Quality Operations Technical Assistance Workgroup Meeting Agenda

Wednesday, January 26, 2022

Via Blue Jean Link Platform

9:30 a.m. – 11:00 a.m.

I.	Announcements	Tania Greason/April Siebert
II.	SUD Updates	Gregory Lindsey
III.	FY2021 Review of Protective Devices (BTPRC)	Daniel Dobija & Fareeha Nadeem
IV.	30 Day Follow-up Hospitalization w/MPH a. VDT (HEDIS – Measures)	Vicky Politowski
V.	NCI Survey	Margaret Keyes-Howard
VI.	Residential Monitoring note and QI Checklist	Kelly McGhee
VII.	MDHHS Waiver Full Site Audit Review March 14 – April 22, 2022	Starlit Smith
VIII.	Obtaining Guardianship Documentation	Starlit Smith
IX.	Michigan Mission Based Performance Indicator Quarter 1 • (Exceptions for 4a and 4b)	Justin Zeller & Tania Greason
X.	PI# 2a Update Best Practice (Provider Discussion)	Tania Greason
XI.	Critical and Sentinel Event Processing Update	Micah Lindsey
XII.	Provider Feedback	Group
XIII.	Adjournment	

Quality Operations Technical Assistance Workgroup Meeting

Wednesday, January 26, 2022

Via Blue Jean Link Platform

9:30 a.m. – 11:00 a.m.

Note Taker: Aline Hedwood

1) Item: Announcements – April Siebert, QI Director

Goal:

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce

NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

<Notes on discussion>

Discussion/Decisions Made		
April Siebert informed the workgroup of the following updates: • DWIHN will host Readmission Integrated Biopsychosocial Assessment Informational Meetings on January 31, and February 1, 2022 from 1:00 p.m. – 2:30 p.m. via Zoom Link Platform. • DWIHN has reviewed the utilization authorization guidelines and made some changes to T1017 SED services. H0031 modifiers has been removed effective January, 21, 2022. A memo was sent out to all CRSP's on January 24, 2022 Re: Standard Utilization Guidelines- T1017 SED and Pre-Authorizations for H0031. • QI would like to welcome new team member Tiffany Thisse she will working under the direction of Starlit Smith, QI Administrator with the performance monitors.		
Action Items	**Assigned To**	**Deadline**
None Required.		

2) Item: SUD Updates – Gregory Lindsey, SUD
Goal: Provide SUD Provider Updates
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Gregory Lindsey informed the workgroup of the following updates for SUD: • LARA changes are in stage three and they propose the following changes: Deregulate prevention providers so that they no longer need a license to provide prevention services; reducing regulations for outpatient treatment providers by having a licensed parent office and each parent provider site could have up to three sites providing services without a license that are within 35 mile radius of the parent site and those sites don't provide over 25 hours of service; Deregulating medication assisted treatment services so that the providers don't need to be licensed and have limits on the amount of people they can prescribe medications; regulate and/or license OTP providers that provide methadone as a treatment modality. • SUD ran a successful holiday campaign DWIHN passed out Naloxone kits, Fentanyl strips, and sleeping bag coats to the providers for the homeless during the month of December. • SUD received an American Rescue Plan Act, Substance Abuse Prevention and Treatment Block Grant (ARPA, SABG) from MDHHS for over one million dollars. Providers must submit an Request For Information (RFI)with information about the specific programs they would like to implement based on the RFI. SUD will select which treatment and prevention providers will be qualified to receive the ARPA,SABG grants. • SUD's Residential Gambling initiative has added another residential site. Sobriety House will be providing residential gambling disorder treatment. • SUD no longer discharges members that test positive for substances from treatment centers. We will offer those members more support to facilitate their recovery.		
Action Items	**Assigned To**	**Deadline**
None Required.		

3) Item: FY2021 Review of Protective Devices (BTPRC) – Danielle Dobija and Fareeha Nadeem
Goal: Review of BTPRC Protective Device Requirement
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Danielle Dobija and Fareeha Nadeem reviewed with the workgroup the requirements for Protective Devices (BTPRC). MDHHS requires the use of bedrails to be monitored to ensure the freedom and rights of the members we support are safeguarded and to ensure the safety and wellbeing of the member due to bedrail entrapment risks. Any plans that propose to use restrictive or intrusive interventions need to be reviewed and approved or disapproved by BTPRC. Per MDHHS, the use of a protective device such as bedrails, does not require BTPRC approval and monitoring IF the following conditions are met: The function of the protective device is to prevent injury due to involuntary movements or assist the individual with independent functioning. For additional information please review PowerPoint presentation 'Quality Improvement - Performance Monitoring Documentation Requirements for Protective Devices" on the following items below: • **Why** • **The Rule** • **Restrictive Techniques** • **Exception to the Rule** • **Documentation that states the use of bedrail** • **Bedrails restrict movement** • **Documenting the Exception** • **The Assessment** • **The IPOS** • **Clinical Record** • **Additional Notes** • **BTPRC Review Required** • **BTP Technical Requirements** • **Summary** If you have any additional question please contact Danielle or Faheem via email ddobija@dwihn.org and fnadeem@dwihn.org.		
Action Items	**Assigned To**	**Deadline**
None Required.		

