
Provider notification received reporting intent to close facility due to lack of staffing. Residential Care Coordination team successfully completed relocating all 3 members to alternate facilities contracted with DWIHN.
Current Status: **CLOSED**

Canterbury #4 Home – 32825
Provider Notification Received: 1/19/22
Confirmed Closure Date: 2/1/22
Provider notification received reporting intent to close facility due to lack of staffing. Residential Care Coordination team successfully completed relocating 1 of the 2 members to an alternate DWIHN-contracted facility; as the other member returned to their family home.
Current Status: **CLOSED**

Bloomfield-South – 32702
CEO Notification Received: 1/21/22
Confirmed Closure Date: 2/21/22
Facility closure notification received from DWIHN CEO reporting intent to close facility due to lack of staffing. Residential Care Coordination team confirmed 1 of the 2 members was transferred to an alternate DWIHN-contracted facility under the current residential provider; as the other member have been placed into DWIHN pre-placement facility until alternate placement has been selected.
Current Status: **CLOSED**

Saltz II Home – 32995
Provider Notification Received: 1/25/22
Confirmed Closure Date: 2/16/22
Provider received reporting intent to close facility due to lack of staffing. Residential Care Coordination team successfully relocated 2 members to alternate DWIHN-contracted facilities under the current residential provider.
Current Status: **CLOSED**

Delanie Home – 27796
Provider Notification Received: 2/2/22
Confirmed Closure Date: 2/2/22
Provider notification received indicating all 3 members were urgently relocated to an alternate DWIHN-contracted facility under the current residential provider due to DCW staff walking off. Service authorizations were updated accordingly.
Current Status: **CLOSED**

Fort Road-AFC – 33459
Provider Notification Received: 1/25/22
Confirmed Closure Date: 2/9/22
Provider notification received reporting intent to close facility due to lack of staffing. Residential Care Coordination team successfully relocated 4 members to alternate DWIHN-contracted facilities under the current residential provider.
Current Status: **CLOSED**

Balfour Home – 22745
Provider Notification Received: 1/25/22
Confirmed Closure Date: 2/24/22
Provider notification received reporting intent to close facility due to lack of maintenance upheld by the home owner. Residential Care Coordination team successfully relocated 3 members to alternate DWIHN-contracted facilities under the current residential provider.
Current Status: **CLOSED**

Bloomfield North – 27555
CEO Notification Received: 1/21/22
Scheduled Closure Date: 2/28/22
Facility closure notification received from DWIHN CEO reporting intent to close facility due to lack of staffing. Residential Care Coordination team is awaiting to confirm where 3 of the 4 members that will be transferred to current residential provider (credentialing process underway). 1 member of the home is scheduled to relocate into an alternate specialized placement on 3/2/22.
Current Status: **PENDING**

Laurel Drive Home – 32536
Provider Notification Received: 1/27/22
Scheduled Closure Date: 3/1/22
Provider notification received reporting intent to close facility due to lack of staffing. Residential Care Coordination team has confirmed 2 members are currently under month-to-month (independent) lease agreement as their CRSP will be selecting a CLS staffing provider to render services in said home.
Current Status: **PENDING**

ALS-Monterey Home – 25890
Provider Notification Received: 1/31/22
Scheduled Closure Date: 3/15/22
Provider notification received reporting intent to close facility due DCW staffing. Residential Care Coordination team has begun the process to relocate 6 members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Reaume Home – 27180
Provider Notification Received: 2/15/22
Scheduled Closure Date: 4/15/22
Provider notification received reporting intent to close facility due DCW staffing. Residential Care Coordination team has begun the process to relocate 3 members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Sargent Home – 25236
Provider Notification Received: 2/15/22
Scheduled Closure Date: 4/15/22
Provider notification received reporting intent to close facility due DCW staffing. Residential Care Coordination team has begun the process to relocate 3 members to alternate facilities contracted with DWIHN.
Current Status: On-Going

K &K SIL-Lexington – 32800
Provider Notification Received: 2/1/22
Scheduled Closure Date: 4/1/22
Provider notification received reporting intent to close facility due DCW staffing. Residential Care Coordination team has begun the process to relocate 4 members to alternate facilities contracted with DWIHN.
Current Status: On-Going

Department Project Summaries

Authorizations Team

- ***New CPT Rates (5% Increases):*** The Residential Unit updated service authorizations that were not completed as of February 1, 2022 with the 5% rate increase. PCE is working on updating all other service authorizations in MHWIN to reflect the new 5% increase. As of February 28th, the Authorizations Team completed 19 service authorization updates.
- ***H2X15/T2X27:*** The Residential Authorization Team has been working to establish a standardized process for approving H2X15/T2X27 authorizations.
- ***H2X15 Unit Shortage:*** With the implantation of the bundled service authorizations (H2X15/T2X27), it appears that MHWIN has a unusual function when a biller submits a claim "without authorization"; the system reduces the units available on any current authorization by the number of units submitted on claims. Providers were inadvertently using up their authorizations, even though they did not intend to do so.
- ***Specialized Residential Service Authorization Refresher Trainings:*** The Residential Authorization Team continues monthly refresher trainings with IDD (11 AM) and AMI (2 PM) CRSP supports coordination and case management staff every first Thursday in TEAMs.

Residential Sponsored Meetings and Trainings

- ***CRSP/Residential Services Monthly Meetings*** - 15 meetings held; ***80 attendees*** total
  - ***1 CRSP meeting*** rescheduled from Friday, 2/25 to Friday, 3/4 due to department and CRSP scheduling conflict
  - ***5 CRSP meetings are bi-monthly*** and are scheduled for March 2022
- ***Residential Assessment | Clinical Alignment of Documentation Refresher Trainings:*** Monday, 2/1 (***100 attendees*** total)
  - IDD CRSP –11 AM (***53 attendees***); AMI CRSP – 2 PM (***47 attendees***)
- ***CRSP DWIHN Residential Service Authorization Refresher Trainings:*** Thursday, 2/3 (***53 attendees*** total)
  - IDD CRSP –11 AM (***21 attendees***); AMI CRSP – 2 PM (***32 attendees***)
- ***CRSP/Residential Providers Monthly Meetings***: 4 meetings held; ***160 attendees*** total
  - Thursday, 2/17 with AMI CRSP/Unicensed-10 AM (***32 attendees***); AMI CRSP/Licensed-2 PM (***36 attendees***)
  - Monday, 2/21 with IDD CRSP/Unicensed-10 AM (***58 attendees***); IDD CRSP/Licensed-2 PM (***34 attendees***)
- ***DWIHN Residential Provider/CRSP Advisory Group***: Monday, 2/28 at 10 AM
  - ***15 attendees*** total; with meeting guests included, CCO Jackie Davis, Quality Improvement's Starlit Smith, Eugene Gillespie, Danielle Dobija, and Faheera Nadeem

Residential Assessment Development *(Darryl Smith)*

- ***Trainings:*** Continued specific training with ***Community Living Services*** and ***Wayne Center's*** new supports coordination staff reviewing the entry process of the residential assessments that produce an increase in the services after their completion.
- ***Reviews and Training of DWIHN Residential Assessment***: Completed 6 billable assessments along with 10 residential assessment reviews with the supports coordination staff of ***Community Living Services, Wayne Center, and All-Well Being Services***. Also beginning review of levels of care for DWIHN members currently residing in (out-of-county) ***Hope Network*** facilities.
- ***Special Assignment:*** Finalizing of the process flow drafts for Residential Assessment entry process and HAB Waiver Referrals.

Department Tasks

- Residential Department Development of Response to Crisis Recommendations (***2/1/22***)
- Teleconference Call: Case Review of MORC (DD) Member @ Ascension-St John Moross Hospital; facilitated by RCS Lezlee Adkisson ***(2/2/22)***
- Development of Project: Reach Out COVID-19 Vaccination Reporting Process Flow (***2/3/22***)
- Teleconference Call: Review of Referral Process with Mark Anderson of Hope Network; facilitated by RCS Jessica Wright ***(2/4/22)***
- Residential Care Coordinators Review of Specialized Placement (Brokering) Process ***(2/4/22)***
- MCO and Residential Department: Provider Inquiry Form (PIF) Changes (***2/7/22***)
- Development Specialized Residential Monthly Monitoring Note Process Role-Out; facilitated by Residential Manager Kelly McGhee ***(2/8/22)***
- Submission of DWIHN Specialized Semi-independent Living providers to complete Narcan Training for ; facilitated by SUD Director Judy Davis (***2/9/22***)
- Residential Staff Metric Reviews; facilitated by department managers and director ***(2/9/22)***
- Teleconference Call w/ Michael Hunter (TWC): Transitional (Westland) Settings Proposal ***(2/9/22)***
- Clinical review of Inpatient Hospital length of stay with Residential and UM ***(2/10/22)***
- Residential Care Coordinators' Specialized Residential Provider Survey (development of fillable form and Smartsheet reporting grid) (***2/10/22***)
- 1915i SPA Workgroup with CCO Melissa Moody ***(2/11/22)***
- Residential Department Process Revision for Pre-Placement Documentation and Process flow for Team Wellness Center-Westland facility: 16 beds ***(2/11/22)***
- Documentation Scan Project for Residential staff at 707 (***2/11/22 – 2/17/22***)
- Residential & MCO Discussion: Internal Review Process for Prospective (Special Assignment) Providers ***(2/14/22)***
- Case Management/Supports Coordinator Monthly Monitoring Note Refresher Review ***(2/15/22)***
- Submission of Residential Department Meetings and Trainings to Vanessa Bradford ***(2/24/22)***

Department Goals

Staffing

- Resignation of Residential Care Specialist Ashley Tomaszewski; effective 2/25/22
- HR to repost (1) open Residential Care Specialist position
- Development of staff metrics
- Reviewing department processes

Automated Productivity Reporting

- Residential Hospitalization Penetration reporting: Reporting of inpatient data of members that have received specialized residential services within 30 days of hospital stay. Report confirms residential members inpatient stay is ***less than 1% overall*** for 2021 fiscal year.
- Continued reformatting of productivity report to monitor timeliness and response to service requests
  - *Smartsheet updates for new fiscal year reporting*

COVID-19 Reporting

	Fiscal Year 2020 (3/30/20 – 9/30/20)	Fiscal Year 2021 (10/1/20 – 9/30/21)	Fiscal Year 2022 (10/1/21 – 2/28/22)
# of Members			
COVID-19 Positive	169	76	93
Related Deaths	34	7	3
# of DCW Staff			
COVID-19 Positive	71	59	59
Related Deaths	3	0	2

Date reporting range: 12/1/21-2/28/22

COVID-19 Vaccine Booster Reporting

- Residential Services Department initiated reporting of (eligible) Members that have received Vaccine Boosters on 12/1/21 through **Project: Reach Out**
  - *Members are eligible for vaccine boosters at least 5 months after completing primary COVID-19 vaccinations*

	# of Members FULLY Vaccinated	Vaccine Booster Received
LICENSED		
City of Detroit	649	221
Western Wayne	1,243	503
UNLICENSED		
City of Detroit	93	92
Western Wayne	678	456

Date reporting range: 12/1/21-2/28/22

DWIHN Residential Facility Home Closures: **February 2022**

# of FACLITY CLOSURE NOTIFICATIONS	14
RECEIVED in February 2022: **ON GOING**	4
Requests ON-HOLD / PENDING	2
Completion of Facility Closure / All Members Relocated	8

RECEIPT DATE	FACILITY NAME	VENDOR / PROVIDER ID	SCHEDULED CLOSURE DATE	NOTIFICATION TYPE	# of Members	CONFIRMED CLOSURE DATE
01/05/22	Parkgrove Home	25943	02/15/22	CRSP Notification	5	02/26/22
01/18/22	Castle Home	25089	02/18/22	Provider Notification	3	02/16/22
01/19/22	Canterbury #4	32825	02/20/22	Provider Notification	2	02/01/22
01/21/22	Bloomfield-South	32702	02/28/22	CEO Notification	2	02/21/22
01/25/22	Saltz II	32995	02/28/22	Provider Notification	2	02/16/22
02/02/22	Delanie Home	27796	03/31/22	Provider Notification	3	02/02/22
02/09/22	Fort Road - AFC	33459	02/09/22	Provider Notification	4	02/09/22
02/16/22	Balfour Home	27745	02/28/22	Provider Notification	3	02/24/22
1/21/22	Bloomfield-North	27555	02/28/22	CEO Notification	4	On-going
1/27/22	Laurel Drive Home	32536	03/01/22	Provider Notification	2	On-going
2/31/22	ALS - Monterey Home	25890	03/15/22	Provider Notification	6	On-going
02/15/22	Reaume Home	27180	04/15/22	Provider Notification	3	On-going
02/15/22	Sargent Home	25236	04/15/22	Provider Notification	3	On-going
02/01/22	K & K SIL- Lexington	32800	04/01/22	Provider Notification	4	On-going

Residential CVD-19 Reporting	Feb-22
	CVD-19+ Residents
February 2022	4
January 2022	60
December 2021	24
November 2021	7
October 2021	4
FY 2021-22	99
FY 2020-21	**76**
FY 2019-20	**169**
Accumulative Total of CVD-19 Positive Residents	**344**
Accumulative Total of CVD-19 Resident Deaths	**44**
	CVD-19+ DCW Staff
February 2022	1
January 2022	39
December 2021	9
November 2021	7
October 2021	2
FY 2021-22	58
FY 2020-21	**59**
FY 2019-20	**71**
Accumulative Total of CVD-19 Positive DCW Staff	**188**
Accumulative Total of CVD-19 DCW Staff Deaths	**4**

