Clinical Leadership Committee (CLC) Agenda

Date: 11-16-2017
Location: Gratiot Integrated Health Network (GIHN) 608 Wright Ave, Alma, MI
Call-In: 888-585-9008; **Conference Room**: 986-422-885

CMH	CLC Member	In-Person	Phone	Absent
BABHA	Karen Amon Joellen Hahn		x x	
CEICMH	Shana Badgley	x		
CMHCM	Kathie Swan		X - Julie	
GIHN	Kim Boulier	x		
HCBH	Tracey Dore		x	
The Right Door	Emily Betz			x
LifeWays	Gina Costa		x	
MCN	Julianna Kozara		x	
NCCMH	Cindy Ingersoll			x
Saginaw CCMH	Linda Schneider	x		
Shiawassee CCCMH	Crystal Eddy		x	
TBHA	Julie Majeske		x	
MSHN/TBD/ Other	Dani Meier Trisha Thrush Sarah Bowman Joe Wager Todd Lewicki Josh Hagedorn	x x x 	 x x x	

Purpose: To advise the PIHP regarding clinical best practices and clinical operations across the region

- *Advise the PIHP in the development of clinical best practice plans for MSHN*
- *Advise the PIHP in areas of public policy priority*
- *Provide a system of leadership support and resource sharing*

1. Review and approve agenda
2. Approve minutes from last meeting September Meeting Minutes

Decisions should be written in the form of questions identifying the precise decision that the group is being requested to make. Include links to relevant documents in Box

SEEKING INFORMATION: LOCUS Presentation (Josh Hagedorn-TBD - called in)

a. **Background:** One of MSHN's strategic plan goals and one of the charges for the PIHPs statewide was to standardize access to and delivery of treatment services. With the implementation of LOCUS as the state-mandated assessment tool for Michigan, a CLC-UM Workgroup was established with Kathie Swan as lead and with the support of Josh Hagedorn from TBD Solutions. The group has made great strides in developing a common way of utilizing the LOCUS and is at

the point of reporting out where things stand. See here: https://tbdsolutions.shinyapps.io/explorelocus_node_mshn/ for Josh's

b. Question: What are next steps in making sure this work makes it to the ground-level across Region 5's 12 CMHs when the LOCUS is being used by access staff to determine levels of care?

c. Discussion: Workgroup meeting monthly and has developed first draft for distribution and feedback. Charge of workgroup was to determine how to use LOCS tool for a service grid for ranges for available basic services. Work towards a common definition of a service grid for adults with SMI who would receive the LOCUS assessment. Partially fueled by MIFast (sp?) assessments from the State. When completed, the LOCUS assessment will produce an outcome score that will get entered into a "decision tree" to assist with what level of care (LOC) will be received. LOCUS scores are then put into broader levels of 0-6. Group tackled how to address the service grid, when the LOCUS has output, but does not have HCPCS codes to correspond with service designations. LOCUS output gives you a number, and how does the number turn into an array of services that can be authorized. Rather than go with the written definitions of the LOCUS which seemed to contradict HCBS, the workgroup examined building the service grid based on the service the region is currently providing for the assessed needs identified on the LOCUS. Pulled in data from 6 CMH's in the region and data from available LOCUs scores in the region. Used a clinically conservative approach to developing an average amount of service. For example, by looking at the service grid in the attached document, each HCPCS code listed, the data across per service per broad category (0-6) took the "maximum number of annualized units per person for each service" to determine what the maximum needs has been of that service. Service grid essentially is what can be authorized without any exceptions. Services outside of this grid (ie. higher level of service need), would then engage in an exception process for authorization. Each CMH would have their process for managing exceptions, with the PIHP having access to reports data through encounter data (after the fact) of services outside of the broad categories. The intent of the LOCUS is to help guide how CMH's use the LOCUS consistently across the region and to help support UM staff with actionable data. When built into the EMR system, the data available will be minimum and maximums. The level of information shared today is for the benefit of the policymakers to know that background of the development process towards the outcome and use. Examples of CMH's process around approval of services when the person is receiving services that do not match the LOC from the LOCUS output score and broad categories. CMH size will impact the amount of time for implementation at each CMH with inclusion in EMR and validation of data, etc. Question regarding the present LOC of services being higher/lower than what the LOCUS would designate as implementation may impact a culture change. Josh indicates the LOCUS gives a range, so CMH's would want to be below the maximum. If certain services are higher in one region, then each CMH can evaluate what is happening in their respective area to evaluate that occurrence (example from Gratiot presented about lack of ACT service which increased CM services in area).

d. Outcome: Next steps to evaluate the data from the region with the LOCUS. Tentative last meeting in January 2018. Work group would like to examine the reports from the available data to determine if the LOCUS is showing face validity when put into effect. When the workgroup completes its work, a presentation to CLC would be made for take back to the local level of implementation.