4) Item: 30 Day Follow-up Hospitalization w/MPH - Vicky Politowski, IHC Director

a. VDT (HEDIS – Measures)

Goal: Review of HEDIS Measure for 30 Day Follow-up

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: X QI #4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

<Notes on discussion>

Discussion/Decisions Made		
Vicky Politowski, Director of Integrated Care, discussed with the workgroup the HEDIS Measure requirements and using HEDIS Quality Score Card via the Affinite PlanLink (VDT)platform. All providers that have access to MHWIN can access their CRSP HEDIS Quality Scorecard. Providers were informed to contact MHWIN please contact the MHWIN help desk at mhwin@dwmha.com if they do not have access. The HEDIS Quality Scorecard includes 15 HEDIS measures and 1 custom measure (UAM45). DWIHN expects CRSP's to have a process of how and who will monitor the scorecard and steps to meet the HEDIS Measures. All employee roles within the CRSP have access to the HEDIS Quality Scorecard. Scores for individual CRSP will be monitored by DWIHN. HEDIS Quality Scorecard includes CRSP total score, member included in score and if they met the measure. All data can be exported to an excel or PDF document. The HEDIS measures is a healthcare effectiveness data and information site develop and maintained by NCQA. IHC will be looking at this data on a monthly basis the score card will include providers total score met for each HEDIS measure, as well as the Member data. For additional information and instruction on how to enter HEDIS measures please review PowerPoint "DWIHN HEDIS Measures Vital Data Quality Scorecard' on the following highlighted area below: • **What is HEDIS?** • **HEDIS Quality Scorecard** • **Provider Link MH_WIN** • **Tips** If you have any additional question reach out to Vicky via email vpolitowski@dwihn.org.		
Action Items	**Assigned To**	**Deadline**
None Required.		

5) Item: NCI Survey Update – Margaret Keyes-Howard, CS
Goal: Review and status report for the NCI Survey
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #5 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Margaret Keyes-Howard provided a brief update on the status for the NCI Survey. • NCI survey FY 2021-22, most of the providers were very responsible for obtaining required demographic information as requested. • There was a decrease in participation on the first part of the survey. • DWIHN's CS unit is working with MDHHS and Wayne State University for ways to lift the barriers of participation in Wayne County. • It is noted that in Wayne County, members are not always available by Zoom or do not have access to the internet. • CS expect the NCI survey interview to start in February 2022 and it is expected that the results will be available by spring/summer of 2022. • Results from the final report/survey will be presented to this workgroup.		
Action Items	**Assigned To**	**Deadline**
Results of the 2022 NCI survey will be shared with the workgroup.	CS Unit (Margaret Keyes-Howard**)**	August 2022

6) Item: Residential Monitoring note and QI Checklist – Kelly McGhee

Goal: Review of the Residential Monitoring Note and QI Checklist.

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems X Quality ☐ Workforce

NCQA Standard(s)/Element #: X QI #1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

<Notes on discussion>

Discussion/Decisions Made		
Kelly McGhee shared with the workgroup that DWIHN's Residential Care Unit (RC) provided a case management monthly monitoring note training on December 14, 2021. Some CRSP's are currently using the required notes which is included as part of QI's check list. Kelly also states that there was a training conducted in March of 2021 by Kim Hoga which addresses the training log and the need for the documentation of the direct care staff and providers. There is an amendment to the IPOS and behavioral treatment plan with this requirement. All events of service must be documented in the member's file and if no CRSP Notification form is in the member's record, please contact Starlit Smith, QI Administrator via email ssmith@dwihn.org. RC wants to ensure members stay in their residential placement. If members are having a difficult time, an evaluation for a BTP is essential for helping that member remain in their home of choice.		
Action Items	**Assigned To**	**Deadline**
None Required.		

7) Item: MDHHS Waiver Full Site Audit Review March 14 – April 22, 2022 – Starlit Smith, QI Administrator
Goal: Update on MDHHS Waiver Full Site Review
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Starlit Smith shared with the workgroup the following information regarding the upcoming MDHHS Waiver Full Site Audit review: • The next MDHHS full waiver review will be held on March 14 – April 22, 2022. • Danielle Dobija, Sara Danny and Dana Stevens will be working with the providers throughout this process. • A list of members that will be a part of the wavier review should arrive from MDHHS on February 1st, or 2nd. QI will send the information out to providers no later than February 4, 2022. • Starlit asked the providers to look back at their previous review findings and processes. MDHHS looks for previous POC, and what the providers are planning to implement as part of their plan, plus documented evidence that providers did comply with the POC submitted. • Pay close attention to the staffing forms, MDHHS review documents that every staff touches for each member served. QI will work with providers completing the staffing forms correctly. • Complete and submit all required documentation to QI timely. • DWIHN received a POC last year for the in-service training log. QI utilizes the log to track the direct care and agency staff members who have been trained on the IPOS. Please pay close attention to completing the in-service training logs. • Follow-up information will be provided to the workgroup as received from MDHHS.		
Action Items	**Assigned To**	**Deadline**
Follow-up information will be shared with the workgroup as made available from MDHHS.	QI (Starlit Smith)	April 30, 2022