Resident Deaths
1
1
0
1
0
3
7
34

DCW Staff Deaths
0
0
1
0
0
1
0
3

Detroit Wayne Integrated Health Network

Director Monthly Report

Reporting Department Substance Use Disorders

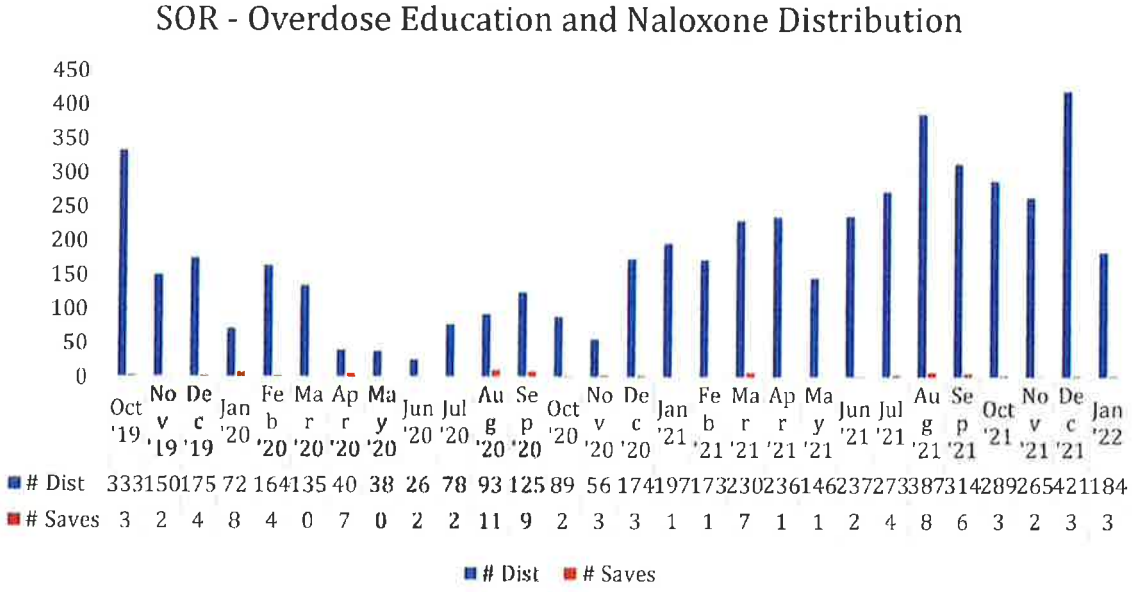
For the Month of February *2022*

Detroit Wayne Integrated Health Network was awarded State Opioid Response funding in 2019 as a measure to reduce overdose deaths related to opioids in Michigan which are of epidemic proportion. The State Opioid Response Grant is a comprehensive program constructed to combat the surge of opioid related overdoses through the provision of prevention, treatment and recovery activities for Opioid Use Disorders (OUD). In addition, the overall goal is to increase access to MAT, and reduce unmet treatment needs. Prevention services have a two-tier approach to prevent the onset of addiction in high risk population groups, and to prevent fatal overdoses through the distribution of naloxone. Treatment services address the onset and progression of opioid use disorder, designed to help the individual progress to remission. Recovery programs are designed to empower and engage individuals in recovery and prevent relapse

The OEND with harm reduction program enhances and expands our existing naloxone training within different caveats in the community.

Year 1: $62, 500
Year 2: $62,500

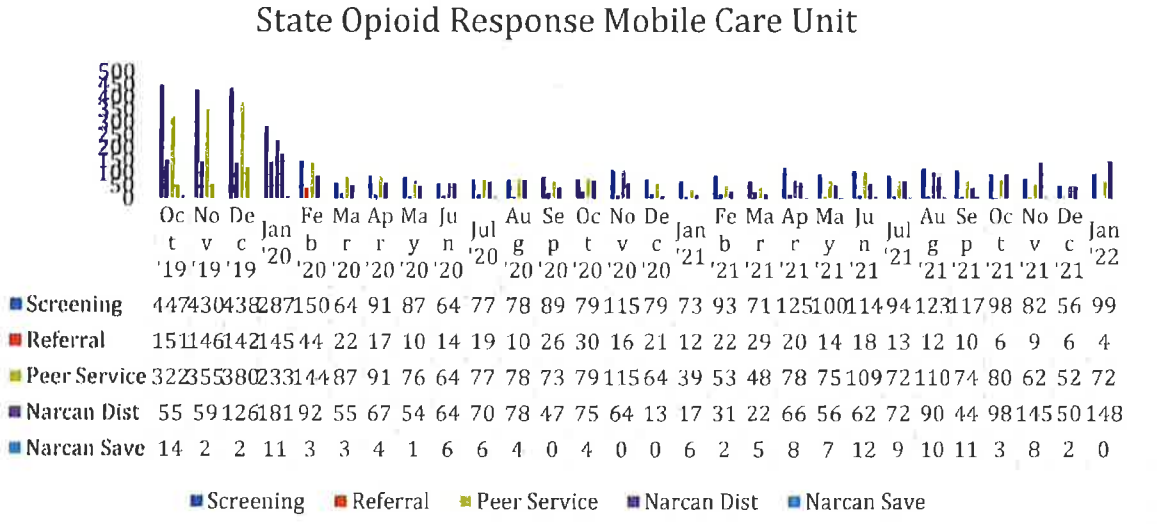
There was a total of 5,098 people served with Naloxone kits and training with over 100 reversed overdoses.



Naloxone distribution in Wayne County has steadily increased since the drop off in March 2020, as service provider programs seek new innovative ways to distribute naloxone and train individuals in a remote setting. Naloxone is distributed as an additional service in a local syringe service program and distributed in the community through partnerships with schools, restaurants, hospital systems, law enforcement programs, faith-based organizations and businesses

DWIHN has two mobile units that provide: SUD screenings for services, referrals to treatment, peer services, drug screenings, therapy, and relapse recovery services, Naloxone training and distribution.

- Approximately 3,730 individuals in Wayne County received screening services
- Over 988 individuals were referred to treatment from various community locations
- Peers services through mobile unit settings made 3,159 contacts with at-risk individuals
- Mobile Units distributed 2,001 naloxone kits that contributed to 134 reversed overdoses



Mobile care unit programs continue to exceed expectations increasing access to services and naloxone. Schedules have not reached the volume achieved pre-COVID; however, additional mobile care units have been deployed, and social distancing protocols are in place to serve all consumers while keeping patients safe. Mobile Care units have identified agencies and community hot spots to partner with, including but not limited to, government housing, senior living facilities, identified overdose hot spots, liquor stores, homeless shelters, food pantries, and at-risk subcultures

The SUD Department has been working tirelessly to address the Opioid Epidemic, which has devastated so many lives and harmed millions nationwide. We will not rest until we dramatically reduce opioid use disorder and overdose deaths and work to provide those suffering from the support they need. Unfortunately, we still have a lot of work to do in this area

DWIHN's Naloxone Initiative programs has saved **1,034** lives since its inception. Again, the saved lives are under-reported, especially during this time of the 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. DWIHN to date has distributed over 11,067 Narcan kits.

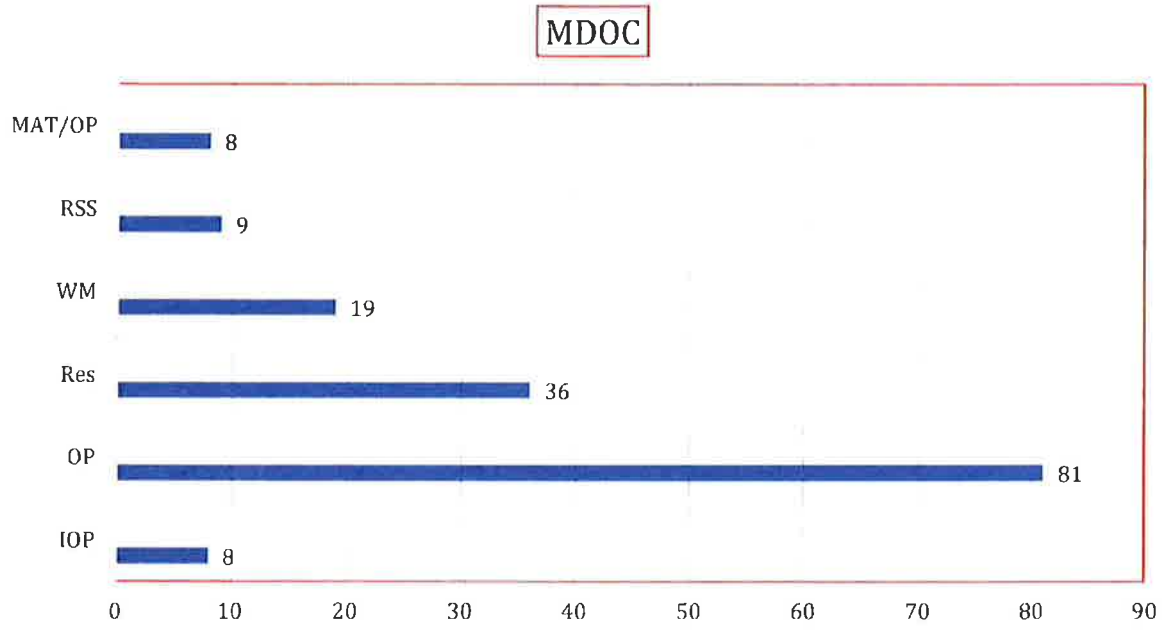
SUD COVID Numbers for the month of February 2022

	# Vaccinated	# of Client Deaths	# of Staff Death	# Client Pos for COVID	# Staff Pos for COVID	# of Hospitalizations
Treatment	96	3	1	248	59	7
Prevention	123	3	0	7	4	1
Total	219	6	1	255	63	8

There were 5 members who were directed to our quarantine facilities due to testing positive for COVID in February a 2/3 reduction in numbers from the previous month. Our numbers reflect the decrease in national COVID reports

Michigan Department of Corrections (MDOC)

***OP- Outpatient * MAT- Medication Assisted Treatment *RSS-Recovery Support Services *WM-Withdrawal Management*Res-Residential*IOP-Intensive Outpatient**



There was a total of 3,991 calls received in the Call Center for February, and 268 were from MDOC. The number of MDOC offenders who received a referral for SUD services totaled 161.

Prevention Efforts

DWIHN DYTURs address the outcomes, activities, and actions needed for FY 2022. Each year, the selected DYTURs connect with all alcohol, marijuana, and tobacco vendors (including vendors of e-vapor and hookah products) to clean the DWIHN region's Michigan Retail List (MRL) list totaling 1848 retailers. This allows the DYTURs to proceed to the next step of the SYNAR process. The MRL for region 7 includes – All of Detroit and Out Wayne locations.

Number of Persons Served by Type of Intervention
PIHP Region: Region 07 - Detroit Wayne Integrated Health Network
Date Range: 02/01/2022 - 02/25/2022

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
Selective	298	0
Universal-Direct	387	0
Universal-Indirect	0	377
Indicated	0	0
Total	**685**	**377**

DWIHN UTILIZATION MANAGEMENT MONTHLY REPORT
February 2022

Executive Summary

- **Autism:** There were 251 authorization requests manually approved during the month of February. There were approximately an additional 145 authorizations approved via the auto approval process for a total of 396 approved authorizations. There are 2,239 cases currently open in the benefit.
- **Habilitation Supports Waiver:** There are 1,084 slots assigned to the DWIHN. As of 02/25/2022, 1022 filled, 62 open, for a utilization rate of 94.3%.
- **County of Financial Responsibility:** The total number of open COFR cases increased by 2 in the month of February. There are currently 54 open cases.
- **Denials and Appeals:** For the month of February, there were fifteen (15) denials reported and seven (7) appeals. There were nine (9) service authorization administrative denials and seven (7) administrative appeal requests
- **General Fund:** There were 349 General Fund Authorization approvals during February 2022, including 17 for the Guidance Center.
- **MI Health Link:** The reporting format of MI Health Link authorizations reflects the total number of authorizations requests and the amount of each authorization type for the 5 ICOs. There were 26 MI Health Link authorizations received in February. The number of MI Health Link admissions to inpatient, partial and CRU are also included in the Provider Network data.
- **Provider Network/Outpatient Services:** A total of 688 admissions including Inpatient, MI Health Link, Partial Hospital and Crisis Residential were managed by the UM Department. There were 1449 approvals for non-urgent, pre-service authorizations.
- **State Facilities:** There were 2 state hospital admissions for the month and 68 NGRI consumers are currently managed in the community
- **SUD:** There were 1903 SUD authorizations approved during the month of February compared to 1815 approved in January. This month's data was collected on 2/25/2021. UM reviewed 1165 authorizations in February, compared to 1185 in January. Access and SUD Providers generated the remaining 738.
- **Administrative Denials**: During the month of February, the SUD team issued 14 administrative denials compared to 31 the previous month.
- **MCG**: Up until 2/25/22 there were 813 individuals screened in Indica which is an average of 32 cases per day screened using the MCG Behavioral Health Guidelines. This remains very consistent with our per day average which is usually between 30-32 screenings each day.

General Report

Utilization Management Committee

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

Autism Spectrum Disorder (ASD) Benefit

There were 251 authorization requests manually approved during the month of February. There were approximately an additional 145 authorizations approved via the auto approval process for a total of 396 approved authorizations. There are 2,239 cases currently open in the benefit.

This month, the UM team partnered with Procedure Code Work Group (PCWG) to ensure that DWIHN's fee schedule is consistent with updates from MDHHS. Specifically, ensuring that DWIHN is utilizing CPT codes 96112 and 96113 (9611x) for ASD Benefit eligibility assessments. DWHIN's various departments updated fee schedules, service utilization guidelines, and auto approval packages with the updated information. DWIHN's UM Department provided training and guidance to the ASD Network on the changes. As a result of these changes, providers will have to resubmit requests for 9611x to replace previously approved 90791 for any evaluation occurring 3/1/22. This is likely to artificially inflate the number of authorization requests for March and possibly April.

ASD Authorization Approvals for Current Fiscal Year to Date*:

	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Manual Approvals	473	450	407	345	251							
Auto Approvals	132	161	173	160	145							
Total Approvals	**605**	**611**	**580**	**504**	396							

*Numbers are approximate as they are pulled for this report prior to when all data for the month is available. Specifically, data for February was pulled 2/15/22.