SEEKING INFORMATION: Population Health Plan (Amanda Horgan will present in December).

a. Background: Per the MSHN Strategic Plan, MSHN has been working on a population health & integrated care plan. The plan includes regional efforts and pilots with MHPs, CMHSPs and SUD providers. CLC has a workgroup to develop a Population Health Integrated Plan and MSHN wants to ensure this effort is coordinated as part of the overall regional plan. MSHN will have a draft by December with input from our Chief Medical Officer (Dr. Alavi) and our SUD Medical Director (Dr. Springer). That will come to CLC's Integrated Care Workgroup to assure coordination of efforts before going to Ops Council for review.
b. Question: What is status of CLC Integration Workgroup?
c. Discussion: Workgroup has met previously, and is willing to come back together again if needed for contribution and collaboration for the regional Population Health Plan.
d. Outcome: Population Health Plan presentation tentatively scheduled for December 2017.

SEEKING INFORMATION: Out of county coordination of care

a. Background: An issue came up with a Recovery Residence and there were questions to our UM department regarding how the CMHs should handle someone in a Recovery Residence who is being served by the CMH due to co-occurring services. In particular, the question was if/why the CMH should be responsible for the costs of treatment when people in the RR are from out-of-county?
b. Question: How are other CMHs handling out-of-county residents for lower levels of care where a COFR may not be appropriate?
c. Discussion: There was some confusion around the recovery housing being a "treatment facility." Recovery housing is not treatment, but is done in conjunction with treatment services (i.e. Outpatient, peer supports, etc.). If an individual seeks services within Region 5, MSHN's position is to help them get services. Struggles discussed with process of referrals from other CMH's/Regions for cost reimbursement to Region 5 providers.
d. Outcome: MSHN can follow-up further on the specific issue of out of county clients, but as a general principle, if they're in our region and seeking treatment, we should make an effort to get them into treatment expediently.

DECISION POINT: Priority Measures Review (Joe Wager)

a. Background: CLC members requested a review of the Priority Measures at the last CLC meeting on 9-21-2017. Discussion indicated that CLC members could offer clinically relevant information on priority measures being discussed/monitored within other groups such as UM, etc. Group discussed potentially having a joint meeting of CLC in December with other groups to review and evaluate the measures to move forward.
b. Question: Would CLC like to collaborate with UM group to review Priority Measures moving forward?
c. Discussion: Collaboration with QIC and UM would be helpful, at least for one meeting. Collaboration on the Clinical Protocols would be good to help understand the process towards the targets across CLC, QIC, and UM. Kim Zimmerman is willing to help support CLC with

attending a future meeting to present the process that QIC has engaged in to develop the targets for the measures that QIC is monitoring.

d. **Outcome:** CLC was agreeable to collaborating with UM to review PM.

DECISION POINT: Priority Measures Update (Joe Wager) (Standing Agenda Item)

a. **Background**: CLC has been delegated the task of identifying a target for the Cardio Screening for Antipsychotics measure. Data to assist in developing this target is available through quarterly updates on the values (Priority Measures Aggregate Data - 11/2017 & Monthly IP Trends, Year over Year Data 11/2017)

Priority Measures:
Initiation AOD Treatment
ADHD Follow Up
Follow Up after Hospitalization for MI
Cardio Screening for Antipsychotics
Diabetes Screening for Antipsychotics
Diabetes Monitoring for Schizophrenia
Adults Access to Primary Care
Children Access to Primary Care
Plan All-Cause Readmissions (30 day)

b. **Question:** What is a reasonable target measure for the Cardio Screening for Antipsychotics measure? Are there any barriers or challenges that need to be addressed to implement?

c. **Discussion:** National 2015 data on aggregate report is from Medicaid Health Plans (MHP) only. Data also include primary care claims data that contributes towards the "completion" of the item. MHP data will contribute to national health plan data as our data is included due to a shared population. The cardiovascular monitoring PM has validated data and is at the phase of needing an established target, which could include monitoring data to determine an appropriate target. Kim Zimmerman is willing to help support CLC with attending a future meeting to present the process that QIC has engaged in to develop the targets for the measures that QIC is monitoring. PM data from 9/1/16 thru 8/31/17:

- Cardiovascular monitoring score: Range across Region 5 is13.33% to 40.00%; National level – 43.70%
- Follow-up children ADHS med initiation: Range across Region 5 is 68.83% to 93.33%; National level – 42.20%
- Follow-up children ADHD med C & M Phase: Range across Region 5 is 97.5% to 100%; National level – 50.90%
- Follow-up after hospitalization for MI for adults: Range across Region 5 is 61.40% to 80.13%, Michigan minimum standard 58%
- Follow-up after hospitalization for MI for children: Range across Region 5 is 60.66% to 100%; Michigan minimum standard 70% (note: delayed claims data impacted this score at time of analysis – the scores have since increased).
- Diabetes Screening for antipsychotics: Range across Region 5 is 76.99 to 100%; National level – 80%

- Diabetes monitoring for Schizophrenia: Range across Region 5 is 16.67% to 69.98%; National level 68.20%
- Adult access to primary care: Range across Region 5 is 90.23% to 96.09%; National level – not available, Health Plans are from 66.87 to 87.70%
- Children access to primary care: Range across Region 5 is 93.92% to 97.45%; National level – 90.18%
- Plan all cause readmission: Range across Region 5 is 7.66% to 15.04%; National level – 10.9%
- Initiation of AOD Treatment: (data 10-1-16 thru 9-31-17) 96.25%
- Engagement of AOD treatment: (data 10-1-16 thru 9-31-17) 89.92%

d. **Outcome:** Relation to Knowledge Services is to set a target, establish frequency of review, and include within meeting agendas.

DECISION POINT: Clinical Protocol Review (Dani & Sarah)

a. **Background**: Last discussed in August 2017. Document for Clinical Protocols review. At the September meeting, CLC members wanted an opportunity to review the protocols.
b. **Question:** Does CLC want to change the wording in the meeting, or set up a workgroup to review and suggest changes?
c. **Discussion:** Shana B. presented info about process that have been implemented (diabetes screening & labs) that impact the data due to dual insurance eligible having services billed to Medicare that would not show up. Due to limited time in meeting, a joint meeting proposed with UM and/or QIC in December to review Clinical Protocols to move forward. Clinical Protocols are suggested ways to approach obtaining/meeting the needs of each priority measure item. Kim Zimmerman is willing to help support CLC with attending a future meeting to present the process that QIC has engaged in to develop the targets for the measures that QIC is monitoring. Consensus of CLC was no opposition to current proposal of clinical protocol for Cardiovascular item.
d. **Outcome:** CLC agreed to protocols in the measure for cardivascular screening. Dani to communicate by email with CLC members for follow-up on item due to time limitations in meeting.

SEEKING INFORMATION: Psychiatry On-Call/After Hours Support (Linda S.)

a. **Background**: Discussion of the MDHHS bulletin regarding Intensive Crisis Stabilization for Youth brought up challenges and barriers to finding and allocating psychiatric support for on-call and after hours.
b. **Question**: What resources are available to support psychiatry on-call or other after hours support across the region?
c. **Discussion:** Need for an on-call psychiatry within Intensive Mobile Crisis response within MDHHS bulletin. Look into the option of MSHN contracting with an on-call psychiatry options for the region for possible cost savings. New MSHN medical director, Dr. Alavi, is also involved in expanding telepsychiatry for CMH's across the region. Some telepsychiatry companies used within CMH's in region include Ortele, Pine Rest, and Genoa.

d. **Outcome:** MSHN continuing to research available telepsychiatry options and report back at future meeting.

SEEKING INFORMATION: Supports Intensity Scale (SIS) Assessments (Linda S.)

a. **Background**: Per Linda S. (11-13-17) - We have heard a few things related to the expectation for those individuals that did not get completed during the first 3 year cycle.
b. **Question**: Are we still trying to catch them up or are we starting fresh? Also, is there now a requirement that the SIS assessment needs to be done prior to the PCP and if so how much before?
c. **Discussion:** The SIS completion prior to the PCP has not been a requirement to date or defined that way by MDHHS. If individuals have not had an initial SIS in the first three-year cycle, then those individuals must have their initial and second SIS assessment in the second three-year cycle. MDHHS will be looking at SIS data in January 2018 for the FY 2017 assessments. Regional completion data indicated MSHN is at approximately 83%.
d. **Outcome:** CLC members to share info at their local CMH.