8) Item: Obtaining Guardianship Documentation – Starlit Smith, QI Administrator
Goal: Overview of obtaining Guardianship Documentation
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Starlit Smith Shared with the workgroup that QI has received a complaint about the downstream provider staffing agencies and residential providers not having guardianship documentation in the member clinical records. This is due to providers having difficulties getting a copy of member's legal guardianship documents. If you are experiencing difficulties or barriers with obtaining guardianship documentation for a member please email Starlit at ssmith@dwihn.org or place your question in the chat box and identify some of the barriers. QI will review noted barriers and bring information back to the workgroup on how to ensure needed documents are in the members case records.		
Action Item	**Assigned To**	**Deadline**
Providers to contact Starlit Smith with identified barriers for obtaining Guardianship Documentation	Providers	Ongoing

9) Item: Michigan Mission Based Performance Indicator Quarter 1 (Exceptions for PI #4a and #4b) - Tania Greason, QI Administrator
Goal: Review of MMBPI 4a and 4b Data
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: X QI #4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Tania Greason discussed with the workgroup the following: • Q1 data for PI #4a and #4b providers can make exceptions, please review your data and make exceptions when the members don't show up for their appointments or reschedule. This is for members that were discharged from an inpatient psychiatrist facility and have a follow-up appointment within 7 days. Justin Zeller will send a list to the providers with out of compliance cases for providers to review and note applicable exceptions. Providers must also document/note the reason for the exception. • PI #4a Justin sent the reports out a couple weeks ago, the due date in February 4th, 2022 and QI received some updates, please review your data via the MH-WIN "View Only" Module and update as required. • PI #4b for members who were discharged from detox unit, the SUD providers can also make exceptions for members that did not show for their appointments or requested appointments outside of the 7-day window. Please make certain to document/note the reason for the exception.		
Action Items	**Assigned To**	**Deadline**
Clinically Responsible Service Provider (CRSP) to review the list provided by QI (Justin Zeller) and also review the "View Only" Module and make required exceptions for members that are a no-show or reschedule. Provider must document/note the reason for the exception.	CRSP's	February 4th, 2022.

10) Item: PI# 2a Update Best Practice (Provider Discussion) – Tania Greason, QI Administrator
Goal: Update for PI# 2a progress
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: X QI #4 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Tania Greason discussed with the workgroup the progress for PI#2a. DWIHN continues to work on PI #2a which is the time a new member request services through access center and amount of time the biophysiological assessment is completed within 14 days from the initial request. DWIHN's current score is 52.9% , there is no current benchmark/standard for this indicator. QI, MCO, CPI and the Access Center continue to have meetings with providers to discuss the identified barriers providers which include staffing issues . QI PI# 2a data is due to MDHHS on March 30, 2022. Updates for the progress and review of identified barriers and interventions will continue to be shared with the workgroup.		
Action Items	**Assigned To**	**Deadline**
QI, MCO, CPI and the Access Center will continue to share with the workgroup identified barriers and interventions for PI# 2a.	QI (Tania Greason)	Ongoing.

11) Item: Critical and Sentinel Event Processing Update- Micah Lindsey, QI RN
Goal: Review of CE/SE Processing
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce
NCQA Standard(s)/Element #: X QI #1 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___
<Notes on discussion>

Discussion/Decisions Made		
Micah Lindsey provided the following provider updates for CE/SE processing: • New CE & SE events training dates are scheduled for February 10, and March 10 and April 14, 2022. • Policy and procedure updates and the revised manual rolled out in January 2022 and will be posted on DWIHN's website the manual will also be disturbed during the CE/SE event trainings. • Member's deaths are to be reported to QI and RRI within 24 hours of the provider knowledge after primary source have been completed. The death reporting procedure link is on DWIHN website under QI meeting document if providers have any question regarding death reporting, please reach out to the QI team for TA. • QI is requesting that providers review and submit SE information within 24 hours of knowledge. • Death that are categorized as sentinel events such as SUD deaths, suicides, and homicides, will require a preliminary Root Case Analyses (RCA) to be uploaded within (5) days and completed within 30 business days of the report. • All required SE/CE documentation is required to be uploaded in the critical event module within 10 days. • When QI request additional information or the providers change information in the CE/SE event, please notify QI of an updates. Providers are required to submit all requested documentation within the specified time frames. • If you have any questions please contact Sinita, Micah or Carla via email sapplewhite@dwihn.org, mlindsey@dwihn.org and cmackey@dwihn.org or message in MH_WIN .		
Action Items	**Assigned To**	**Deadline**
Providers to upload all required documents within the specified time frames. Please review the CE/SE manual on DWIHN's website and have staff sign up for required trainings.	Provider Network	Ongoing

