Outpatient Provider Meeting Q&A

Friday, September 16, 2022

Virtual Meeting

10:00am –11:00am

1. What background checks are monthly?
   A. ICHAT and OIG exclusions

2. STEP has never done a TB test. Please let me know if it is required.
   A. Hi Cherie, please email compliance@dwihn.org and I am happy to clarify for you.

3. Do we no longer need a signed copy of the employees "employment agreement" or signed "job description"?
   A. Yes, you are required to have a signed job description for each employee.

4. Is an at-hire TB test new? We have been through DWIHN surveys and this has been asked for annually.
   A. At-hire is not new. Depending on the employee's job/qualifications, it may be required annually.

5. Do all employees have to be over 18 years of age?
   A. Yes, all staff must be at least 18 years of age.

6. Good morning, I noticed a number of DWIHN job postings that DIRECTLY COMPETE with current CRSP jobs and they pay A LOT more that we can as a CRSP because of our low reimbursement rate from DWIHN. What is DWIHN doing? Are you trying to put your CRSPs out of business and take over everything? What happened to partnering with us? I heard DWIHN is also associated with a CCBHC who will be processing DWIHNs billing. Is this the case?
   A. DWIHN is always looking at ways to augment services to the members we are all responsible for by providing additional resources to cover gaps and enhance service delivery. This is especially critical when we are all are struggling with staffing resources and also ensure that we are putting holistic care for the member to provide them 365 degree of care around both physical and BH needs so all these upcoming partnerships are in the same spirit.

7. Where can we find a copy of the CCM brochure that was just reviewed?

A. Thank you for your question. The CCM Brochure can be found on our website at https://www.dwihn.org/providers-integrated-healthcare I can also send more CCM information if you would provide your email

8. When will we be getting our updated contracts for review? We are credentialled but still have not received our contract for FY 23
   A. Contracts for FY 23 will start to commence within the next 2 weeks.

9. Ms. Bond please place in chat your contact information please... Thanks
   A. Abond1@dwihn.org

10. I have a staff who has an expired TB from 2021 that stated the test expires 3/2023 that my HR accepted becuase my company policy is that they accept TB tast up to 20month past -Does this need to be current ?
    A. If the test is not expired then it will suffice.

11. We were told by the quality team at DWIHN that only DCW workers are only required to have TB testing and that it did not apply to CRSP agencies, but is recommended. Can you clarify since we are receiving conflicting information? Thank you.
    A. Marleen, you are correct. The presentation was specifically for direct care staff.

12. Credentialing I never received anything from Medservant
    A. Please send an email to pihpcredentialing@dwihn.org. You may need to attend training for Medversant or be connected with your office manager.

13. I completed the credentialing steps last year with Medservant and updated this year and I never received my Certificate
    A. Please reach out to pihpcredentialing@dwihn.org. so that we may look into your file.

14. Melissa Moody recently sent a letter to CRSP Leadership that explained DWIHN would be receiving a CCBHC grant as of today however, no formal notification was announced via SAMHSA. Can someone speak to this please for clarification.
    A. There has been no communication sent to Providers regarding DWIHN's CCBHC status. DWIHN has applied for the SAMHSA grant, but like other applicants, we are awaiting a response. If you have a copy of the letter, send to jwhite1@dwihn.org.

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

DWIHN PRE-PLACEMENT AGREEMENT

I, _____ accept and agree to transfer to _____
(Member's Name) **(Pre-Placement Facility)**

on _____ as a temporary placement not to exceed **14 days** from the Admission
(Admission Date)

Date of _____ . I further agree to cooperate with all efforts to secure more permanent
(Admission Date)

specialized housing for me. I understand to be eligible for specialized housing; I must be a recipient of third-party assistance (Medicaid, SSI, and/or SSD); and if it is determined that I am ineligible for the third-party reimbursement as listed above, I will cooperate with my assigned case manager who will assist me to locate alternate housing.

_____* _____
Member/ Guardian Signature **Date**

Member Refused to Sign ***Date:*** _____

==========

_____* _____
Member/ Guardian Signature **Date**

Signature required prior to admission or 24 hours of admission to DWIHN Pre-Placement Facility

Detroit Wayne
Integrated Health Network
Residential Services

DWIHN Pre-Placement Process

Referral Sources

DWIHN Residential Care Specialists

C.O.P.E.