SEEKING INFORMATION: 24 - Hour Authorizations for Psychiatric Hospitalization (Shana B.)

a. **Background**: CEI is reporting they are only able to approve psychiatric hospitalization in 24-hour increments per following the MSHN contract.
b. **Question**: How are other CMH's approving authorizations for psychiatric hospitalization?
c. **Discussion:** CEI is saying the MSHN contract indicates psychiatric hospitalizations need to be approved in 24-hour increments, while Saginaw and Huron are indicating they are approving for 3 days at a time.
d. **Outcome:** MSHN will review contract and follow-up with CLC to clarify.

Information

All available information should have been shared and reviewed prior to the meeting. Prior to the meeting, attendees review materials and prepare questions/feedback. Information includes previous minutes, data reports/dashboards, announcements, etc.

- **UPDATE**: Deaf Mental Health Care 2017 Training Video – MDHHS provided a hard drive to the PIHP directors. It needs to be circulated to each CMH for review by relevant staff. We'll go alphabetically, starting with those CLC members in the room at the meeting.

- **UPDATE**: Clinical Protocols (Sarah)

- **UPDATE:** CLC Measures for Review (Joe W.) - Reports placed in CLC agenda folder 9-21-17 for CLC member access. CLC requested the data be updated monthly and reviewed quarterly. CLC requested the data be emailed out to the CLC members for ease of access to data.

- **UPDATE:** SUD Integration & Access Issues/Updates

- **UPDATE:** CLC Workgroup Leads Updates

Measure	Development/ Implementation Stage	Scheduled Review	Action Needed?
ADHD Follow-Up	11. Engage in QI Efforts PRN	Jan, April, July, Oct	Yes: June Review Over Due
Cardio Screening for Individuals on Antipsychotics	9. Develop Target	Not set yet	Yes – Set Target; Group reviewed national MHP performance (43.9%) Did not have time to address target setting.
ER Visits by ER Treated Diagnosis	10. Publish Performance	Jan, April, July, Oct,	Yes: July Review Over Due
ER High Utilizers	5. Review Draft Measure	Not set yet	Yes: Review new report
Monthly Inpatient Visits Year over Year	11. Engage in QI Efforts PRN	Feb, May, Aug, Nov	Yes: May Review Over Due
Continuum of Care: Follow Thru By CMHSP	4. Draft Measure Using Data	•	N/A
Primary Care Coordination – PCP Seen	6. Validate Data	•	N/A
Compliance with Trauma-Competent Standards		-	Yes: Review initial performance

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Action List:

This is a running list of actions that (a) are being requested of group members by the committee lead or (b) have been identified as to-do items based on group decisions. These are actions that occur outside of a committee, which can be items for individuals, sub-committees, workgroups, etc.

1. Todd Lewicki – Sent CLC members list of names on HAB waiver workgroup by email on 10/10/17.

   HSW Waiver Work Group Members:

   a. Bay-Arenac – Melanie Corrion or Karen Amon
   b. CEI – Karla Block, Marie Carrell
   c. Central – Barb Mund, ShaVonne Brubaker
   d. Gratiot – Pam Fachting, Brandan Snook
   e. Huron – Amanda Sulkowski, Sherry
   f. Ionia – The Right Door:
   g. LifeWays – Shannan Clevenger
   h. Montcalm – Dawn Herriman, Joel Sneed
   i. Newaygo – Cindy Ingersoll
   j. Saginaw – Letisha Randle
   k. Shiawassee – Teresa Bolger
   l. The Right Door – Emily Betz
   m. Tuscola – Jeannette Folcik
   n. MSHN – Barb, Todd, Katy

HCBS workgroup to address PCP recommendations: Almost every CMSHP has a representative. First meeting on December 1st, 10-12 at CMHCM. Hoping that the CMHSP will take a lead role in this workgroup, review the readiness tools, and talk about the best place in the PCP to add language that would help with HCBS compliance.

2. Carolyn Watters – Email sent 10-23-17 to CLC members with the application for the MDHHS Mobile Crisis Response. Requested return of application by 12-1-17.

3. Dani Meier & Trisha Thrush – Researching psychiatric on-call services across the State.

**Next Agenda: HCBS Rules

Next Meeting: December 21, 2017 at 9:30-12p at Gratiot CMH.