Clinical Leadership Committee & Utilization Management Committee

Date: Thursday, November 19, 2020
Time: 1-2pm CLC, 2-3pm Joint, 3-4pm UMC
Location: Online/Phone ONLY; No in-person Meeting
Zoom Meeting: https://zoom.us/j/7242810917
Call-In: 1-312-626-6799; Meeting ID: 724 281 0917

Meeting content linked here: UMC November Meeting Materials CLC November Meeting Materials

CMHSP	Participant(s)
Bay-Arenac	Karen Amon; Joelin Hahn
CEI	Shana Badgley; Elise Magen; Tonya Seely; Tamah Winzeler
Central	Julie Bayardo; Renee Rauschi
Gratiot	Sarah Bowman; Taylor Hirschman
Huron	Natalie Nugent; Levi Zagorski
Ionia-The Right Door	Julie Dowling
LifeWays	Gina Costa; Dave Lowe
Montcalm Care Network	Julianna Kozara;
Newaygo	Kristen Roesler
Saginaw	Kristie Wolbert; Vurlia Wheeler
Shiawassee	Crystal Eddy; Craig Hause; Jennifer Tucker
Tuscola	Michael Swathwood
MSHN	Skye Pletcher, Todd Lewicki
Others	

CLC

I. Welcome & Roll Call

II. Review and Approve October Minutes, Additions to Agenda
*Reminder: December meeting is cancelled due to holidays.

III. Informational: FY20 Performance Based Incentive Pool (PBIP) Narrative Report
Thank you for CMH-specific contributions to the annual report. Please connect with Skye with any questions/feedback

IV. MDHHS Memos/Guidance/Proposed Policies
- **A. Proposed Policy: Behavioral Health Treatment**
- **B. BHDDA Services and Education Guide (Revised)**
- **C. Relaxing Face-To-Face Requirements (Update)**

Informational- no additional discussion requested/required by committee

V. Status of the Specialized Residential System
- **A. Background:** A discussion needs to occur regarding staff and resident exposure and positivity, staffing levels and strategies to address, training requirements during the pandemic, and audits and reviews.
- **B. Discussion:** *As pandemic spikes again many CMHSPs are experiencing significant staffing challenges. Is it possible for MSHN to temporarily suspend site review activities, trainings and/or other administrative*

functions to preserve staffing resources at CMHSPs? Huron reported that they are not receiving much cooperation from local health department for testing or contact tracing despite county positivity rate being >16%. CMHSPs report varying levels of engagement/assistance from local health departments. GIHN established incentive bonus payments for staff in certain cases.

C. **Outcome:**

VI. Children in Emergency Departments (10.30.20 Meeting Minutes)

A. **Background:** Children boarding at Emergency Departments awaiting psychiatric placement is not a new issue but COVID 19 and an increase in children involved in child welfare are new contributing factors. Children are waiting in ED's anywhere from 3 days to 5 weeks. MSHN, BABHA and CEI participated in meeting with MDHHS and other PIHPs/CMHSPs to advocate around this issue.

B. **Discussion:** *Statewide feedback indicates on average children are waiting 5-7 days in EDs for appropriate placement. Kim Batche-McKenzie is point of contact at MDHHS for these concerns. A related issue is community placements not always being willing to accept individuals back into care that are being discharged from hospital.*

C. **Outcome:** *Pass along these types of incidents to Todd or Skye; MSHN will continue presenting these concerns to MDHHS in weekly COVID-19 calls*

VII. MSHN Balanced Scorecard

A. **Background:** Review FY20 MSHN Balanced Scorecard, discuss CLC priorities for FY21-22 balanced scorecard metrics

B. **Discussion:** *Ideas for consideration include initiatives related to integrated care (ex: health home models vs CCBHC); enhancing person-centered planning training and culture; improved efficiency related to regional SUD access; increased capacity for children's acute services such as crisis residential*

C. **Outcome:**

JOINT CLC/UMC

I. MiCAL Follow-Up Discussion- Krista Hausermann, MDHHS

A. **Background:** Intent is for MiCAL to interface with CMHSP/PIHP system and perform warm handoffs. There is concern about the proposed intention for CMHSPs to end current afterhours crisis lines and link to MiCAL instead, as the mental health code currently requires CMHs to maintain 24/7 crisis lines (330.1165 Michigan crisis and access line, Sec. 165). Krista Hausermann joining meeting to receive feedback from Region 5 and address questions/concerns

B. **Discussion:** *State's vision for crisis system is a comprehensive public network available to all Michiganders regardless of payer type. Primary entry points currently exist through law enforcement, hospital and community mental healths. MiCAL is not intended to replace all crisis services provided by CMHSPs; it is meant to act as a referral point for people who do not know where to go for services. "Another option." Questions/Clarifications:*

- *Confirmation that CMHSPs who contract with after-hours third party vendors will forward to MiCAL instead of a third-party provider.*
- *CMHSPs who directly operate 24/7 crisis lines would not need to change operations.*
- *Common Ground was selected as provider.*
- *MiCAL will be rolled out initially in 2 regions (Oakland and Northern MI) and then expand to other regions with full statewide implementation occurring by September 2022.*
- *Crisis alerts where CMHSPs would enter information on specific consumers to flag MiCAL when they interact with the individual.*
- *CMHSPs will also have access to a daily services report for members served.*

