Residential Provider Meeting Q&A

Friday, August 18, 2023

Virtual Meeting

11:30am –12:30pm

1. Does a member who frequently elopes from the home meet the requirements for CCM? She endorses hearing voices that tells her to leave.
   A. They may but it depends, please feel free to email or call me so we can discuss the case (abond1@dwihn.org 313-402-1424)

2. If an authorization has expired is it best to contact the case worker or email the mentioned entities?
   A. Hi Kimberly, any and all authorization issues should be sent to residenntialauthorizations@dwihn.org, they will instruct you further.

3. Will you be sending this presentation out to us?
   A. Yes

4. How do we reschedule the class if the dates does not work for staff?
   A. Email the ORR Trainers at orr.training@dwihn.org, and they will assist you.

5. Hi will the NHRRT classes begin on site at any time this year or next year?
   A. That question hasn't been decided yet. I do know that DWIHN employees will work a "hybrid" schedule, meaning working in the office and remote. As soon as the decision has been made, we will let Providers know. We thank you for your patience.

6. Can we get the tool for the on-site inspections?
   A. You can't receive the actual tool, but you can email the ORR Monitoring RRI, Ed Sims at esims1@dwihn.org, to request the items to prepare for the site review.

Claims Department

Quinnetta Allen-Robinson

Claims Manager

CLAIMS REMINDERS

Claims Billing and Adjudication

- Providers should be reviewing the comments left on claims by the adjudicator **prior** to sending an email to pihpclaims@dwihn.org. The comments will identify the issue and steps to take for resolution.
- Providers should be utilizing the valuable resource on the DWIHN website.

➢ **Rate Charts** – to identify rates for services rendered

➢ **Provider Payment Schedule** – to identify expected payment dates

➢ **State FY2023 Behavioral Health Code Charts & Provider Qualifications –** to assist with coding decisions, provides descriptions of services, outlines rules and updates, etc.. This always be used as a reference guide and is a great way to stay abreast of the current updates as they arise.

Claims Reminders

- Issues should be sent to the appropriate department.

- Authorizations – pihpauthorizations@dwihn.org / residentialauthorizations@dwihn.org

- Contract issue – contact your Contract Manager

- System issue – mhwin@dwihn.org

- Finance issue - tomani@dwihn.org

Goals of CCM

- Connect to appropriate community resources
- Develop teams that include family, medical, and behavioral health professionals
- Improve quality of life
- Provide early intervention to prevent crisis

CMM services do not take the place of current services but are integrated with the clinically responsible service provider's case management services.

Referral Process

The DWIHN CCM staff may receive referrals for services via:

- E-mail
- Fax
- Phone

A referral form is available on the DWIHN website on the Integrated Health Care page.

Referrals can be faxed to 313-989-9529 or e-mailed to pihpccm@dwihn.org.

Along with the referral form please send current bio Psychosocial assessment, LOCUS/SIS assessment and any other relevant clinical documents.

Detroit Wayne Integrated Health Network

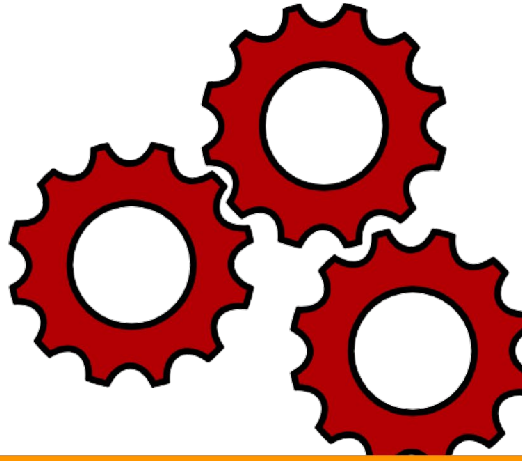
707 W. Milwaukee Street
Detroit, MI 48202
313-833-2500
www.dwihn.org

24-Hour Access Center

800-241-4949

Detroit Wayne Integrated Health Network
DWIHN
Your Link to Holistic Healthcare

COMPLEX CASE MANAGEMENT



What is Complex Case Management (CCM)?