Clinically Responsible Service Provider (CRSP)*

(*with Supervisor Approval)

- Reviews Member **Pre-Placement Agreement** form, and obtains consumer's/guardian's signature
- Faxes following forms to selected Pre-placement Facility:
  - Consumer's referral packet/COPE PAR documents
  - ***Signed*** Member **Pre-Placement Agreement**
  - ***Consumer Pre-Placement Initial Plan*** for the designated Pre-Placement facility*

Refer to Member Pre-Placement Location listing for facility contact information.

Pre-Placement Facility

Placement to these facilities are coordanted by RCS Lezlee Adkisson

Akwaaba House

Georgia's Care

Glenwood Home

Lewis Manor-NW

***Detroit Family Home-Boston**

***Angel Patience**

- Immediately ensures receipt of member's Pre-Placement referral packet for placement review
- Submits timely response on accepting members also confirming scheduled pick-up date and time member once accepted into pre-placement
  - If referral is refused/denied, the Pre-placement Provider is to send email to notify assigned Residential Care Specialist within 2 hours noting the following:
    - ***Member MHWIN ID#***
    - ***Referral Agent***
    - ***Reason for denial (i.e. behaviors, age of member, etc.)***
    - ***Pre-placement Provider Contact Information***
- Transports member from referral site to designated Pre-Placement facility within 2 hours of notification that all prescribed medications are available:
  - ***Community Hospital D/C:*** 14-day written prescription with 7-day (in-hand) supply
  - ***Emergency Department D/C:*** Up to the discretion of the ED to provide medications
  - ***Crisis Center / COPE D/C:*** Medication prescription to be coordinated with the member's designated CRSP
- Confirms scheduled CRSP follow-up appointment, providing/coordinating transportation or tele-health communication
- Completes daily **Member Pre-Placement Progress Note** for every member
- Confirms member weekday census ***via phone call*** to designated Residential Care Specialist reporting:
  - ***New arrivals, confirming Referral TYPE***
  - ***Extended lengths-of stay (if needed)***
  - ***Consumer discharges***
  - ***Bed availability***
- Completes **Member Pre-Placement Discharge form**, sending to Residential Department
- Immediately reports urgent concerns and/or issues to designated Residential Care Specialist as they occur

Residential Services

- Designated Residential Care Specialist updates weekday facility census:
  - Verifies member admissions, extended lengths-of-stay, and discharges
  - Emails daily bed census for step-down availability to Residential Team, UM, and COPE
  - Submits Internal Auth Requests for incoming members, authorization extensions, and/or member discharges
    - ***Service Authorizations are not to exceed 14 days; unless reviewed and determined clinically necessary by RCS; or upon review with department Director and Manager for approval)***
  - Completes member's assessment if needed prior to permanent placement
- RCS verifies effective date and Medicaid status via MHWIN system and uploads all relevant documentation into member's chart
  - **Consumer Accepted:** RCS obtains verbal consent to proceed with specialized placement process. The member's HMWIN chart would then be documented of placement consent.
  - **Consumer Refused/Denied:** RCS notifies CRSP of pre-placement facility with expectant discharge date, to coordinate alternate services and resources
- Documents member's chart of pre-placement activity

CRSP
Supports Coordinator/ Case Manager

Within 5 Days,
Including initial 3-day Authorization

- Receives email of pre-placement census to update member contact information
- Revises **Member Initial Pre-Placement Referral Plan** as needed and verifies next scheduled outpatient appointment
- Contacts and informs RCS of member's refusal for placement
- Assists member with identifying other housing options available

Pre-placement Locations & Contact Information

Akwaaba House II
2635 Calvert
Detroit MI 48206
Contacts: **Zakiya Aniapam** (P)

House#: (313) 826-7411
Zakiya's Cell#: (248) 935-7722
Fax#: (313) 894-7460

BEDS AVAILABLE: ***(AMI) All Male – 4***

Georgia's Care
1026 E Grand Blvd
Detroit MI 48207
Contact: **Ms. Monroe** (HM) | **Ms. Gray** (P)