12) Item: Provider Feedback – Group

Goal:

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce

NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

<Notes on discussion>

Discussion/Decisions Made		
Provider: When is the first clinical record review date for the self-monitoring? QI want to make sure the tool is inclusive to all of the NCQA, HSAG, and MDHHS requirements, there were some revisions to case record review tools which is in the process of being finalized with an anticipated date of completion for Monday January 31, 2022. **Provider:** Can you provide a new tool for internal self-monitoring and can it be updated for FY 2022? **QI** will make the revision and rollout the updated tools. **Provider:** Is the MDHHS review process for all providers**? QI:** The review will only include SED, IDD and the Waiver programs including Children Waiver.		
Action Items	**Assigned To**	**Deadline**
None Required,		

NEXT MEETING: Wednesday, February 23, 2022 @ 9:30 a.m. – 11:00 a.m. via Zoom Link Platform

ADJOURMENT: 11:30 a.m.

ah_01.28.2022

DETROIT WAYNE INTEGRATED HEALTH NETWORK

Quality Improvement - Performance Monitoring
Documentation Requirements for Protective Devices

Presented

Jan. 26, 2022

at the

Quality Operations Technical Assistance Workgroup

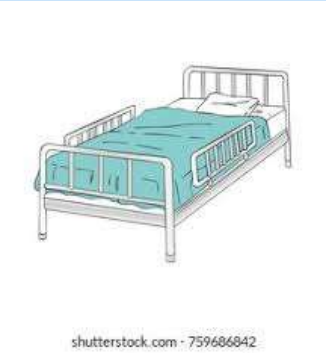
Why? Why? Why?

Historically, physical restraints (such as vests, ankle or wrist restraints) were used to try to keep patients safe in health care facilities. In recent years, the health care community has recognized that physically restraining patients can be dangerous. Although not indicated for this use, bed rails are sometimes used as restraints.

Source: A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Factshttps://www.fda.gov/medical-devices/hospital-beds/guide-bed-safety-bed-rails-hospitals-nursing-homes-and-home-health-care-facts

Why? Why? Why?

MDHHS requires the use of bedrails to be monitored to ensure the freedom and rights of the members we support are safeguarded.



And to ensure the safety and well being of the member due to bedrail entrapment risks.

The Rule

MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as required by the 1997 federal Balanced Budget Act (BBA) at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code.

Source: MDHHS Technical Requirement for Behavior Treatment Plans, 7/29/2020

The Rule

Any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious, or other challenging behaviors that place the individual or others at imminent risk of physical harm are to be review and approve or disapprove by a specially-constituted committee, often referred to as a "behavior treatment plan review committee" (BTPRC).

Source: MDHHS Technical Requirement for Behavior Treatment Plans, 7/29/2020

Why? Why? Why?

Although bedrails are most often used as a protective device, they are still considered a restrictive intervention because bedrails restrict an individual's movement.

The Rule

Restrictive Techniques

Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal BBA. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual are prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes), using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

Source: MDHHS Technical Requirement for Behavior Treatment Plans, 7/29/2020

Protective or Restrictive?

The Rule

Per MDHHS, any protective device being used to address a behavior that has the potential for causing serious injury requires BTPRC review.

Unless the function of the protective device is to prevent injury due to involuntary movements or assist the individual with independent functioning.

Exception to the Rule

Per MDHHS, the use of a protective device such as bedrails, does not require BTPRC approval and monitoring ***IF*** the following conditions are met:

The *function* of the protective device is to

- prevent injury due to *involuntary movements* ***or***
- assist the individual with *independent functioning*

The Rule

Documentation that states the use of bedrail is for

- fall prevention
- Health and safety
- Guardian request

Requires BTPRC review, approval or disapproval

Source: MDHHS Behavior Treatment Plan Review Committee (BTPRC) FAQ, Updated 3/02/2021

The Rule

Bedrails restrict movement

Any plans that propose to use restrictive or intrusive interventions need to be reviewed and approved or disapproved by BTPRC.

Source: MDHHS Behavior Treatment Plan Review Committee (BTPRC) FAQ, Updated 3/02/2021

Exception to the Rule

Per MDHHS, the use of a protective device such as bedrails, does not require BTPRC approval and monitoring ***IF*** the following conditions are met:

The *function* of the protective device is to

- prevent injury due to *involuntary movements* ***or***
- assist the individual with *independent functioning*

Documenting the Exception

Today's presentation is to identify the documentation required to be in the member's clinical record in order to validate that approval and monitoring by the BTPRC for the use of a protective device, such as bedrails, is not required.