ASD Open Cases and Referral Numbers Per WSA*

	Fiscal Year to Date											
	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Open Cases	2130	2184	2198	2229	2239							
Referrals	98	47	64	83	Pending Update from the WSA							

*Numbers are approximate as they are pulled for this report prior to when all data for the month is available. Specifically, data for February was pulled 2/25/22.

Habilitation Supports Waiver

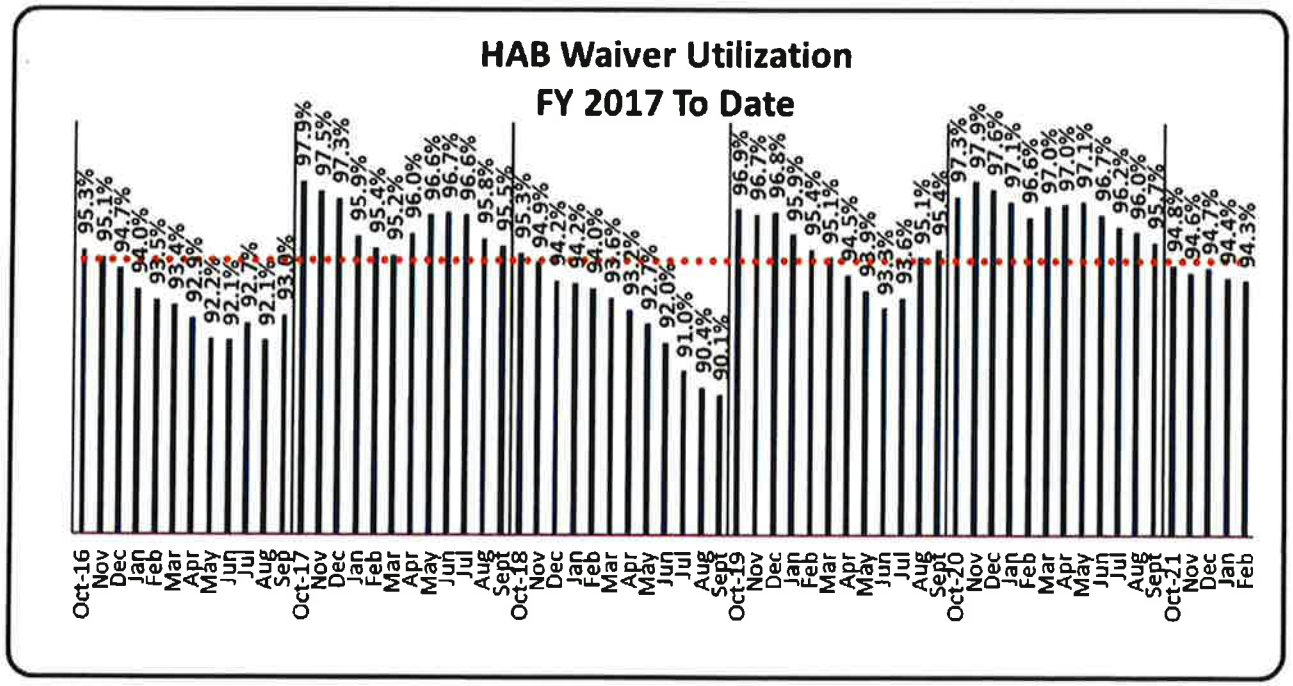
February Utilization (as of 02/25/2022)

HAB Utilization	February
Allocated	1,084
Used	1,022
Available	62
% Used	94.3

Program Details for January

Outcome Measurement	February
# of applications received	8
# of applications reviewed	8
# of app. Pended PIHP level for more information	2
#of pended app. resubmitted	
# of app. withdrawn	
Total of application sent to MDHHS.	6
Technical Assistants contacts	9
# of deaths/disenrollments (Recertification forms reviewed & signed)	12 (11 deceased; 1 moved out of state)
# of recertification forms reviewed and signed	32
# of recertification forms pended	12

Historical Trend



Serious Emotional Disturbance Waiver (SEDW)

# of youth expected to be served in the SEDW for FY 21-22	65
# of active youth served in the SEDW, thus far for FY 21-22	67
# of youth currently active in the SEDW for the month of February	59
# of referrals received in February	11
# of youth approved/renewed for the SEDW in February	4
# of referrals currently awaiting approval at MDHHS	0
# of referrals currently at SEDW Contract Provider	13
# of youth terminated from the SEDW in February	1
# of youth transferred to another County, pursuing the SEDW	2
# of youth coming from another county, receiving the SEDW	1
# 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 February. Weekly meetings are expected to continue. In January 2022, 52 cases were pending, February 2022 shows an increase of 2.

	Adult COFR Case Reviews Requests	Children COFR Case Reviews Requests	Resolved	Pending*
February 2022	3	2	3	54

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

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 349 General Fund approvals during February 2022, including 17 for The Guidance Center.

Denials and Appeals

For the month of February, there were fifteen (15) denials that did not meet medical necessity criteria, and seven (7) medical necessity appeals to report. From the seven (7) appeals, five (5) were overturned and three (3) were upheld. This report does not reflect the full month of February.

	Oct 21	Nov. 21	Dec. 21	Jan. 22	Feb. 22	Mar 22	Apr 22	May 22	Jun. 22	Jul. 22	Aug. 22	Sept 22
Denial	0	2	4	0	15							
Appeal	0	0	2	2	7							

Service Authorization Administrative Denials

During the month of February, there were nine (9) service authorization administrative denials and seven (7) administrative appeals. Of the seven (7) service authorization administrative appeals, there were five (5) appeals that were overturned and two (2) were upheld. This report does not reflect the full month of February.

Timeliness of UM Decision Making

Quarter 2 report will be provided in April.

State Hospital Liaison Activity Report

Hospital	Caro Center		Kalamazoo		Walter Reuther	
Census	Total	2	Total	6	Total	94
	NGRI	0	NGRI	1	NGRI	33
	Non-NGRI	2	Non-NGRI	5	Non-NGRI	61
Wait List	0		0		3	
Admissions	Total	0	Total	0	Total	2
	NGRI	0	NGRI	0	NGRI	0
	Non-NGRI	0	Non-NGRI	0	Non-NGRI	2
ALS Status	0		0		68	

- State hospital admissions continue to be restricted to forensic referrals. However, community referrals may be prioritized if hospital or residential placement options have been exhausted. The MDHHS Careflow Workgroup reviews these referrals and makes the determination for an expedited admission to the first available state hospital facility. This month 1 referral was submitted for expedited review and admitted.
- Community referrals remain wait listed and monitored by DWIHN to ensure case coordination and assessment of consumer needs. DWIHN continues to coordinate with community hospitals to review state hospital referrals and facilitate alternative options to state hospital admission. Currently, 3 DWIHN members are awaiting state hospital admission.
- Liaison staff continue to monitor and provide consult to the CMH provider network serving the 68 DWIHN members under NGRI status. This month, liaison staff worked to coordinate and establish the process for CMHSP transfer of NGRI cases. A member was transferred to Kent County upon request and approval of the NGRI Committee.

MI Health Link

Monthly ICO Authorization Report-February 2022

Report Filters

Date Range Selected: 2/1/2022 thru 2/25/2022

ICO's Selected: AETNA BETTER HEALTH OF MICHIGAN; AMERIHEALTH MICHIGAN, INC.; FIDELIS SECURECARE OF MICHIGAN; HAP MIDWEST HEALTH PLAN, INC.; MOLINA HEALTHCARE OF MICHIGAN INC

	Preservice Authorizations		Urgent Authorizations		Expedited Authorizations (Currently No DWIHN Authorizations labeled as Expedited)		Post Service Authorizations	
Total # of Auth's Received for the Month	Total Amount Preservice Auth's Received	Total Preservice processed ≤14 days	Total Amount Urgent Auth's Received	Total Urgent processed ≤24 hrs	Total Amount Expedited Auth's Received	Total Expedited processed ≤72 hrs	Total Amount Post Service Auth's Received	Total Post Service processed ≤14 days
26	1	1	8	8	0	0	17	17

***The number of MI Health Link admissions to inpatient, partial and CRU are included in the Provider Network data.*

The data for February 2022 delineates the total number of authorizations requests and the amount of each authorization type for the 5 ICOs. The table(s) account for the total number of authorizations by ICO, the type of authorization and the amount of time taken to process the request. Additionally, the data only includes those authorizations that required manual review and approval by UM Clinical Specialists. It does not include those authorizations that were auto approved because the request fell within the UM Service Utilization Guidelines.

As of 2/25/22, there were 26 MI Health Link authorizations received compared to 35 authorizations during the month of January, a 25.7% decrease. By ICO, there were 7 authorizations for Aetna, 5 for AmeriHealth, 0 for Michigan Complete Health (Fidelis), 7 for HAP Midwest and 7 for Molina. Out of the 26 MI Health Link authorizations reported, 100% of the requests were processed within the appropriate timeframes.

The UM Department received results for an audit conducted by Median Healthcare (formally Michigan Complete) and scored a 98.39%. The audit did not result in any corrective action plans.

Provider Network

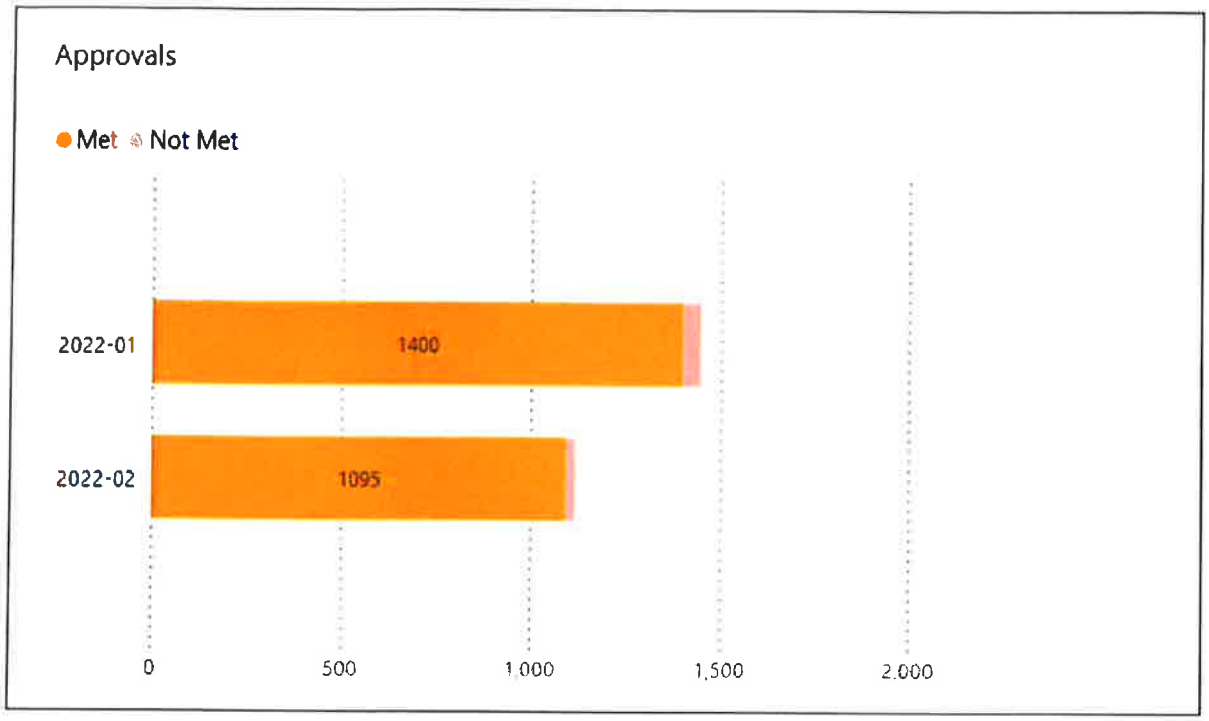
As of 2/28/22, the UM Team has managed a total of 688-member admissions within the provider network including Inpatient, MI Health Link, Partial Hospital and Crisis Residential. To date, there were 579 admissions for inpatient treatment reflecting a 14.34% decrease from the 679 inpatient admissions during January 2022. There were 13 members in February who readmitted within 30 days of a prior hospitalization compared to 57 members in January. The total number of recidivistic members is likely to increase once the monthly total for February is finalized. There were 52 Partial Hospital and 49 Crisis Residential admissions for adults and children. The two Adult Crisis Residential Units at Boulevard and Oakdale House have again reduced capacity due to a staffing shortage. Hegira Boulevard had seven available beds and Hegira Oakdale house had five available beds through the month of February. Only one location (Warren) of Safehaus remains open. The Grand Rapids and Rose City locations have been permanently closed.

The data outlined below reflects the number of admissions as of 2/28/2022:

- Inpatient: 579
- MHL: 8
- Partial: 52
- Crisis Residential (adults-37 and children-12): 49
- Total Admissions: 688
- Average Length of Inpatient admissions: 8.19

Outpatient Services (Non-Urgent, Pre-Service Authorizations)

As of 2/28/22, there were 1122 approvals for non-urgent, pre-service authorizations. These are authorization requests that required manual review by UM Clinical Specialists. The chart below depicts the number of approvals (1122), those that were approved within 14 days of the request (1095) and the 27 authorizations that were approved beyond 14 days. For comparison, the number of approvals from January are also included (3.38% approved beyond 15 days, 96.62% approved within 14 days). Out of the 1122 approvals in February, 97.59% were approved within 14 days of the request and 2.41% were approved 15 days or more after the submission. The UM Department continues to review and update the Service Utilization Guidelines to allow for auto approval of medically necessary services and decrease the number of authorizations requiring manual review. The Department also provided authorization guidance for providers who service children to support the network with the authorization process, help reduce the number of errors and decrease any delays in service provision.



Data Source: Power-BI

Substance Use Disorder

SUD Authorizations

There were 1903 SUD authorizations approved during the month of February compared to 1815 approved in January. This month's data was collected on 2/25/2021. UM reviewed 1165 authorizations in February, compared to 1185 in January. Access and SUD Providers generated the remaining 738.