CCM is a collaborative process that includes assessment, planning, facilitation, and advocacy. It explores options and services to meet a person's identified needs with the ultimate goal of promoting high quality, person

friendly and cost effective outcomes.

CCM does not take the place of services already being received- it compliments them. Participation is not dependent upon the health benefit available to enrollee.

CRITERIA TO PARTICIPATE IN CCM

The DWIHN CCM program has general eligibility criteria for adults and children/youth.

ADULTS

- An active member of outpatient behavioral health services with a disability designation of SMI, DD/IDD, or SUD as evidenced by at least one visit within the quarter with a
- DWIHN provider AND
- Evidence of one or more gaps in services, i.e., absence of primary care or specialty medical care visits within the last 12 months, or gaps in medication refills for behavioral health and /or medical chronic
- conditions AND
- One or more of the following chronic medical health conditions: hypertension, diabetes, asthma, COPD, heart disease and obesity as well as ten or more visits to the ED
- in the last six monthsOR
- Willingness to be an active participant in the program for at least 90 days.

•CHILDREN/YOUTH

- Diagnosed with serious emotional disturbances (SED) and Autism Spectrum Disorder (ASD) seen for services at a DWIHN
- provider at least once in the last quarter AND
- Should range between the ages of 2-21 years of age- those enrollees in this cohort that are 18-21 are usually designated as youth with learning disabilities, court wards,
- I/DD, etc. - AND
- Diagnosed with chronic asthma or other medial health condition AND
- 4 or more ED visits related to medical and/or behavioral health in the last 12 months OR
- Gaps in service/ care - i .e., absence of primary care visit within the last six months and gaps in refilling medications AND
- Willingness of Legal Guardian & Child/Youth to be an active participant in the program for at least 90 days

Integrated Health Care Initiatives
Complex Case Management
Referral Form

Complex Case Management is designed to assess, plan, implement, coordinate, monitor and evaluate options and services needed to meet an enrollee's chronic complex health (behavioral and physical) and human service needs. Enrollees are chosen for Complex Case Management because of frequent inpatient admissions, frequent visits to the Emergency Department, and because they have complex medical and behavioral needs that are not being resolved using traditional means/resources. Along with this referral form, please include the psychosocial assessment, current LOCUS, medication sheet, and any other clinicals that would be useful in managing this enrollee's care.

Referral Source:

____Behavioral Health Provider ___ Medical Health Provider/Primary Care Provider

____ DWIHN ___ Self-Referral

____Other (specify): _____

Name of Facility/Agency/Referral Source: _____

Telephone #: _____

Fax #: _____

Enrollee Name: _____ **Date of Birth**: _____

Enrollee Telephone #: _____

Reason for Referral:

_____

_____

_____

Please fax completed form to: 313-989-9529

Please send via secure email to: pihpccm@dwihn.org

For DWIHN USE:

Date Referral Received: _____

Case Assigned To:_____ Date Referral Assigned: _____

Hs11012016

DETROIT WAYNE INTEGRATED HEALTH NETWORK

800-241-4949

www.dwihn.org

ORR New Hire Recipient Rights Training

Updates:

- *ORR Training dept-MDHHS Triennial Assessment in 10/2023, to assess compliance w/training requirements.
- *ORR Conference-NO NHRRT this week-**09/19-09/22/23**
- *NHRRT-seats available increased to accommodate increase # of attendees.
- *ORR Trainer-Jacqueline Frazier leaving ORR-08/18/23
- *Register staff for NHRRT during the **onboarding/orientation** process. NH vs. ARRT-currently updating ARRT on DWC
- If Providers need to **cancel/reschedule** their staff, notify ORR Trainers at **orr.training@dwihn.org.** Please **do not** mark the person as cancelled in MHWIN.
- NHRRT conducted Mon-Wed each week from 10am-12pm. Evening NHRRT-2nd Tuesday of the month from 4pm-6pm. Check MHWIN for available training dates.
- If your staff experiences any issues with NHRRT, you may contact us via email at: orr.training@dwihn.org no later than ½ hour prior to the class start time.
- *Participants must be present **online**, with working cameras, and remain **visible** and available to communicate with us **throughout** the course.
- *NHRRT is held via the Zoom App, therefore participants need a strong Wi-Fi signal to participate. Participants be aware of your Wi-Fi strength ***prior*** to training or request to use employer's office computer/laptop to take the training.
- *If your staff are **OBSERVED DRIVING OR OTHERWISE NOT ENGAGED DURING THE TRAINING**, they WILL be removed from the training and will need to be rescheduled.
- NHRRT must be completed **w/in 30 doh** for new staff.
- Please go on the DWIHN website and/or review MHWIN newsflash for updates re: NHRRT.

OFFICE OF RECIPIENT RIGHTS: MONITORING (SITE REVIEWS)

Updates:

- ORR Monitoring dept. continues to prepare for MDHHS Triennial Assessment-**10/16.23-10/20/23**; to assess monitoring compliance;
- Continue to see an Increase in staff *not* attending NHRRT; found w/ site reviews and complaints-Providers please adhere to the requirement of the MMHC mandate

Site Review Process:

- ORR Site Visit conducted onsite (in person). Covid 19 Questionnaire-If +exposure, an alternative site review will be arranged
- Review new staff hired since the previous site review-**NHRRT must be completed w/i 30 doh**
- ORR accepts NHRRT obtained from *different* counties w/ evidence provided/verification
- ORR Reviewer looks for: required postings, confidential items stored, health/safety violations, interior/exterior of facility, interviews staff & members re: rights
- Any violation(s) found requires a Corrective Action Plan. Provider has 10-business days from the date of the site visit to remedy violation
- End of site review visit, Site Rep **required** to sign & date page #4 of site review tool

Important Reminders:

- Provider contact info and staff records should be kept current, as required in MHWIN

ORR Prevents Rights Violations

Prevention Unit Primary Responsibilities

- Develop and implement prevention-related training initiatives & provide input with updating specific DWC trgs, ex: IRs
- Review Policies and Procedures & provide recommendations to address Recipient Rights-related matters
- Review substantiated complaint investigations and address concerns identified for prevention opportunities
- Ensure remedial action trainings & recommendations related to RR violations are in adherence to the Michigan Mental Health Code and MDHHS Administrative Rules.
- Goal is to decrease the number of complaints by ensuring providers and staff are equipped with the required trainings & knowledge of RR policies & procedures, to assist in preventing/decreasing # of RR violations