The Assessment

Medical Diagnosis

Examples of medical diagnosis in which there might be involuntary muscle movement

- Seizure disorder
- Neurological conditions that result in spasticity, such as Cerebral Palsy
- Other neurological conditions, such as Dystonia (a neurological muscle disorder characterized by involuntary muscle spasms)

The Assessment

Assessed Need Specific to the Individual

- Typically the assessment for protective devices such as bedrails is completed by an occupational therapist (OT) or physical therapist (PT)

- Individual's level of functioning in multiple areas
  - identifies areas of need

The Assessment

Potential Benefits

- Increase independence / functional capacity / quality of life
  - Aiding in turning and repositioning within the bed.
  - Providing a hand-hold for getting into or out of bed.

The assessment should identify how the use of the protective device will treat or address the individual's specific condition.

The Assessment

Benefits of use (cont.)

- If for fall prevention, the record must document the medical condition that prevents the individual from protecting themselves from falls.

Per MDHHS, any protective device being used to address a behavior that has the potential for causing serious injury requires BTPRC review.

Source: MDHHS Behavior Treatment Plan Review Committee (BTPRC) FAQ, Updated 3/02/2021

The Assessment

Risks without the use of the protective device

- Safety concerns specific to the individual and their condition

The IPOS

Identify the specific time periods the protective device will be used (instruction for when the protective device will be used)

Time limit for the use of the protective device (this may be identified on the medical order for the protective device)

Treatments or plans to address the individual's specific condition to reduce and or eliminate the use of the protective device

Clinical Record

A medical order for the protective device

Specific consent for the use of the protective device

- Risks and benefit of use

Proper use of the protective device / Protective Device Guidelines (instruction for how the protective device will be used)

Clinical Record

Training of direct support professionals / aides on the proper use of the protective device

- documentation of training shall identify
- the date of the training,
- the name and credentials of the individual who provided the training,
- the specific protective device staff are being trained on, and
- the names of each individual trained on that date

Clinical Record

At minimum, the record needs to include ANNUAL

- Assessments for the continued need for the protective device
- A medical order for the protective device
- Specific consent for the use of the protective device
- Protective Device Guidelines (instruction for how the protective device will be used)
- Training of direct support professionals / Aides on the proper use of the protective device

Additional Notes

Per MDHHS, the following are insufficient rationales by themselves for the use of a protective device

- "health and safety"
- Individual or guardian preference

However, these should be considered along with the individual's needs and condition

BTPRC Review Required

If the function is to prevent “risk of harm” alone, then BTPRC technical requirements need to be followed.

BTPRC Review Required

The use of a protective device to *manage or control* seriously aggressive, self-injurious, or other challenging behaviors that place the individual or others at risk of physical harm, requires that the individual receives a functional behavior assessment, a behavior treatment plan, and special informed consent prior to being reviewed by the BTPRC for approval / disapproval and follow up BTPRC reviews based on committee recommendations, but no less than quarterly.

BTP Technical Requirements

FBA to

- rule out medical / environmental causes
- Identify positive behaviors supports tried but unsuccessful

BTP

- including fade plan

Special Consent

BTPRC approval

Quarterly BTPRC monitoring

Summary

The function of the protective device needs to be clearly identified.

If the function is to prevent “risk of harm”, then BTPRC technical requirements need to be followed.

If the function of the protective device is to prevent injury due to involuntary movements or to assist the individual with independent functioning, then BTPRC review is not required.

BTP Technical Requirements

References:

MDHHS Technical Requirement for Behavior Treatment Plans, 7/29/2020

MDHHS Behavior Treatment Plan Review Committee (BTPRC) Frequently Asked Questions, 10/30/2020