OHH Contract

A meeting was held with IT, OHH, and UM to address some OHH contract set-up issues primarily with Hegira and the small percentage of consumers that may be receiving primary Mental Health services and only OHH services. Some follow-up regarding TEDS requirement was needed. There may be a request to PCE to program the system to bypass SUD admission and NOT require ASAM for this small population.

Medical Necessity Denials

There were no SUD medical necessity denials this month.

SUD Appeal Requests and Appeal Determination Forms

There was one SUD administrative appeal received during the month and the denial was overturned. Administrative appeals have a 30-day response time.

SUD Timeliness Dashboard

As of 2/25/22 there were 259 urgent authorizations approved. Out of the 259 257 (99%) were authorized within 72 hours. There were 858 non-urgent authorizations and 846 (99%) were approved within 14 days. There is some inconsistency in the numbers reported of the bar graphs versus the pie charts. IT has been requested to review the variance.

MCG

As of 1/27/22, there were 764 individuals screened in Indica which is an average of 28 cases per day screened using the MCG Behavioral Health Guidelines. Projecting until the end of the month, the per day average is usually between 30-32 screenings each day. There is a quarterly meeting with the MCG account representative is scheduled early in March. The Parity workgroup met in February and those minutes and documents discussed are on the Teams platforms. Briefly discussed was the upcoming rollout of the 26th edition. MCG will be invited to the next meeting to discuss the 26th Behavioral Health updates.

Procedure Update

Several procedures pertaining to Medical Necessity, Indicia and IRR were updated and routed through the approval process.

IRR

IRR testing continues with new hires. Several orientation sessions have been held to train staff member assigned to assist in the IRR functions.

FY 21 Annual UM Evaluation

The evaluation is scheduled to be presented in March to QISC and later to PCC and the Full Board. The FY 20/21 Annual IRR report was presented and approved at QISC.

Workforce Training & Program Development March Report: February 2022 Highlights

Reach Us Detroit 24/7 Virtual Therapy Line continues to be offered to residents of Wayne County that are 14 and up. An increase in calls requesting support for risk assessments of youth that were suspended from school due to making verbal threats occurred. Student Advocacy Center provided RUD as a resource to families within Wayne County to complete behavioral health screenings and risk clinical risk assessments. Additional referrals from law firms have been made to support youth pending expulsion. Non-Wayne County individuals were referred to local resources.

Consultation was given to providers about ways to engage student learners within the organization and motivate clinicians to provide supervision was provided. A meeting was facilitated Area Health Education Centers and area universities to identify ways to engage students in being prepared for integrated healthcare in urban communities with health care shortages as a sustainability plan following the HRSA efforts

52 students are currently placed within provider networks that have followed the centralized training program developed during the HRSA training grant. During the month of February, incoming students were trained in Recipient Rights.

Training regarding Implicit Bias has been provided to Michigan School Social Work Association. Technical support for providers regarding new implicit bias requirements for health care professionals (specifically social work) was provided. Training also continued on the subject in collaboration with the U of M School of Public Health, Oakland, Wayne and Macomb Counties.

For the month of February, the Workforce Development department continues to offer hybrid training events and conferences. To achieve this goal all staff were utilized to assist in all phases of event planning and execution. The team facilitated 4 Mental Health 101 training sessions for the Michigan Department of Health and Human Services. The sessions' content provided insight and knowledge on common mental illnesses, as well as provided ways to help those in need cope with their illnesses. The training was also designed to help encourage resiliency and hope. The department also hosted DWIHN's 7th Annual Trauma Conference, which aimed to provide definitions and examples of health inequity, marginalized communities, and historical trauma. In addition to providing the relevance of trauma and the pandemic, stress and community disproportionately observed in marginalized communities for traumatic stress. Staff participated in additional training on safety planning to support the increase in recent violent incidents. We also hosted an active shooter training for DHHS staff. Training was completed to increase knowledge in Sexual Orientation Gender Identity and Expression (SOGIE).

DWIHN was awarded over $4 million in support of a flooding crisis counseling grant. To provide CCP supports and services, DWIHN and OCHN will contract with local provider organizations, who will hire and deploy Crisis Counselors from the areas to be served. Crisis Counselors will provide both outreach and CCP services delivery.

DWIHN's contracted local providers are ACCESS, Team Wellness, and Lincoln Behavioral Services. These three providers will each hire teams of 12 Crisis Counselors, led by a Provider Project Manager and 2 Team Leaders.

Each team of 12 will have 2 Crisis Counselors dedicated to Macomb County flood survivors, and the remaining 10 Crisis Counselors dedicated to Wayne County flood survivors.

The Veteran Navigator continued to help Veterans and providers find relevant resources that can help them with their mental, physical, legal, financial, and spiritual health. There was interaction with 19 new veterans via face-to-face, phone, text, and email. The Navigator continued to assist 8 veterans with complex issues that have been receiving support for over six months. A meeting was held with the Prison Liaison over Zoom to discuss how she could be assisted in helping Veterans who are released from prison. The Navigator also met with Peer Support at the Guidance Center to provide them community resources and improve our communication for a more team approach.

The Navigator attended food distribution events with Soldiers Angels in Detroit and Veterans Haven in Wayne. It was the regular food distribution events with 123+ being served in Detroit and 62+ served in Wayne/Romulus. It continues to be a good way to connect with Veterans while they are waiting in their cars to get food. Was able to assist a number of Veterans on the spot with resources.

Justicc Involved Efforts

Detroit Police Department/DWIHN Pilot Partnership - ***To ensure that reporting is accurate, data for this project will be presented for the previous month.***

Central City Integrated Health (CCIH) serves as the lead behavioral health provider for the homeless outreach team. There were 611 encounters - 10 people agreed to complete a mental Health Screening as reported by the Detroit HOT team.

CNS and Team Wellness continued to support law enforcement through our co-response partnership with the Detroit Police Department. During the month of January Co-Responders made a total of 183 encounters. We had a total of 51 individuals who were connected to a service. This month we had 11 suicide calls, the CIT team was able to intervene and provide the appropriate interventions to prevent harm to the consumers. There was a total of 3 overdose calls for the month of January. The CIT team was able to coordinate with both the EMS and Nurses at the hospital where the consumer was conveyed due to medical issues. A total of 43 resource cards were provided and reviewed with consumers for assistance with mental health, substance use, and homelessness.

DWHIN facilitated an AOT meeting with providers to provide insight into AOT orders, where they can be located, and who to contact if any issues arise. This information was helpful as it can be used to determine if a consumer can be taken directly to the hospital for an evaluation if they are non-compliant with the order.

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

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

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

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

Contract Title: SUD Prevention Funding FY 22 Revised

Address where services are provided: 'None'

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

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

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

Program Type: Continuation

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

Date Contract First Initiated: 10/1/2021

Provider Impaneled (Y/N)?

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

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

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

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

Source of Funds: PA2

Fee for Service (Y/N): N

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

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

Type of contract (Business/Clinical):

ACCOUNT NUMBER: MULTIPLE

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Wednesday, February 23, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Thursday, February 17, 2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK
BOARD ACTION

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

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

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

Contract Title: Behavioral Health Home

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

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

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

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

Program Type: New

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

Date Contract First Initiated: 4/1/2022

Provider Impaneled (Y/N)? Y

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

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

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

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

Source of Funds: Medicaid,Other

Fee for Service (Y/N): Y

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

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

Type of contract (Business/Clinical): Clinical

ACCOUNT NUMBER: 64939.827050.00000

In Budget (Y/N)?

Approved for Submittal to Board:

Eric Doeh, Chief Executive Officer

Signature/Date:

Eric Doeh

Signed: Monday, February 28, 2022

Stacie Durant, Chief Financial Officer

Signature/Date:

Stacie Durant

Signed: Monday, February 28, 2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK

QAPIP Annual Evaluation

Fiscal Year 2021

QAPIP ANNUAL EVALUATION

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

QAPIP ANNUAL EVALUATION

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

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

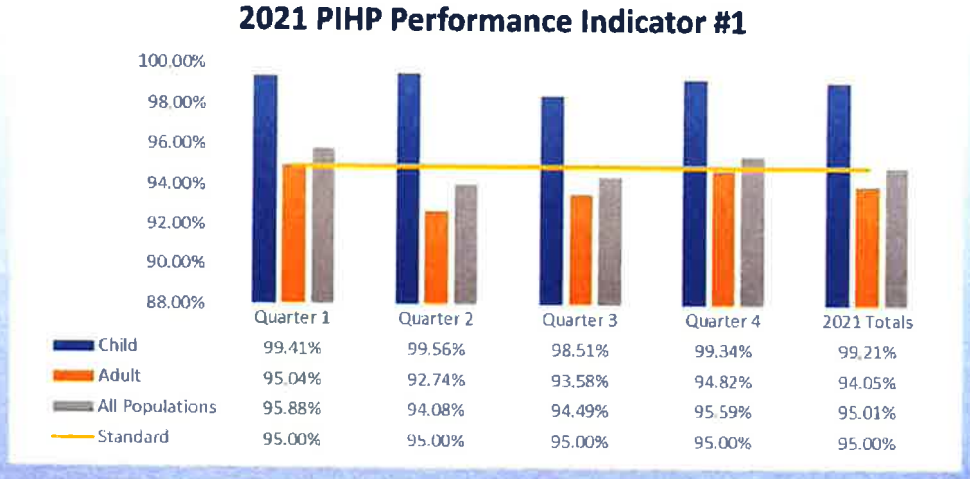
QAPIP ANNUAL EVALUATION

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

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

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

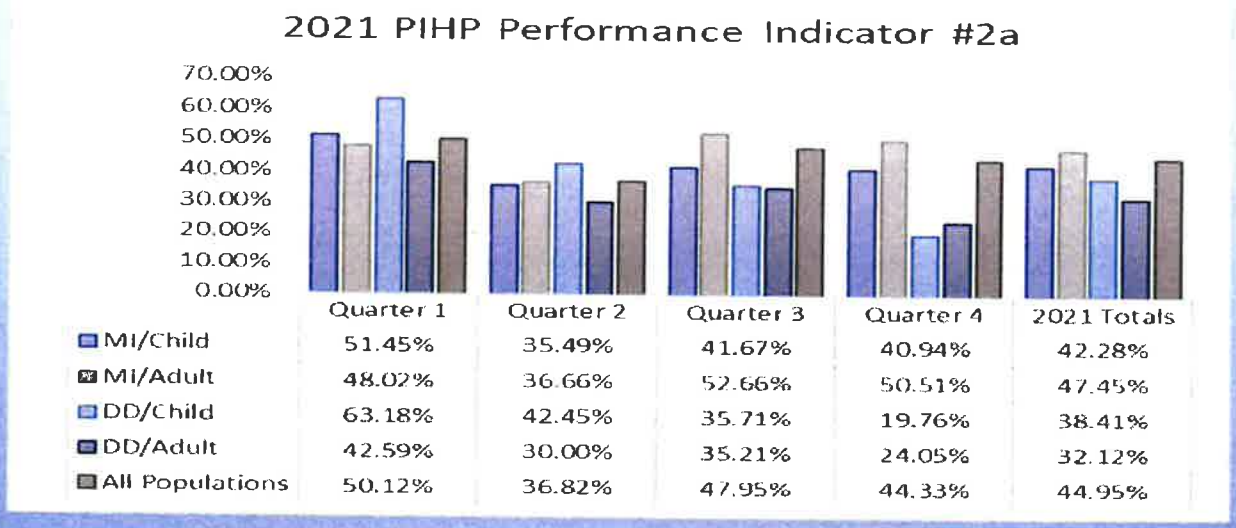
Results: FY21 standard met for <u>all</u> populations (95.01%)



