Clinical Leadership Committee (CLC) Agenda

Date: 8-23-2018
Time: 1-4p
Location: Gratiot Integrated Health Network (GIHN) 608 Wright Ave, Alma, MI
Call-In Information for joint session portion of the meeting: Conf: 888-585-9008/Room #:818-235-935

CMHSP	CLC Participant	In-Person	Phone	Absent
BABHA	Karen Amon		X	
	Joelin Hahn		X	
CEICMH	Shana Badgley	X		
CMHCM	Julie Bayardo	X		
GIHN	Kim Boulier	X		
HBH	Tracey Dore		X	
The Right Door	Julie Dowling		X	
LifeWays	Gina Costa		X	
MCN	Julianna Kozara	X		
NCCMH	Denise Russo-Starback		X	
Saginaw CCMHA	Linda Schneider	X		
Shiawassee CCCMHA	None			
TBHS	Julie Majeske		X	
MSHN/TBD/ Other	Todd Lewicki	X		
	Skye Pletcher	X		
	Kim Zimmerman	X		
	Joe Wager		X	
	Amanda Horgan		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 (Agenda Content Linked Here)
2. Approve minutes from last meeting: 7-26-18 CLC 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

REMINDER: Start meeting with roll call.

Joint Session with UMC

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I. LOCUS Review System (J. Hagadorn & S. Pletcher)

A. Background: Using guidance from the LOCUS workgroup, CLC Committee, and UM Committee, the LOCUS Exception Report Guidance was adopted for use. The common service grid was developed using regional service utilization data to establish minimum and maximum use patterns for each service code at each LOCUS level of care. The LOCUS workgroup developed an agreed upon a testing protocol for vetting the LOCUS exception data. Once the initial testing has occurred by all CMHSPs, please return the testing template by 9/14/2018. Following completion of testing, CMHSPs will be sent their local-level data for ongoing periodic reviews of exception cases.

B. Question: Do UMC or CLC members have questions regarding the process for reviewing and reporting on exceptions?

C. Discussion: Getting back to progress on LOCUS process the workgroup established. LOCUS exception report guidance, testing protocol document. Skye has updated exception reports that she will send out. Reviewed the testing protocol-if this service grid is implemented, what is the impact of the parameters (min-max) at CMHs? Whether the individuals triggered by the service grid min-max and raised to attention are people that it really makes sense to review (metric=of all flagged reviews, how many seem to have a reasonable cause for review)? Third relates to anytime a system like this is created do people react to the reality of the process, which may impact other parts of the system. Please think through these issues and be prepared once this system goes live. What systemic or operational barriers do you see being affected? May recommend removing acute service codes and codes associated with inpatient episodes because of the MCG process that is forthcoming. We need to consider what happens with dual-eligibles and how these are interpreted. Reviewed the LOCUS exception testing template. The CMHSPs discussed how many consumers should be reviewed where there are outliers (over and under). Recommend taking the bottom ten and top ten cases to review.

D. Outcome: Need to be clear on the denominator relative to the dual-eligibles. Look at revising denominator based on this finding. Recommend taking the bottom ten and top ten cases to review. The timeframe for return is 30 days and can re-evaluate at that point, by September 27th UMC meeting. October meeting will be next for review.

II. MCG Implementation, Policies & Procedures (A. Horgan)

A. Background: Members of CLC and UMC attended a demonstration by DWMHA of their use of MCG for medical necessity criteria in UM decision-making. CLC and UMC are tasked with leading the region in developing a plan for implementation of MCG for acute services as well as guiding policies and procedures.

B. Question: What will be the recommendation of CLC and UM?

C. Discussion: Status on MCG. MCHE is still in negotiations in finalizing the contract with MCG. Leads have asked MCG to begin process of working with the PIHPs, which has begun. The PIHPs have gotten a survey re: training needs and Amanda has shared this with Ops Council and asked for input due to timeline. Options=conduct locally at CMH at point of acute care; same option except using a retro review on a sample compared to MCG; retain by MSHN but contracted to a single entity; or MSHN to fully retain and perform on a sample. Dave Schneider at MDHHS indicated that the sampling process would be in compliance, but we need to check with Jeff Weiferich. Awaiting his response. Preferences by CMH are varied at this point. We will be drafting a high-level procedure

for MSHN as to how to use MCG. Training on standalone feature-training conducted via a webinar. Dates in September for these trainings. Will come out as soon as possible. We can't be more restrictive by limiting services as compared to the med/surg side.

D. Outcome: Develop standards or processes based on parity guidelines. Looking for input into development of these procedures. Comply with parity but honor person centered planning processes. Amanda will keep us posted on developments.

III. Populating the Diagnosis in the Electronic Health Record

A. Background: Discussion needed on how diagnosis is being populated in the electronic record, and how the process is working for others to choose the correct diagnosis for the service being billed.