MDHHS Behavior Treatment Plan Review Committee (BTPRC) FAQ, Updated 3/02/2021

DWIHN HEDIS Measures
Vital Data Quality Scorecard

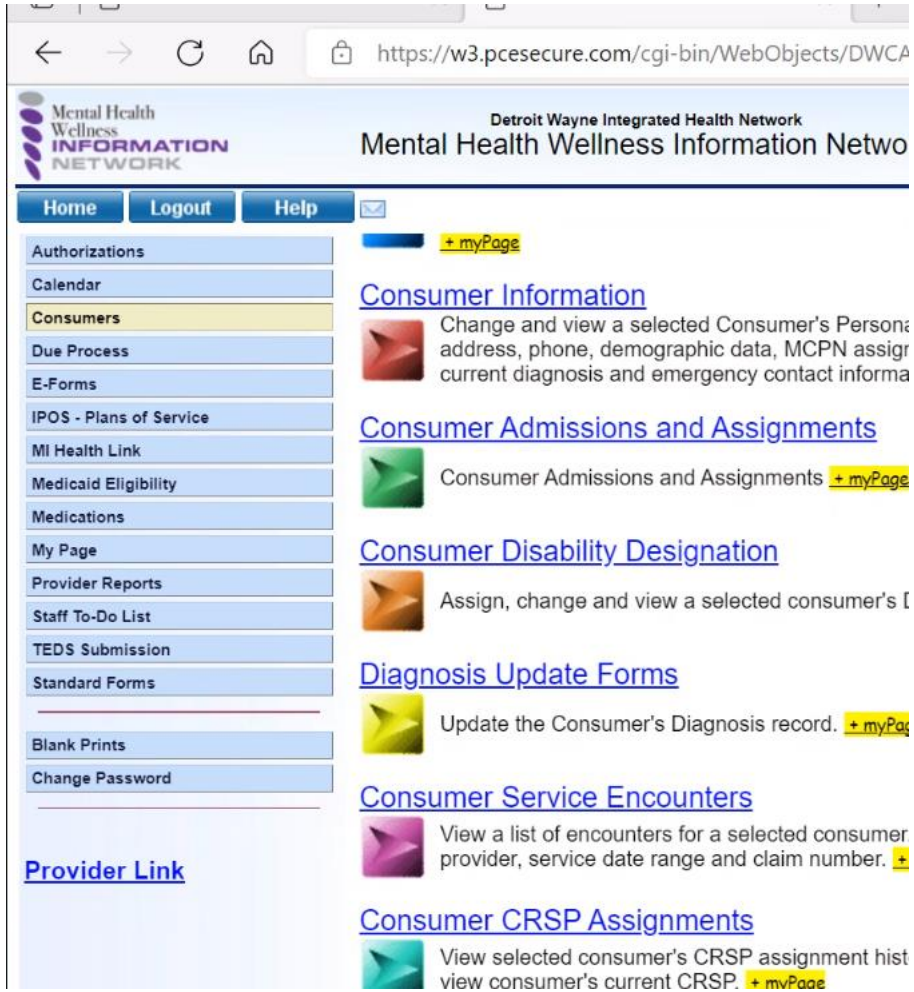
What is HEDIS?

- The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of performance data developed and maintained by the National Committee for Quality Assurance (NCQA), and is the most widely used standardized performance measure in the managed care industry. HEDIS is part of an integrated system to establish accountability in managed care.
- Behavioral health has multiple measures that include ensuring continuity of care, for example; appropriate psychotropic medication management/adherence, follow up after hospitalization, and diabetes monitoring. Detroit-Wayne Integrated Health Network collects HEDIS data to measure and improve the quality of care that the members receive.

HEDIS Quality Scorecard

- Anyone who has access to MHWIN can access their CRSP HEDIS Quality Scorecard. If you do not have access to MHWIN please contact the MHWIN help desk at mhwin@dwmha.com.
- The HEDIS Quality Scorecard includes 15 HEDIS measures and 1 custom measure (UAM45).
- DWIHN expects CRSP's to have a process of how and who will monitor the scorecard and steps to meet the HEDIS Measures.
- All employee roles within the CRSP have access to the HEDIS Quality Scorecard.
- Scores for individual CRSP will be monitored by DWIHN.
- HEDIS Quality Scorecard includes CRSP total score, member included in score and if they met the measure. All data can be exported to an excel or PDF document.

To Access Click on **Provider Link**

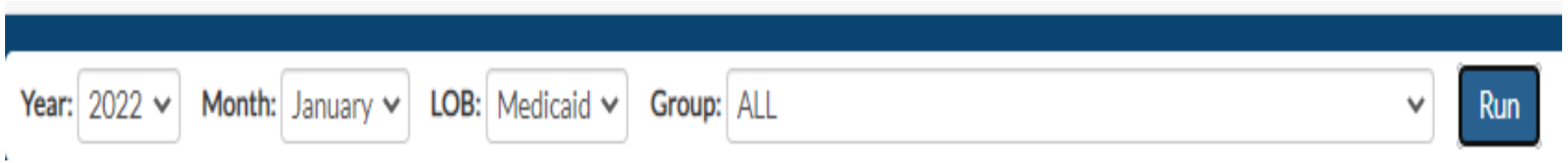


HEDIS® Quality Scorecard

Year: 2021 Month: December LOB: Medicaid Group: ALL Run

EOC PCR

Measure	Measure Name	Eligible	Total Compliant	Non Compliant	HP Goal	Year To Date	Estimated Year End
ADD	Follow-Up Care for Children Prescribed ADHD Medication						
AMM	Antidepressant Medication Management						
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics						
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsych...						
BCS	Breast Cancer Screening						
CBP	Controlling High Blood Pressure	11834	1437	10397	50	12.14	12.14
CCS	Cervical Cancer Screening	30583	8907	21676	50	29.12	29.12
COL	Colorectal Cancer Screening						
FUH	Follow-Up After Hospitalization for Mental Illness						
FUM	Follow-Up After Emergency Department Visit for Mental Illness						
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment						
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	3992	171	3821	50	4.28	4.28
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	1218	233	985	50	19.13	19.13
SPR	Use of Spirometry Testing in the Assessment	89	13	76	50	14.61	14.61
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Ar...	5963	2606	3357	50	43.7	43.7
UAM45	Use of three or more antipsychotics for 45 or more days	13403	83	13320	50	0.62	0.62



- Year: Data from 2019-2022 can be filtered.
- Month: Can look at data until a certain month.
- LOB: Medicaid Members.
- Group: CRSP that is assigned to user.
- RUN: Press RUN after Year and Month are selected.