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

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

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



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

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

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

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

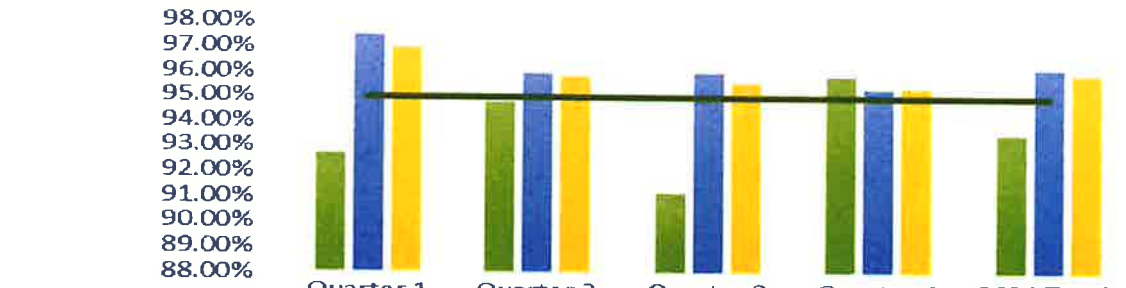
2021 PIHP Performance Indicator #3

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

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

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

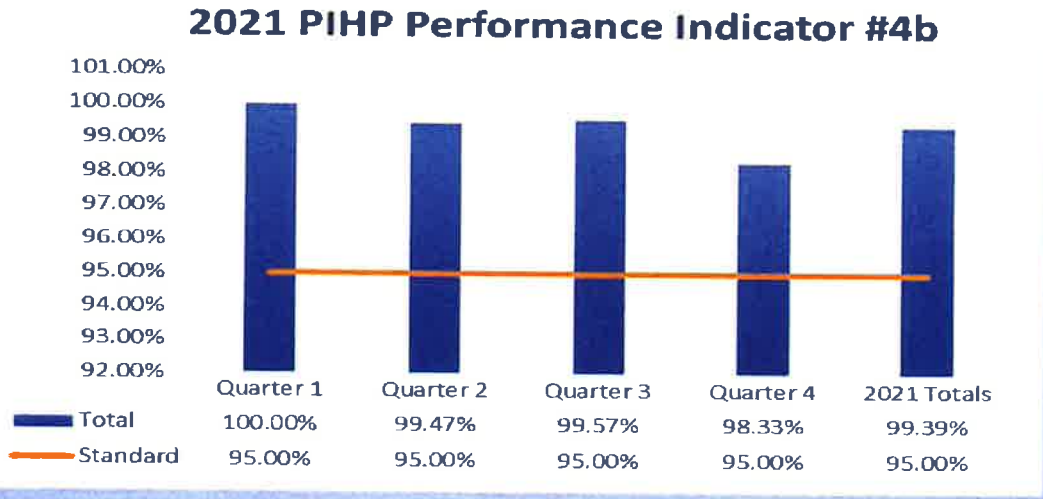
2021 PIHP Performance Indicator #4a



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

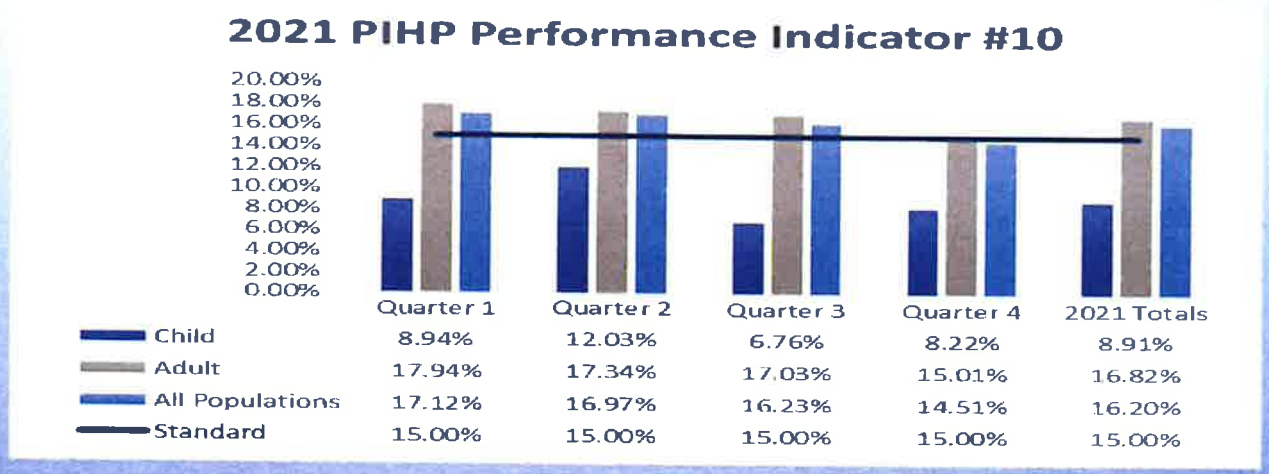
INDICATOR 4B: SUBSTANCE ABUSE DETOX DISCHARGE SEEN FOR 7-DAY FOLLOW-UP CARE WITHIN 7 DAYS (THRESHOLD 95%)

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



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

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



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

QAPIP ANNUAL EVALUATION

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

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

Year End Monitoring Data FY 2021

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

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

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

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

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

QAPIP ANNUAL EVALUATION

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

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

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

QAPIP ANNUAL EVALUATION

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

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

QAPIP ANNUAL EVALUATION

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

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

QAPIP ANNUAL EVALUATION

External Quality Reviews

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

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

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

QAPIP ANNUAL EVALUATION
OVERALL EFFECTIVENESS

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

Detroit Wayne Integrated Health Network

(DWIHN)

Quality Assurance Performance Improvement Plan
Annual Evaluation Fiscal Year 2021

Submitted by:

April L. Siebert - Director of Quality Improvement

Approved:

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

Table of Contents

Introduction

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

Executive Summary

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

Description of Service Area

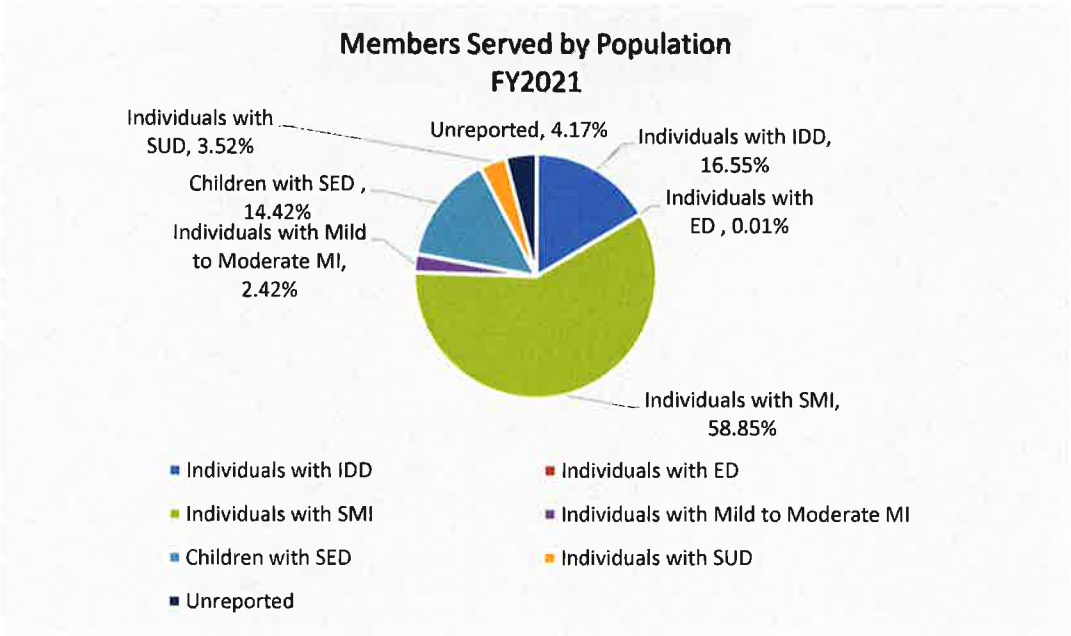
Wayne County is the most populous county in the State of Michigan. As of 2020, the United States Census estimated its population as 1.7 million, and ranked 19th in population in the United States. Wayne County is comprised of 34 cities and 9 townships covering roughly 673 miles. The municipality of Detroit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

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

Demographics

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

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



Customer Pillar

Member Experience

Activity Description

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

Quantitative Analysis and Trending of Measures

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

ECHO Reporting Measures, Comparison Across Years

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

Evaluation of Effectiveness

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

ECHO Reporting measures, Child Comparison to Adult Results FY21

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

Barrier Analysis

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

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

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

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

Interventions and Actions

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

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

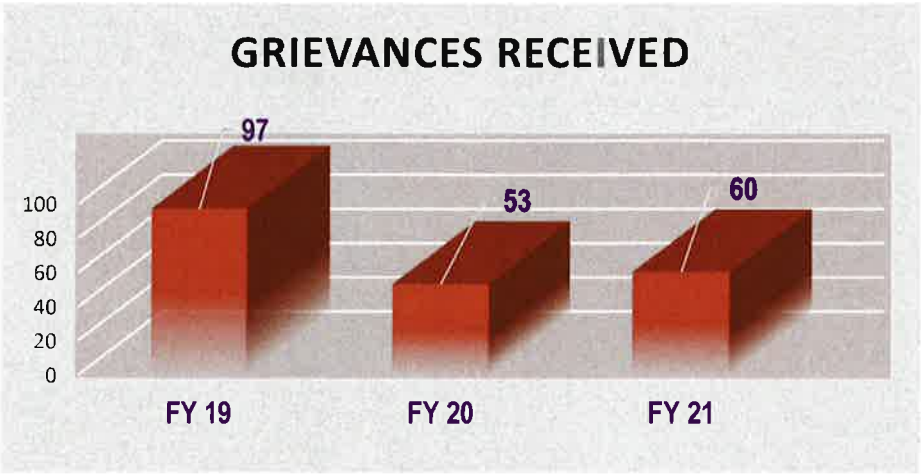
Member Grievances

Activity Description

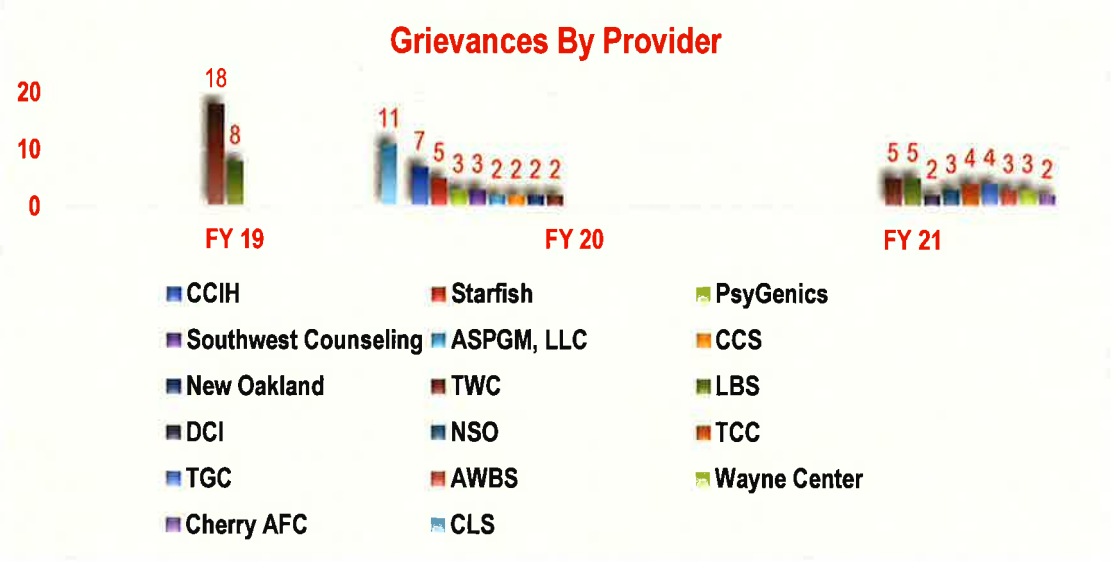
DWIHN's Customer Service completes an analysis of member experience trends and occurrences through review of Grievances, Appeals, Recipient Rights and Sentinel Events data. DWIHN uses this data and other initiatives to determine priority actions and improvements to better engage members and stakeholders.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

Quantitative Analysis and Trending of Measures

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



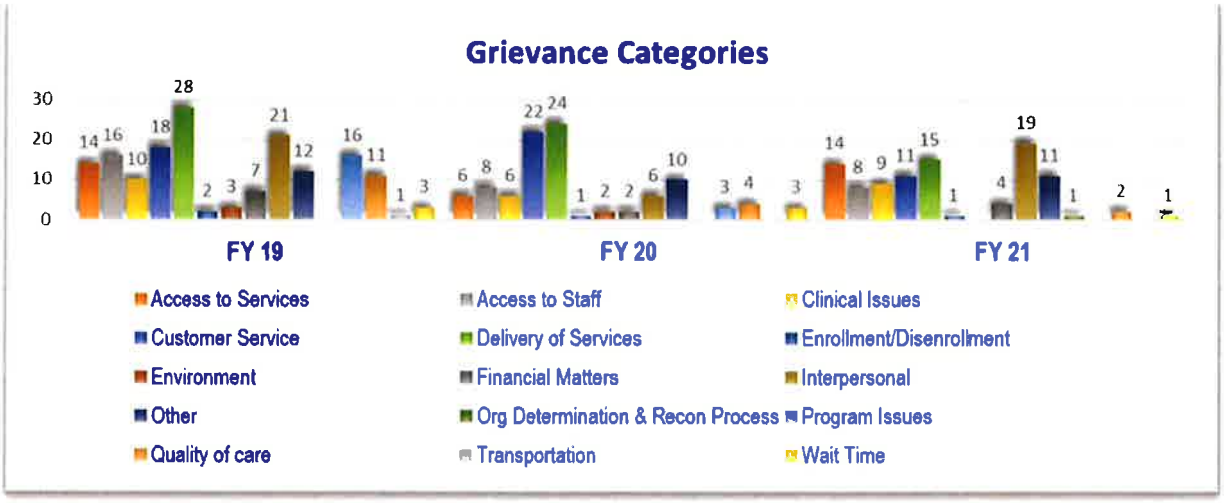
DWIHN has network of approximately 120 providers. However, grievances were not reported against every provider. Although grievances were filed against several providers. For the purpose of this report, recipients filed the most grievances against the providers as identified in the graph below.