- *MiCAL is utilizing statewide crisis call data and national crisis response line standards to determine staffing needs (standards include ratio of staff per population, resources needed to accommodate calls by 3rd ring, etc).*
- *Will CMHSPs have access to a specific point of contact at MiCAL for their CMHSP? Unknown at this time but there will be a portal for bi-directional communication between CMHSPs and MiCAL.*
- *Suggestion that CMHSPs should have access to information for all individuals who accessed MiCAL from their catchment area and not only those open to CMHSP services so that outreach/follow-up can be conducted. MDHHS has not considered but agrees this should be explored*
- *Has there been consideration for integration measures with large EHR vendors such as PCE? Yes, this is in exploration phase*

C. Outcome/Action Steps: *Submit additional questions/considerations/feedback through the MiCAL email address. MDHHS appreciates all feedback as it helps them to shape the design of the project*

II. MSHN Regional Videoconferencing Memo

III. Strategic Planning Input

A. Background: The FY21-22 MSHN Strategic Priorities (Board Established) will be the quintuple aim: Better Care; Better Health; Better Providers; Better Value; Better Equity (new). Seeking input for high level strategic goals related to one or more of the 5 strategic priorities.

B. Discussion: *Covered above*

C. Outcome/Action Steps:

IV. Regional Crisis Residential Proposal

A. Background: Travis Atkinson from TBD Solutions worked with MSHN over the last year to conduct an updated feasibility study for development of new crisis residential program within the region. Objective for today's meeting is to review the updated Crisis Residential Project Brief and take a formal committee vote to determine if there is sufficient support in region to move forward with issuing an RFP.

B. Discussion: *CMHSPs would have right of first refusal to hold contract, if a single CMHSP does not wish to develop this new contract another option would be for MSHN to hold contract for the region. Advantage to regional approach is increased bargaining to drive cost down by committing to a minimum number of bed days annually which could be more difficult for one CMHSP to assume the risk up front. Authorization and UM functions would continue to be delegated to each CMHSP, not centralized through MSHN.*

C. Outcome: *Support to move forward to Operations Council. The CMHSPs were offered the right of first refusal and at this time no individual CMHSP indicated interest in pursuing the contract. Recommendation for Operations Council to support MSHN issuing an RFP on behalf of the region.*

V. Use of Service Ranges on PCPs

A. Background: A finding of the recent 2020 MDHHS Waiver Audit indicated that service "ranges" should not be used on person-centered plans. How are CMHSPs documenting amount, scope, and duration on plans of service without requiring an addendum each time a person's needs change, physician makes a medication change and needs to review more frequently, etc?

B. Discussion: *Small variations should be documented via progress notes (ie: no-shows that result in underutilization of authorized services, acute crisis that necessitates a brief increase in services). Having this issue is against the philosophy of person-centered planning and is going to be a barrier. We question how this will fit parity requirements. If a reasonable range is used, this will give the person a little more autonomy to empower them. On the other side, the use of ranges allows the clinician to allow for a*

reduced quality of care. There should be more flexibility in looking at the year and considering periodic reviews as a time to determine whether adjustment needs to occur. CMHs can not anticipate what the need is for a person and should have the flexibility to be able to see someone extra when there are needs, like seeing someone more with CSM to assist. This can also be spelled out in the plan in terms of need and how services will be approached.

C. **Outcome:** *Continue for advocacy of a fair requirement to ensure that there is tightness in service ranges where there can be and flexibility where needed based on serving a population that has varied but chronic needs.*

UMC

VI. MCG Reports

A. **Background:** Recent training for CMHSP MCG leads around the use of system reports. Discuss feasibility of switching from our current manual reporting process each quarter to generating reports from MCG for FY21

B. **Discussion:** *How to explain the reason for variance and what follow up items would be. One difficulty may be that if during a retrospective review a person was found to have not met criteria for inpatient, what is the implication for retrospective reviews? It would be a change in practice for some if they had to go into the EHR to document the review. MSHN was looking to generate reports from the EHR system. There are CMHs that do reviews and keep the reviews separate from the chart itself. Other CMHs are using the static guidelines, some are doing it concurrently and putting it in the EHR. There are variances in how this is being done from CMH to CMH*

C. **Outcome:** *This will be reviewed to determine the most appropriate method to ensure consistency in how retrospective reviews are documented throughout the region*

VIII. MSHN Balanced Scorecard

A. **Background:** Review FY20 MSHN Balanced Scorecard, discuss UMC priorities for FY21-22 balanced scorecard metrics

B. **Discussion:** *Shared the current strategic plan and elicited feedback regarding perspectives. Ideas CLC had included integrated health, increased access for SUD services or evaluating the process for availability of SUD services.*

C. **Outcome:** *These suggestions will be considered in strategic planning sessions.*

VII. SUD Residential Utilization & Detox Recidivism Reports

Per this committee's prior feedback MSHN is exploring the possibility of generating this report specific to how CMHSP consumers are utilizing SUD detox and residential services. If unable to generate reports specific to CMHSP consumers the recommendation is for these reports to be moved to the SUD Provider Advisory Committee for review and action rather than UM Committee

Parking Lot/Upcoming:

Draft Jail Diversion regional TA – Awaiting revised policy/procedural guidance from MDHHS

Case Management/Supports Coordination Workgroup Next Meeting: 12/4