EOC | PCR

	Measure	Measure Name
⊞	ADD	Follow-Up Care for Children Prescribed ADHD Medication
⊞	AMM	Antidepressant Medication Management
⊞	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics
⊞	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsych...
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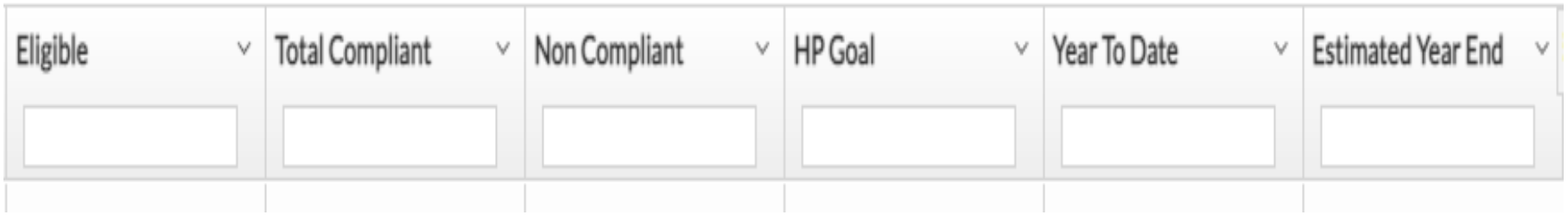
⊞	FUH	Follow-Up After Hospitalization for Mental Illness
⊞	FUM	Follow-Up After Emergency Department Visit for Mental Illness
⊞	IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
⊞	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia
⊞	SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia
⊞	SPR	Use of Spirometry Testing in the Assessment
⊞	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Ar...
⊞	UAM45	Use of three or more antipsychotics for 45 or more days

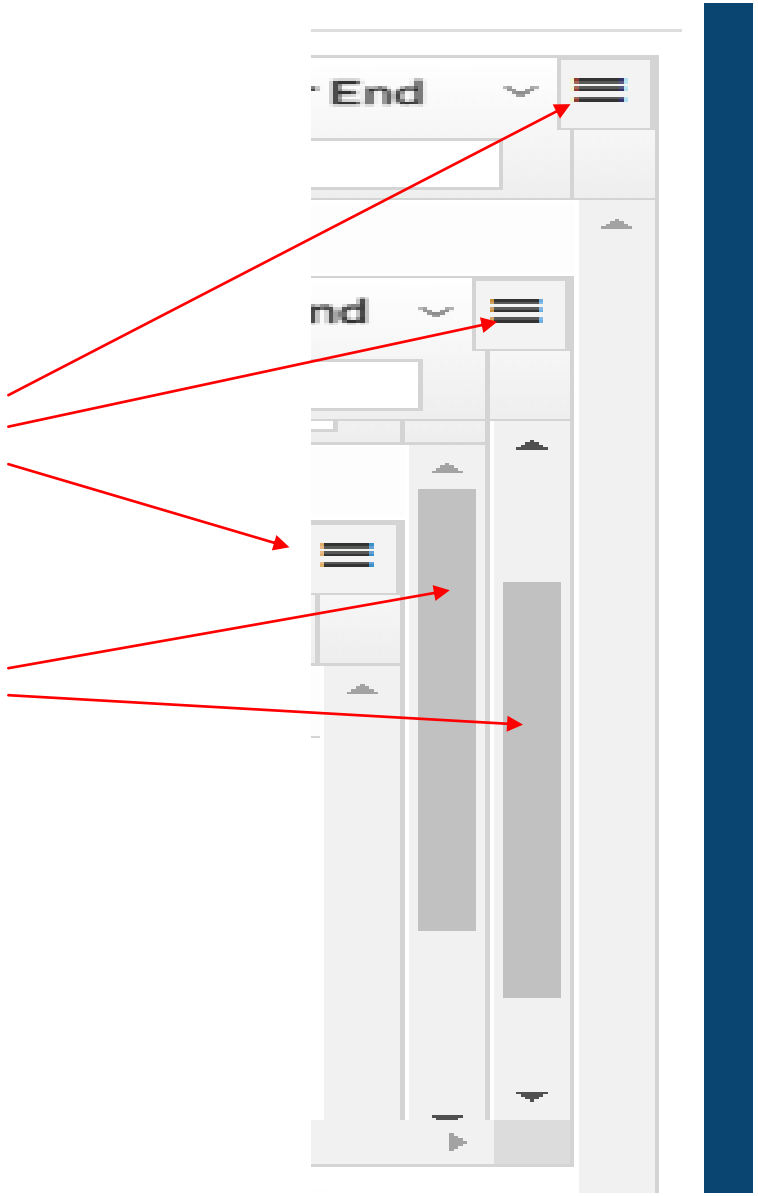
- EOC: HEDIS Measure
- PCR: Plan All-Cause Readmission Rate
- Measure: Acronym of HEDIS Measure
- Measure Name: Name of HEDIS MEASURE
- + Allows measure to be expanded down to member detail.