DETROIT WAYNE INTEGRATED HEALTH NETWORK

800-241-4949

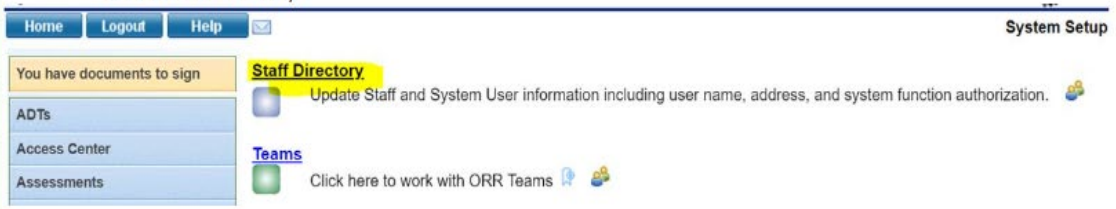
www.dwihn.org

MHWIN STAFF FILE MAINTENANCE

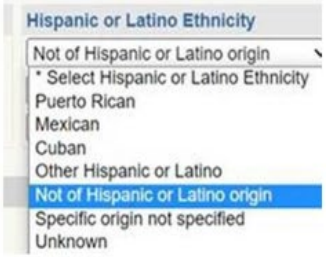
- DWIHN is making sure that it's members have choice of practitioners based on several factors with race and ethnicity being two of them
- The MHWIN staff record has been revised to include both of those elements
- The staff that your organization has assigned the responsibility of maintaining the staff directory will have a month to add these element(s)
- They will go to staff setup on the MHWIN menu
- Select Staff Directory
- Go to the appropriate staff record and there are two drop downs Race/Ethnic Origin and Hispanic or Latino Ethnicity in which the correct information will be added
- The completion deadline is Monday 9/18/2023
- Additional questions about this can be sent to pihpcredentialing@dwihn.org

1. Select System Setup from the menu

2. Select Staff DIrectory



3. Go into the applicable staff record and locate the 2 data fields and select from the dropdown accordingly, then select Save at bottom of screen



HCBS Remediation and Validation

WHAT'S GOING ON?

- MDHHS gave DWIHN a list of Survey Responses from the 2020 HCBS Survey.
- DWIHN is required to work with all of you to validate and or remediate the responses from this list.
- The validation and remediation process begins now and ends Sept. 15, 2023

WHAT IS VALIDATION?

- **Validation** is used when your response to a question on the HCBS Survey supported your compliance with HCBS requirements.

- This means you will now provide evidence that you are doing what you said you are doing. The evidence you provide will validate your answers on the survey.

How do we VALIDATE?

- The Evidence you need to provide to Validate your answers can be one or more of the following

  - Policies and procedures that are in place to support an HCBS Setting,
  - Progress Notes
  - Case Notes
  - Individual Plans of Services (IPOS)
  - Activity Calendars
  - Appointment Calendars
  - Community Meeting Notes
  - Staff Meeting Notes
  - House Logs
  - Pictures of HCBS Required Equipment (Bedroom and Bathroom Locks)
  - Interviews with Member(s), Guardian(s), and Supports Coordinator(s), etc.

WHAT IS REMEDIATION?

- **Remediation** is used when your response to a question on the HCBS Survey did NOT supported compliance with HCBS requirements.

The remediation process will go as follows:

- 1. Did you answer the survey question wrong by mistake?
  - If yes, you will provide evidence that you have been and continue to follow the HCBS requirements.
  - If no, you will correct (i.e., remediate) the non-compliance and provide evidence of the correction (i.e., remediation).

How do we REMEDIATE?

- The Evidence you need to provide to Remediate your answers can be one or more of the following:
  - Individual Plans of Services (IPOS)
  - Activity Calendars
  - Appointment Calendars
  - Community Meeting Notes
  - Staff Meeting Notes
  - House Logs
  - Pictures of HCBS Required Equipment (Bedroom and Bathroom Locks)
  - Interviews with Member(s), Guardian(s), and Supports Coordinator(s), etc.

Validation and Remediation Process

The Provider will receive a notice by email from DWIHN. It will include the following:

- A notification letter briefly outlining the Validation and Remediation process
- HCBS Validation/Remediation Attestation Form with the member's MH-WIN ID # and the list of survey questions that need validating and / or remediating
  - You will receive a separate checklist for each member
  - Each member may have the same survey questions that need validating and or remediating
- Guidelines instructing you on what evidence you need to submit for each survey question.

Validation and Remediation Process: Step 1

- Review the notice to ensure DWIHN has the correct contact information for you or your designated representative.

- Email correct contact information immediately, if needed

Validation and Remediation Process: Step 2

- Begin reviewing the information right way and start collecting needed information.

- Someone from the DWIHN HCBS team will call you within 3 business days of sending you the notice to review instructions and answer questions.

Validation and Remediation Process: Step 3

- Begin sending in the required documentation right away
- All PHI needs to be sent via secure email, MH-WIN message box, or fax (313-833-2086)
- Additional follow up calls can be arranged as needed.

Validation and Remediation Process: Step 4

- In order to ensure all evidence strongly demonstrates HCBS compliance, evidence, such as policies / procedures, may be returned to you for edits. You may also be required to submit additional documentation.