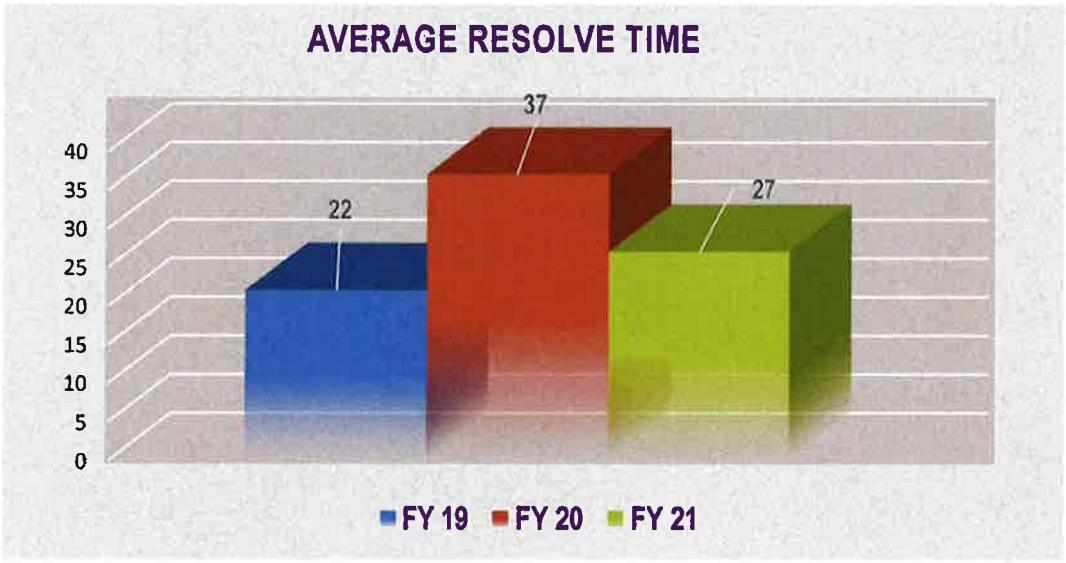
Team Wellness Center (TWC) had the highest volume of grievances, total of 25, reported over the past three years. It is important to note there was a decrease by 92% in FY '20 and 80% decrease in FY '21 compared to the number of grievances reported in FY '19 LBS had the second highest number of grievances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

Evaluation of Effectiveness

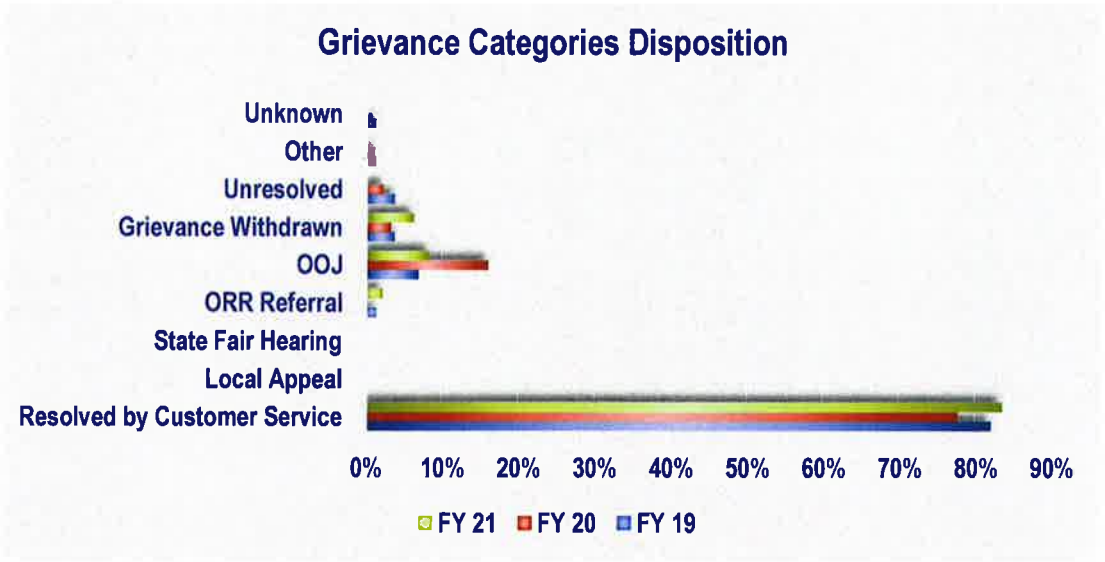
The number of categories identified within a grievance can be significantly greater than the number of grievances received. However, a grievance is not considered resolved until all the categories within a grievance have been thoroughly investigated and considered appropriate for closure. DWIHN identifies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



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



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



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

Barrier Analysis

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

Opportunities of Improvement

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

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

Provider/Practitioner Survey

Quantitative Analysis and Trending of Measures

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

Evaluation of Effectiveness

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

Intervention and Action Taken

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

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

Barrier Analysis

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

Opportunities for Improvement

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

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

National Core Indicators Survey (NCI)

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

Complex Case Management (CCM)

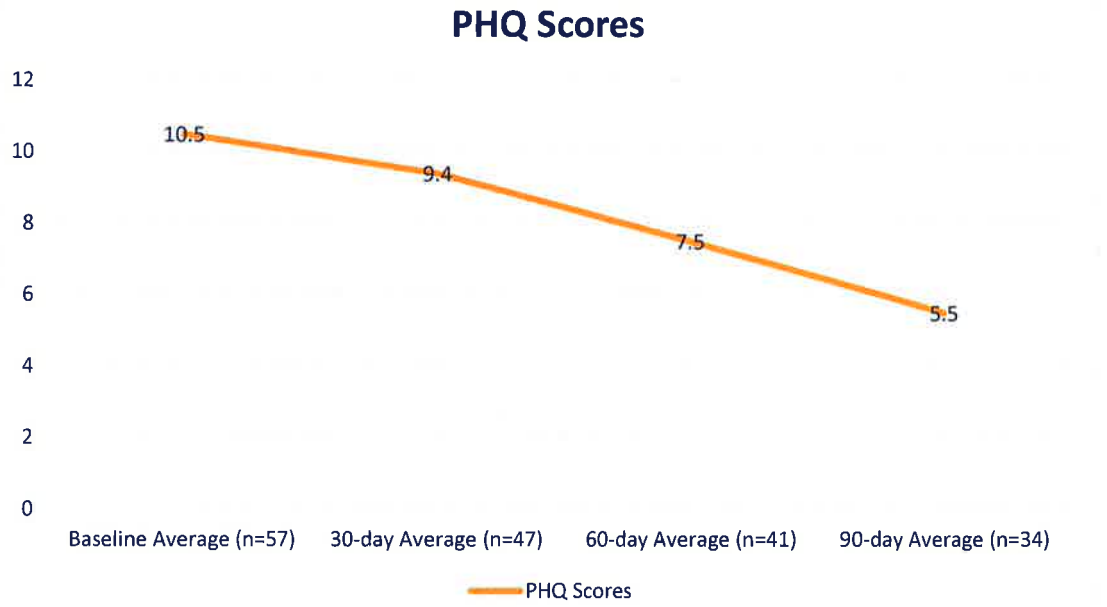
DWIHN's CCM program has innovative methods to identify and proactively reach out to members who are at high risk for psychiatric hospitalization, to help them understand their behavioral health clinical condition, adhere more closely to outpatient treatment recommendations and gain condition self-management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

Quantitative Analysis and Trending Measure

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

Evaluation of Effectiveness

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



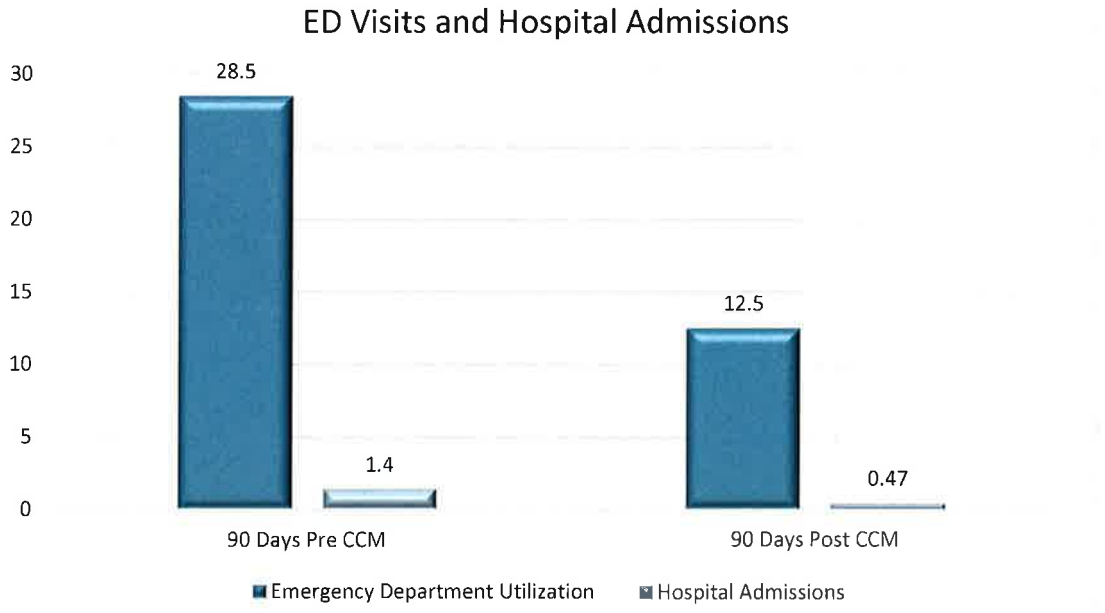
57 out of 60 members were included in the denominator for the initial PHQ scores. 3 of the members were not included in the denominator due to being unable to reach for assessment completion. 47 out of 60 members were included in the denominator for the 30-day PHQ scores. 13 of the members were not included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

Causal Analysis

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

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

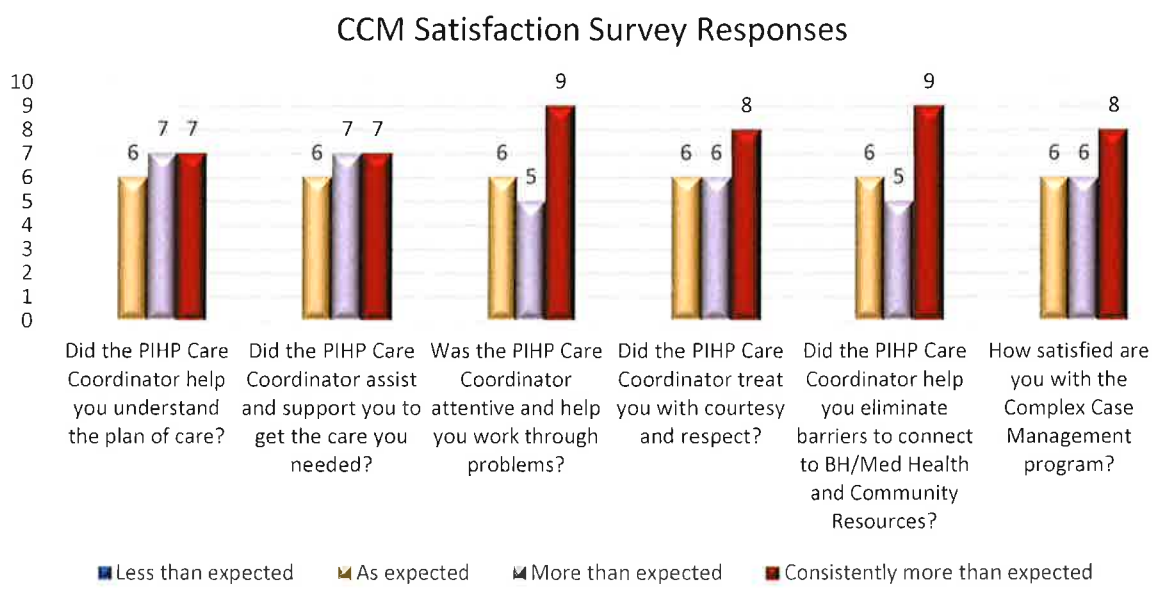
DWIHN analyzed member Admission, Discharge and Transfer (ADT) alerts and DWIHN claims data to measure utilization of Emergency Department and Hospital Admissions 90 days prior to participating in CCM services and 90 days after starting CCM services. Members participating in CCM services showed an average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



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

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

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



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

Barrier Analysis

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

Opportunities of Improvement

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

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

Cultural and Linguistic Needs

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

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

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

Credentialing

Activity Description

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

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

Quantitative Analysis and Trending of Measures

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

Barrier Analysis

No barriers identified

Office of Recipient Rights

Activity Description

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

DWIHN has identified the following as opportunities for improvement:

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

Access Pillar

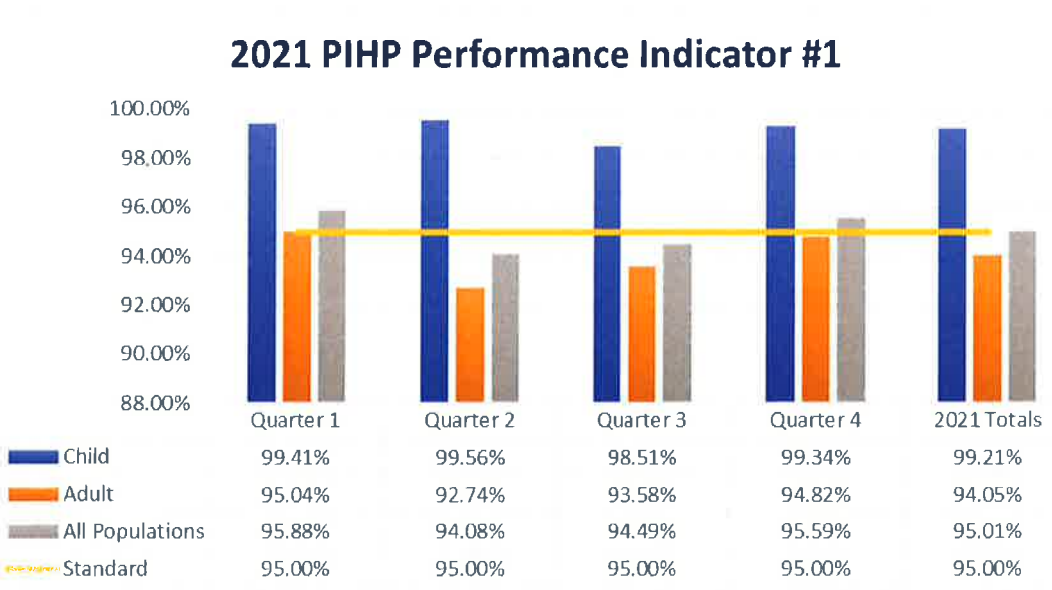
Michigan Mission Based Performance Indicators (MMBPI)