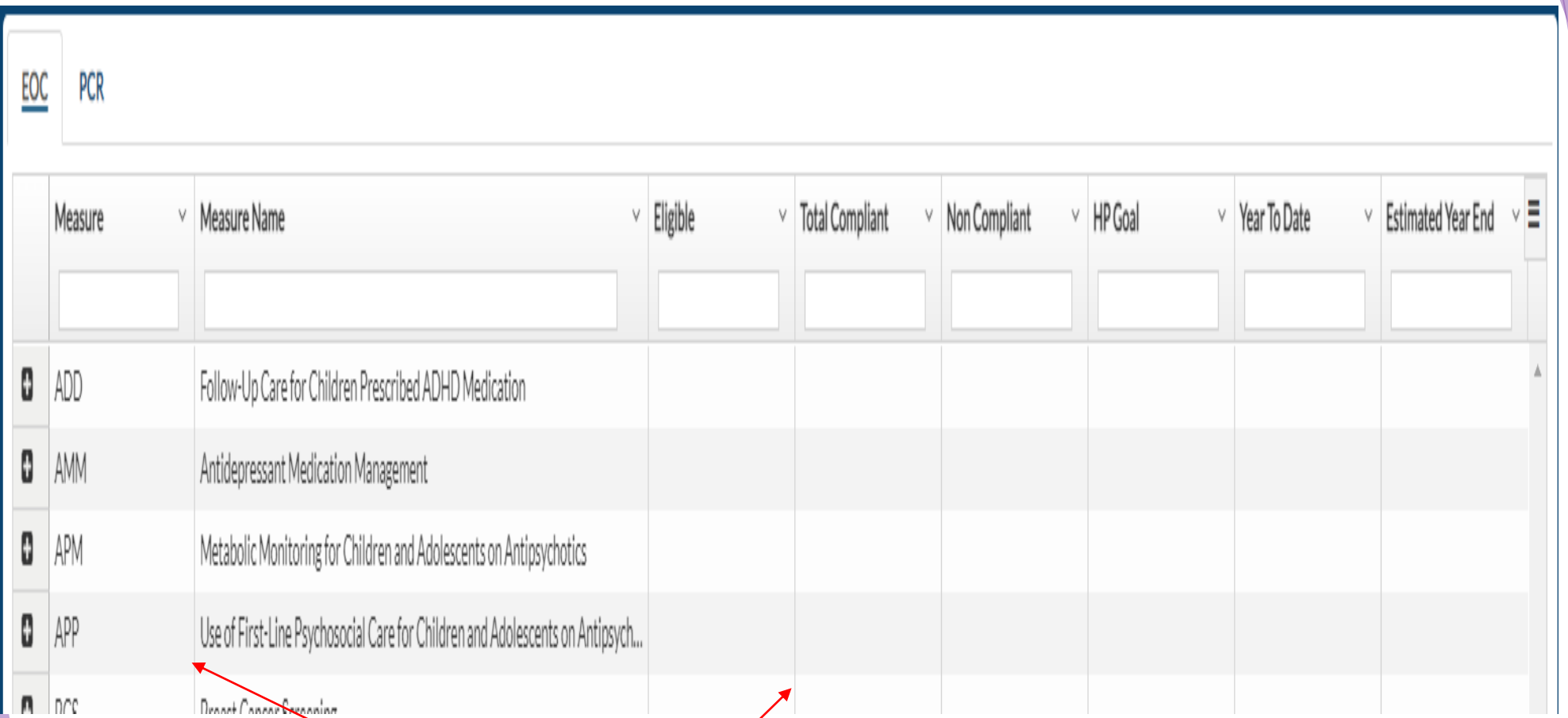


- **Eligible**: Number of members eligible for measure
- **Total Compliant**: Number of members that meet the measure
- **NON-Compliant**: Number of members not meeting measure
- **HP Goal**: Goal percent set by HEDIS measure as of today
- **Year to Date**: CRSP percentage on goal
- **Estimated Year End**: The current trend based on how many are meeting the goal as of that date

Click this button to export data to an excel or PDF document.

Use this bar to move the screen up or down.





All lines separating columns can be moved to further see text.

Tips

- **All Data is pulled from the states data warehouse, there is a lag time depending on when the data is received after it is billed to Medicaid.**
- **If a mistake is made while navigating system, log out and log back in and it will be reset.**

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CRITICAL/SENTINEL EVENTS

January 26,2022

Highlights:

- **New Critical/Sentinel Event Training Dates** (due to clinical leadership meetings)
  February 10, 2022
  March 10, 2022
  April 14, 2022

- **Upcoming Policy and Procedure updates**

- **Reporting deadline requirements with MDHHS and ICOs**

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