House#: (313) 925-7620
Fax#: (313) 925-7620

BEDS AVAILABLE: ***(AMI) Female/Male – 4***

Lewis Manor-NW
1625 Webb St
Detroit MI 48206
Contact: **Ellen Lewis** (P)

House#: (313) 826-5204
Ms. Lewis' Cell#: (313) 833-6017
Fax#: (313) 861-6017

Call provider prior to submitting referral request.
Transportation Available

BEDS AVAILABLE: ***(AMI/DD) Female – 6 | Male – 2***

Glenwood Home
29803 Glenwood St
Inkster MI 48141
Contact: **Sam O.** (HM) | **Ms. Nweke** (P)

House#: (734) 721-5552
Fax#: (734) 973-7897

Transportation Available

BEDS AVAILABLE: ***(AMI*) All Male – 6***

Stallworth AFC (E. Grand)
1221 E. Grand Blvd.
Detroit, MI 48211-3428
Contact: **Gail Stallworth** (P)

House#: (313) 319-5526
Ms. Stallworth Cell#: (313) 319-5526
Fax#: (866) 321-7891

Call provider prior to submitting referral request.
Transportation Available

BEDS AVAILABLE: ***(AMI) Female – 3 | Male – 3***

DWIHN Pre-placement Member Discharge Form

(To be completed by pre-placement facility staff and faxed to Residential Services @ 1-313-989-9525.)

Member Name:				Admission Date:	
MHWIN ID#:			Pre-placement Facility:		
Did Resident Leave AMA?	☐ YES	☐ NO		Discharge Date:	
After-care Appointment Location:				Date:	Time:
Reason After-care Appointment Was Not Arranged:					

Forwarding Contact Information

Please check one of the following:	Name	Address	Phone Number
☐ Specialized (Licensed) Setting			
☐ Living with Relative			
☐ General Room & Board			
☐ Unlicensed/Semi-Independent Living			
☐ Substance Abuse Treatment Center			
☐ Shelter			
☐ COPE / Hospital			

Member discharged with Medications?	☐ YES	☐ NO
Amount of Medication Dispensed:		
Member took all belongings?:	☐ YES	☐ NO
Guardian has been notified (if applicable)?	☐ YES	☐ NO

Total # of days to be entered into MHWIN by Authorized Referral Resource:

Number of Days	Initial date	End Date

DWIHN Pre-placement Staff Signature	Date

DWIHN Pre-placement Member Referral/Initial Plan

(To be faxed to Pre-placement Provider/Staff, CRSP Supports Coordinator, & DWIHN Residential Services @ 313-989-9525)

Member Name:			MHWIN ID#:
Date of Birth:		Social Security #:	
Supports Coordinator:			Phone#:
Clinically-Responsible Service Provider (CRSP):			Phone#:
Pre-placement Facility:			Phone#:
Outpatient Appointment Scheduled? ☐ YES ☐ NO		Date:	Time:
Member has Medicaid? ☐ YES ☐ NO		Facility:	
SSI / SSD? ☐ YES ☐ NO		Appointment With: _____	
Medicare? ☐ YES ☐ NO			

Referral Made By:				
☐ **COPE**	☐ **CRSP**	**Person completing form:**		
☐ **DWIHN UM**	☐ **RCS | RCC**	**Phone#:**	**Date:**	
Has Member Agreed to Residential Pre-placement (signed form):			☐ **YES**	☐ **NO**

Initial Plan (special diet, safety precautions, any unusual needs/circumstances): _____

Authorized # of Days:	**From:**	**Through:**

Intervention Plan

Observation:

☐ No Restrictions

☐ Full Restrictions until seen by primary treatment team

Risk Behaviors / Monitoring

☐ Physical Health Conditions: _____

☐ Self-injurious Behaviors: _____

☐ Physically Aggressive/Property Destruction: _____

☐ Non-compliant with Medications: _____

☐ Auditory/Visual Hallucinations: _____

☐ Substance Abuse: _____

☐ Preferred Placement (Facility Name): _____

☐ Other: _____

_____ _____

Signature of Person Completing Form **Date**

CC: DWIHN Residential Services
Clinically-responsible Service Provider (CRSP)