- This must all be completed by the close of the validation and remediation process on Sept. 15, 2023

Post Validation and Remediation Phase

- DWIHN will report the completion of the validation and remediation process to MDHHS
- MDHHS will make the final assessment as to HCBS Compliance
- Further information or evidence may be requested by MDHHS. DWIHN will follow up with you with further instructions if needed.

Validation and Remediation: Follow Up

- MDHHS may request a follow-up review by Michigan State University's Institute for Health Policy to further validate the evidence provided during the review. This is conducted by the Health Policy Unit.

- If found 100% HCBS Compliant to MDHHS' Satisfaction, Provider will be fully deemed an HCBS Compliant Home until next round of reviews (Survey, Audit, Spot Review)

- If found non-compliant, MDHHS may designate home as on Heightened Scrutiny and the respective sanctions will be imposed and enforced as directed by MDHHS.

SUMMARY

- Receive checklist of survey questions that need to be validated and / or remediated.
- Collect and submit evidence of compliance with HCBS requirements.
- Consult with DWIHN for technical assistance as needed
- GOAL: Receive HCBS Compliance from MDHHS and retain the ability to provide and be funded for the provision of HCBS service

Thank you for your support of our Members and Community!

Questions?

Contact the Quality Residential/HCBS Team:

HCBSInforPIHP@dwihn.org

ARE HEALTH HOME SERVICES FOR ME?

You can participate in a Health Home if:

- You have Medicaid, MiChild, or the Healthy Michigan Plan
- You have a qualifying mental health condition or opioid use disorder

To learn more ask your Provider or contact Detroit Wayne Integrated Health Network's 24/7 Access Helpline

800-241-4949

WILL A HEALTH HOME CHANGE THE PEOPLE I WORK WITH NOW?

No... You can work with the same people!

Health Home services may add more people to your team to help you achieve your health goals

You can still work with your case manager/supports coordinator, therapist, doctors, nurses, counselors, peers, and other professionals you are used to working with!

- Health Homes will help you be as healthy as you can be
- You can choose whether or not to participate
- There is no cost to be in a Health Home
- Which Health Home (Behavioral or Opioid) you participate in is based on your needs and conditions
- Being in a Health Home does not change your eligibility for other services

HOW CAN A HEALTH HOME HELP ME?

A GUIDE ON BEHAVIORAL HEALTH HOMES & OPIOID HEALTH HOMES

A HEALTH HOME ISN'T A PLACE, IT'S YOUR TEAM!

What is a Health Home?

- A Health Home helps you manage behavioral, recovery AND medical care to improve your overall wellness
- A Health Home will connect you to providers and resources to achieve your overall wellness goals
- Health Homes can help you with health concerns like diabetes, heart disease, or quitting tobacco
- Health Homes use a **whole -person approach to care**
- Health Homes are an additional Medicaid entitlement available at no cost to eligible people

HEALTH HOME SERVICES

Comprehensive Care

- You and your provider will create your Health Home Care Plan
- You will set goals and address challenges in your recovery, behavioral health, and physical health needs

Care Coordination

- You will have one location to help you coordinate most of your services and support
- Your Health Home will help you make appointments and connect you to appropriate specialty care providers

Health Promotion

- You will work with your provider to gain knowledge about your overall wellness
- You will have access to support and resources specific to your needs and health challenges

Comprehensive Transitional Care

- Your Health Home will help you if you transition between providers or care locations

Individual & Family Support

- You will have support to manage your health
- Your Health Home will help you to live to your full potential in your community

Community & Social Support

- You will have connections to a wide range of community programs
- learn about your conditions and how you can be healthier

HOW DOES A HEALTH HOME HELP ME?

Health homes can help you...

- Schedule appointments
- Transition between care settings
- Learn about your conditions and how you can help yourself be healthier
- Stop smoking, get educated on nutrition and healthy habits

Get referrals to specialists