Activity Description

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

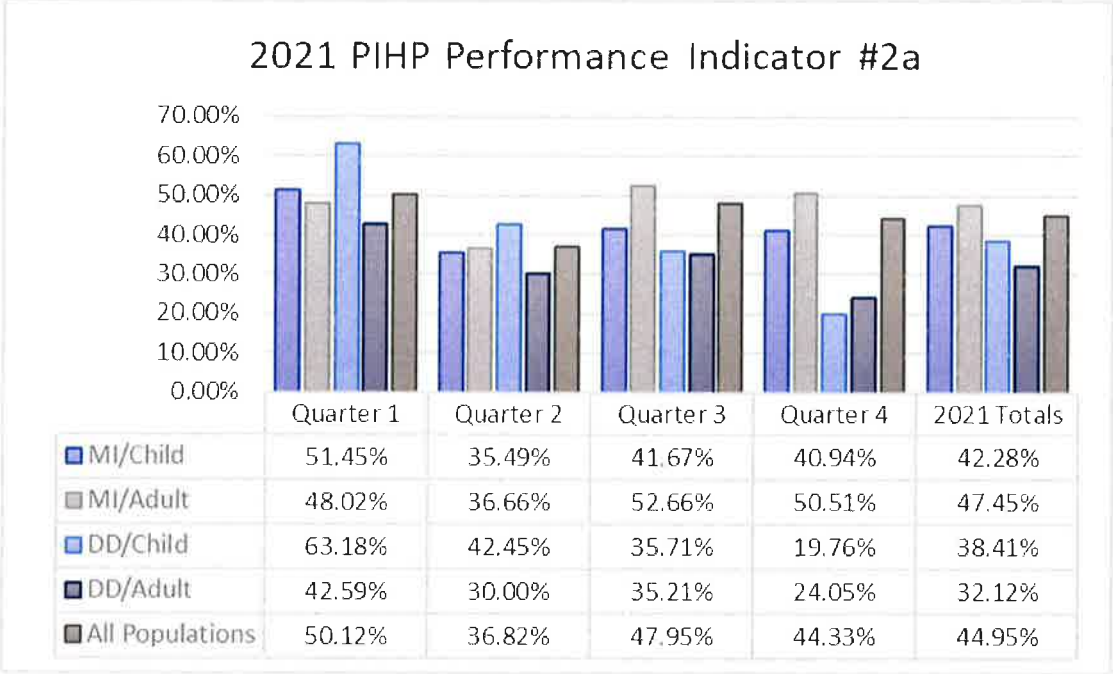
Quantitative Analysis and Trending of Measures

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



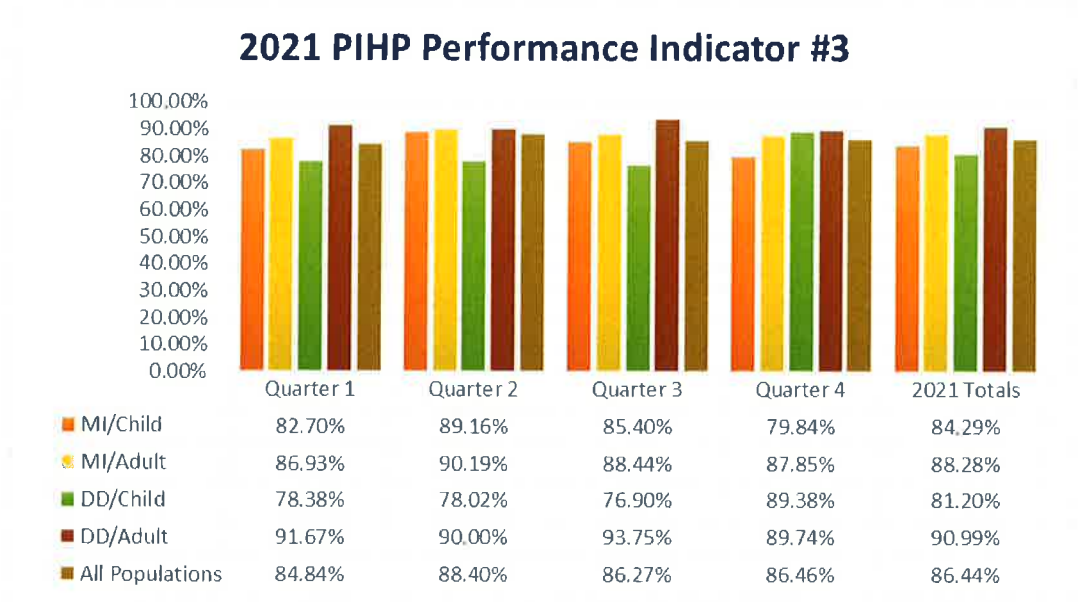
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	99.41%	99.56%	98.51%	99.34%	99.21%
Adult	95.04%	92.74%	93.58%	94.82%	94.05%
All Populations	95.88%	94.08%	94.49%	95.59%	95.01%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

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



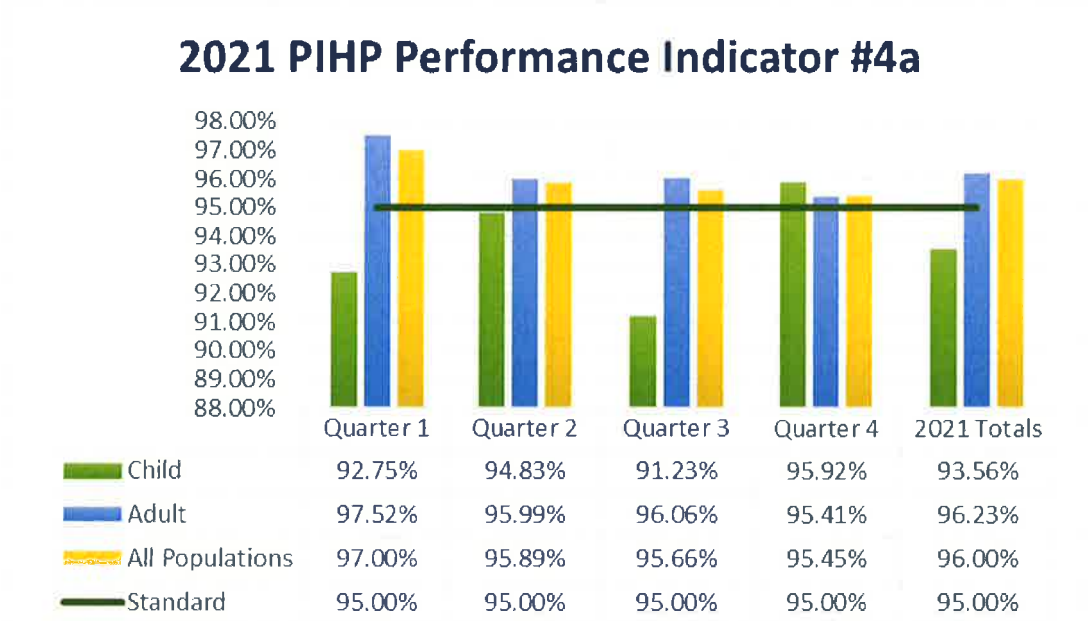
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	51.45%	35.49%	41.67%	40.94%	42.28%
MI/Adult	48.02%	36.66%	52.66%	50.51%	47.45%
DD/Child	63.18%	42.45%	35.71%	19.76%	38.41%
DD/Adult	42.59%	30.00%	35.21%	24.05%	32.12%
All Populations	50.12%	36.82%	47.95%	44.33%	44.95%

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



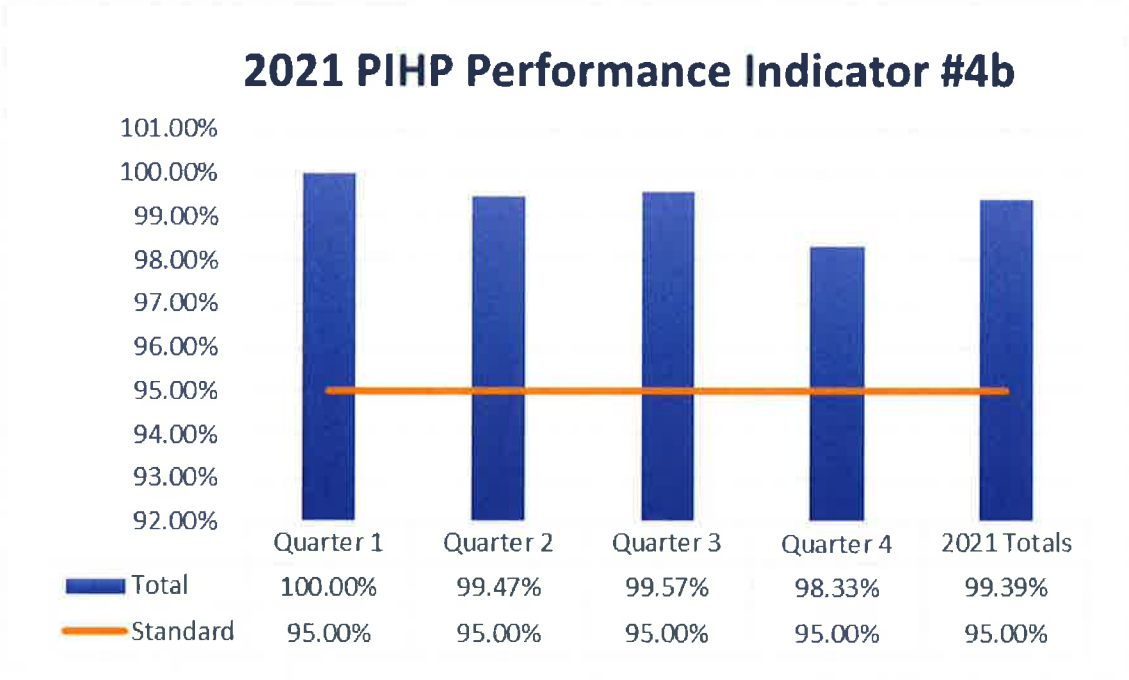
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
MI/Child	82.70%	89.16%	85.40%	79.84%	84.29%
MI/Adult	86.93%	90.19%	88.44%	87.85%	88.28%
DD/Child	78.38%	78.02%	76.90%	89.38%	81.20%
DD/Adult	91.67%	90.00%	93.75%	89.74%	90.99%
All Populations	84.84%	88.40%	86.27%	86.46%	86.44%

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

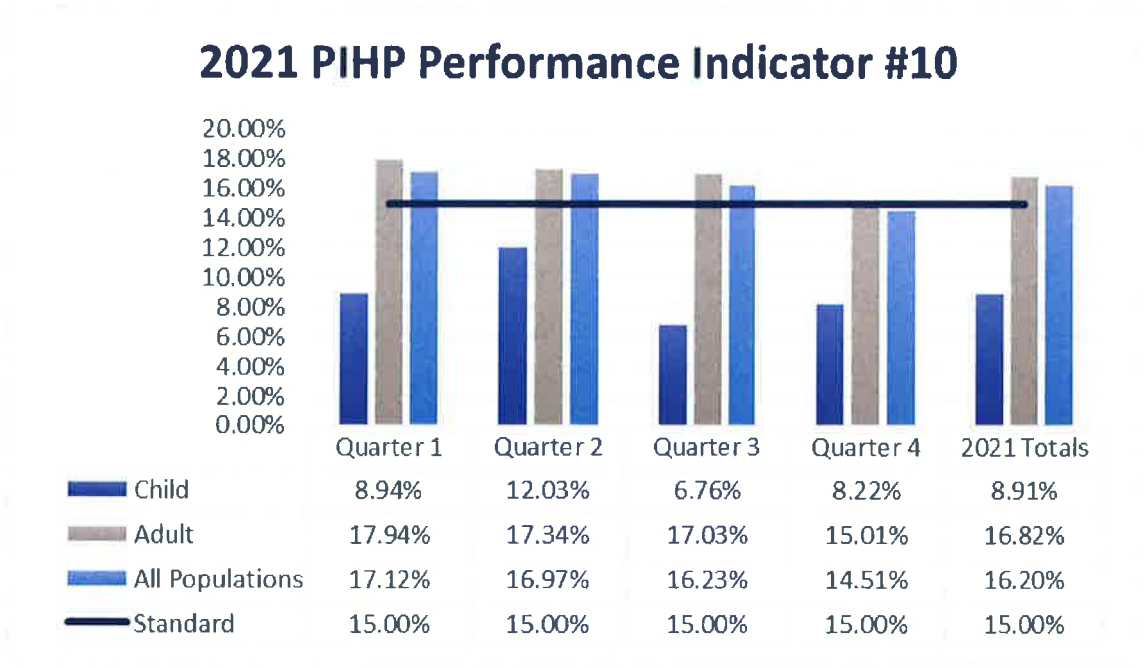


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2021 Totals
Child	92.75%	94.83%	91.23%	95.92%	93.56%
Adult	97.52%	95.99%	96.06%	95.41%	96.23%
All Populations	97.00%	95.89%	95.66%	95.45%	96.00%
Standard	95.00%	95.00%	95.00%	95.00%	95.00%

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



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



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

Evaluation of Effectiveness

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

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

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

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

Data Analysis

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

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

Barrier Analysis

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

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

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

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

Opportunities of Improvement

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

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

Improving Access and Crisis Services

Activity Description

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

Quantitative Analysis and Trending of Measures

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

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

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

Evaluation of Effectiveness

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

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

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

Barriers Analysis

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

Opportunities of Improvement

The following opportunities were identified:

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

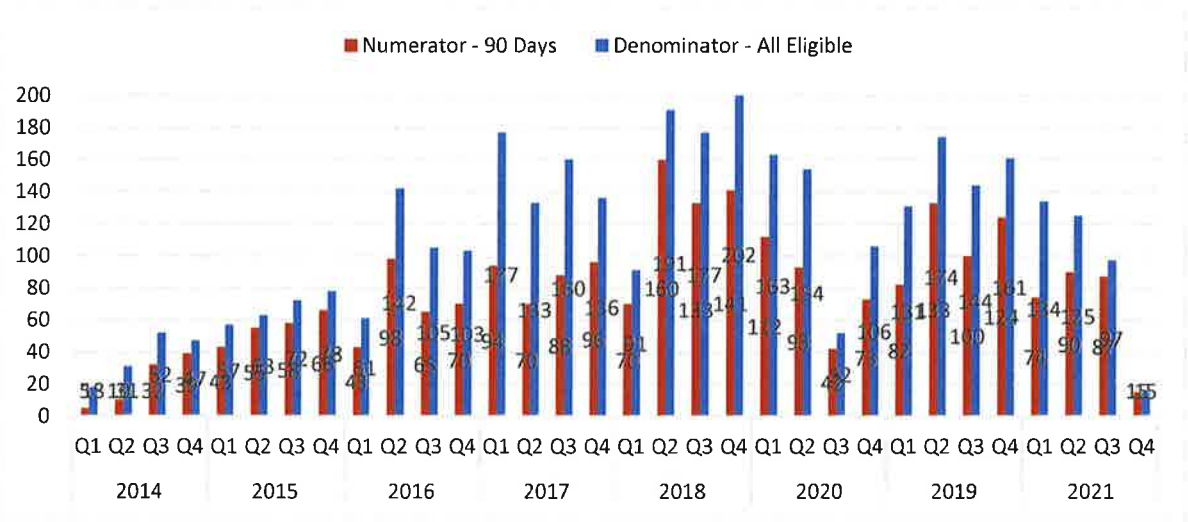
Access to Autism Services

Activity Description

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

Quantitative Analysis and Trending of Measures

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



Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities of Improvement

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

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

Access to Substance Use Disorder (SUD) Services

Activity Description

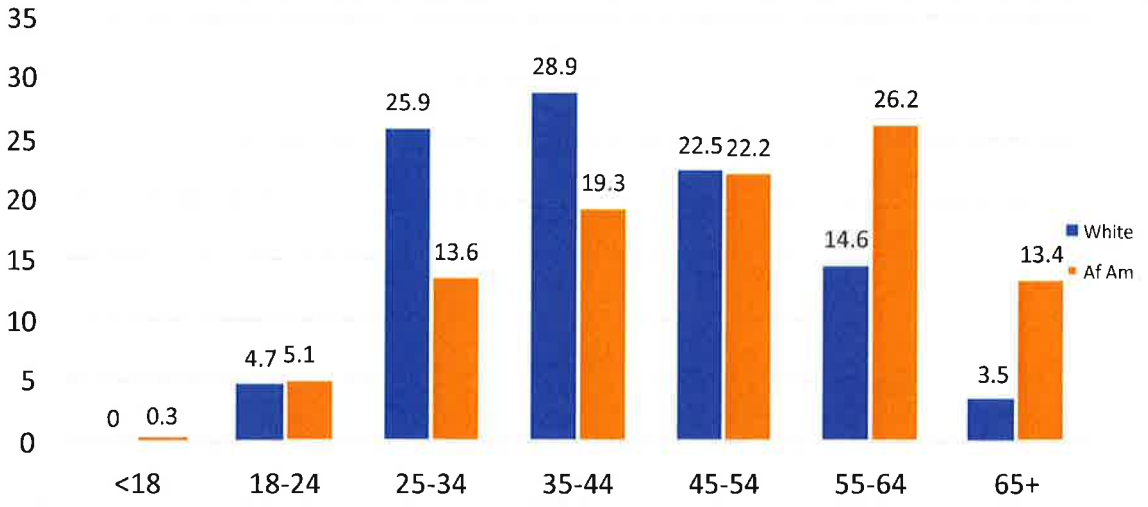
In FY21, the Substance Use Division focused on improving treatment services for individuals with opioid use disorder. The goal of this improvement was to develop and implement an Opioid Health Home (OHH) model of care. An Opioid Health Home is a model of care that provides comprehensive care management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

Quantitative Analysis and Trending of Measures

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

Evaluation of Effectiveness

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



Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

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

Quality Pillar

Performance Monitoring

Activity Description

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

Quantitative Analysis and Trending of Measures

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

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

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

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

Evaluation of Effectiveness

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

Barrier Analysis

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

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

Opportunities of Improvement

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

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

Activity Description

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

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

Quantitative Analysis and Trending of Measures

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

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

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

Evaluation of Effectiveness

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

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

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

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

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

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

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

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

Patterns, Trends, and Recommendations:
Substance Use Disorder

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

Behavioral Health

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

Barrier Analysis

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

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

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

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

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

Opportunities for Improvement

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

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

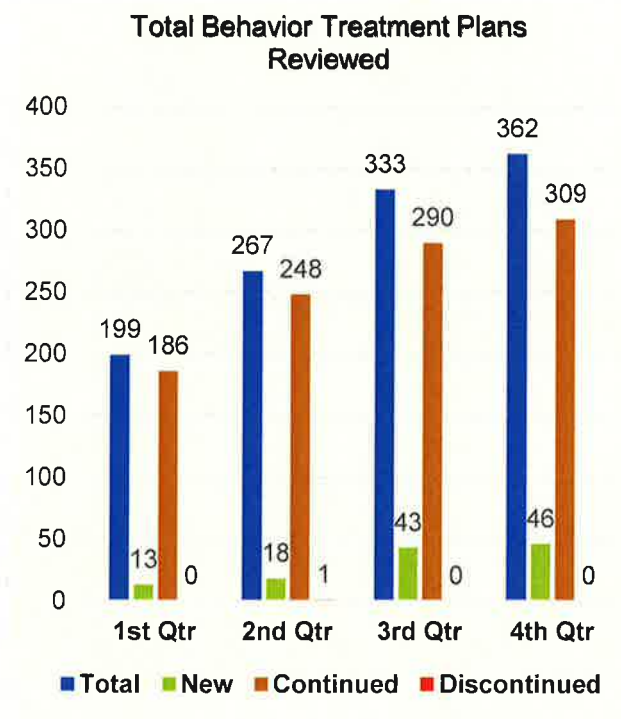
Behavioral Treatment Review

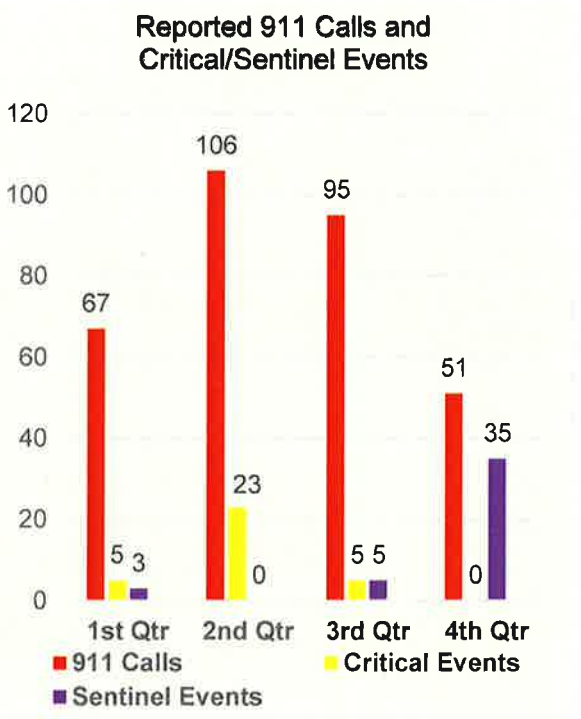
Activity Description

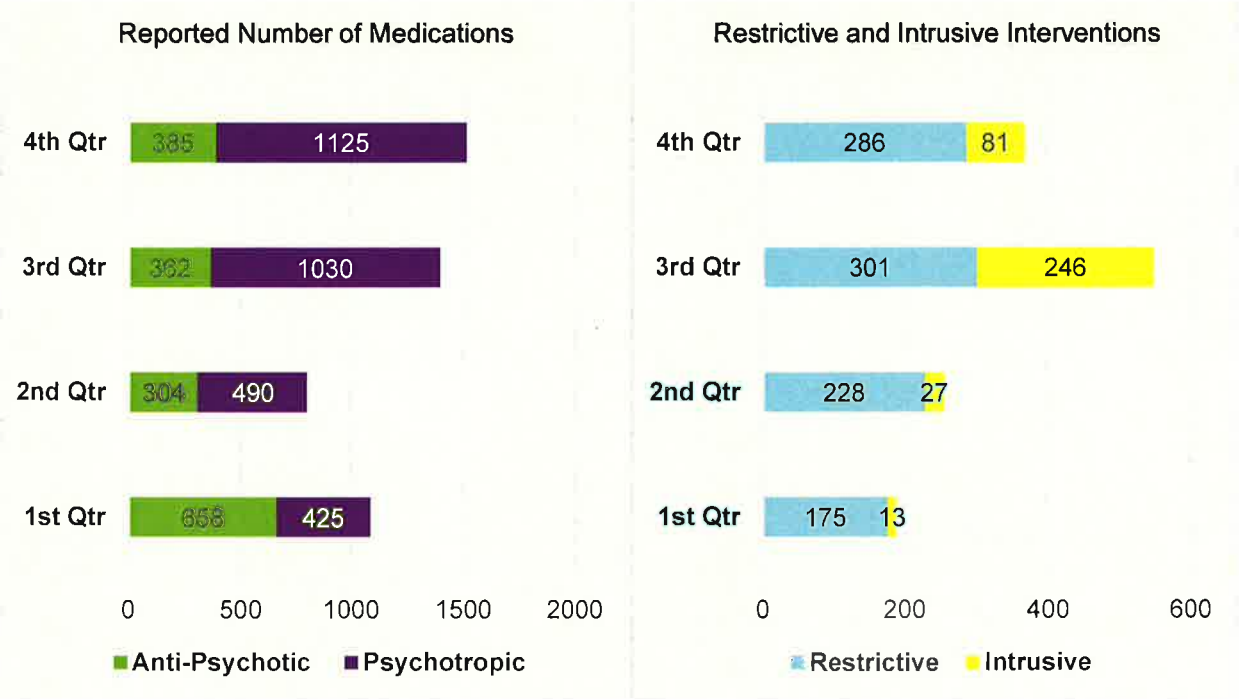
The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee (BTRC) where intrusive or restrictive techniques have been approved for use with members and where physical management has been used in an emergency. The data track and analyze the length of time of each intervention.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

Quantitative Analysis and Trending of Measures

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







Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

DWIHN has identified the following interventions and improvement efforts:

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

Performance Improvement Project

Activity Description

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

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

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

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

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

Barrier Analysis

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

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

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

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

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

Opportunities for Improvement

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

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

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

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

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

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

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

Evaluation of Effectiveness

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

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

Barrier Analysis

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

Improving Diabetes Monitoring for People with Schizophrenia and Bipolar Disorder

Activity Description

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

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

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

Care Coordination

Activity Description

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

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

Quantitative Analysis and Trending of Measures

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

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

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

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

Workforce Pillar

Activity Description

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

Quantitative Analysis and Trending of Measures

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

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

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

Evaluation of Effectiveness

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

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

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

Barrier Analysis

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

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

Opportunities for Improvement

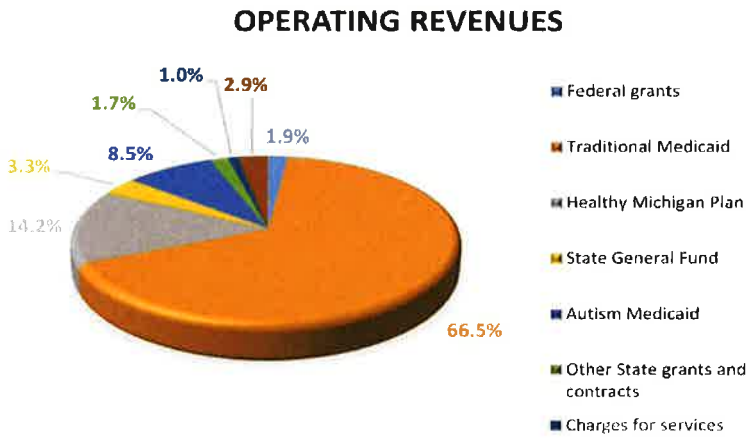
DWIHN plans to help build on the phases within DWIHN's System Transformation process. This momentum will assist and provide direct guidance on the measurable importance of holistic care. The network expansion will include technical assistance on the use of evidence-based screening and assessment tools,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

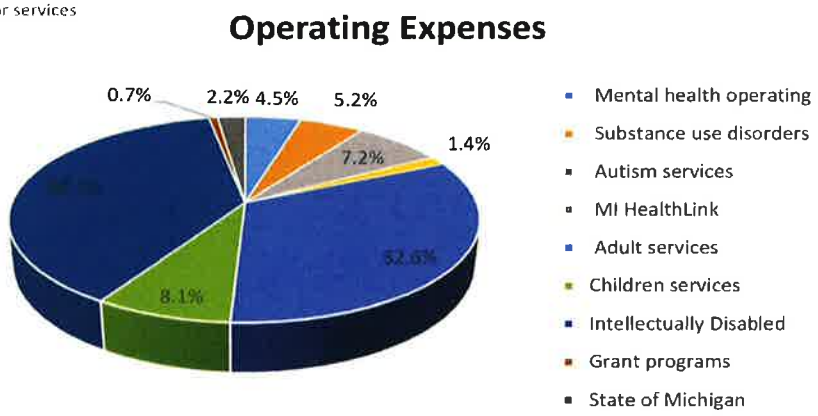
Finance Pillar

Verification of Services

Quantitative Analysis and Trending of Measures

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





Evaluation of Effectiveness

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

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

Barrier Analysis

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

Opportunities of Improvement

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

Advocacy Pillar

Home Community-Based Services (HCBS)

Activity Description

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

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement:

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

Community Outreach

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

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

DWIHN Website

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

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

Find a Provider

https://www.dwihn.org

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

Sharing of Information

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

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

DWIHN Accreditation

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

External Quality Reviews

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

Barrier Analysis

DWIHN determined the following barriers:

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

Opportunities for Improvement

To address these barriers, DWIHN initiated the following interventions:

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

Performance Measures Validation (PMV)

Activity Description

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

Quantitative Analysis and Trending of Measures

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

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

DWIHN identified the following improvement efforts:

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

Compliance Review

Activity Description

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

Quantitative Analysis and Trending of Measures

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

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

Evaluation of Effectiveness

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

Barrier Analysis

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

Opportunities for Improvement

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

Utilization Management

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

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

Adequacy of Quality Improvement Resources

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

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

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

Overall Effectiveness

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

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

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

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

Analysis

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

Committee Structure

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

Practitioner Participation

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

QI Program Effectiveness

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

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

2022 Work Plan Goals and Objectives

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

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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

QAPIP Workplan
FY 2021-2022

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