B. Question: Discussion to lead to conclusion.

C. Discussion: PCE has added up to 12 diagnosis fields. After primary dx is counted on the encounter and what is the logic for sorting/prioritizing the dx and what verification is being sought? Are importance diagnoses falling off the list? How are diagnoses being prioritized on the encounter? At Gratiot, the clinician chooses the dx for which the person came in for the day. This is coming out of the Medicaid rate setting meeting. The worker is picking from what is in the system for the consumer.

D. Outcome: Each CMH should go back and look and report on how this turned out.

CLC-Only Agenda (Same Call-In as Above)

IV. First Episode Psychosis

A. Background: Dr. Henry Nasrallah, renowned neuropsychiatrist, educator and researcher has published 11 books and hundreds of research articles. He is an expert in schizophrenia. His message is on the seriousness of the first psychosis and how it should be treated. He indicated that the first psychosis and any future psychosis kills hundreds of brain cells and the longer you stay in a psychotic state the more damage that is done. He suggested that we should address psychosis similarly to how we address strokes. We need to treat it immediately and do everything possible to prevent a reoccurrence. He indicated that you never get the same response to treatment after the first episode because the brain is shrinking.

B. Question: There is something called "a first episode psychosis protocol." However, when working in the public sector, it is often difficult to implement the protocol, which consists of neuropsychological evaluation, imaging study e.g. CT and an aggressive treatment with a well-tolerated agent along with evidence-based psycho-social interventions. What is CLC's recommendation to developing and implementing a "first episode protocol " - as it applies to the CMH setting?

C. Discussion: There had been a program called the "Raise" program. It is in the community, but not at the CMHSPs. Cathy Adams in Lansing has this program. Dr. Pinheiro and Julie B. have had some outreach with CMU and their counseling center. Many do not have any process or response to this issue. Central has used ACT to address this. Raise combined with FPE work was discussed as a recommended best practice. Financially how could this be done? Least restrictive appears to be a higher level of care first. Julie-Right Door has a process she will send.

D. Outcome: Once a protocol has been created, we will need to consider communicating this to the hospitals. Julie D. and Julie B. will share what they have to start. Share with the medical directors.

V. Handling Medical Clearance Following a Pre-Screen

A. Background: Some CMHSPs have had success in having more consumers start to come to their Access Center vs the Emergency Department, but then the CMHSP has to send them to the ED for medical clearance if they require inpatient.
B. Question: What process is each CMHSP using? What successes have there been?
C. Discussion: CEI-freestanding crisis services. Volume is high, and McLaren is paying for two positions for staff to be there. Must send people to the hospital for medical clearance prior to hospitalization and it is a drain on resources. There are really no ways around this. Forestview will take people who have not been medically cleared, but they have a protocol in place and are piloting it. Labs generally are the issue (urinalysis, drug screen).
D. Outcome: Consider using the medical directors to address this area. The issue typically is with labs. Admitting psychiatrists should be considered for insight as well. Find out from the inpatient units-what is exactly needed. Forward to the meetings with the MHPs as well.

VI. Access Staff Burnout and Turnover

A. Background: CMHSPs are reporting burnout and turnover in many positions throughout their respective organizations. This has brought up questions around recruitment, retention, referral programs, etc.
B. Question: What are strategies that could be used to address recruitment and retention of CMHSP employees?
C. Discussion:
D. Outcome: Carry forward to next meeting.

VII. 2018 Scorecard on State Health System Performance Michigan Scorecard

A. Background: The scorecard reveals that states are losing ground on key measures related to life expectancy. On most other measures, performance continues to vary widely across states; even within individual states, large disparities are common.
B. Question: As part of your external environmental review to inform our improvement efforts, what is CLC's reaction and recommendations to the scorecard?
C. Discussion:
D. Outcome: Carry forward to next meeting.

VIII. HCBS-MDHHS Audit Takeaways

a. Background: MDHHS is completing its review of HSW home visits, including an HCBS review that does not count against the CMHSPs or PIHP. There are some takeaways that have helped inform survey outcomes and opportunities for improvement. Community inclusion/integration with individuals without disabilities: HCBS standard is **greater than** one time per week. We are seeing many PCPs with goals/objectives indicating that individual will be offered or have access to one community inclusion activity per week. This does not meet the

standard. ***This does include opportunities for activities to which the individual may choose to attend or refrain, but it must be documented.*** Additionally, we are seeing CLS logs that indicate what activity took place, but not where (home, community, etc.).

b. Question: Informational update.
c. Discussion: Discussed the MDHHS process. Also, the quantification of the how many outings should be occurring. This quantification was confusing. A reviewer had been difficult to deal with. Saginaw's experience has been a negative one. There had been an error on information that would have helped Saginaw prepare. The feeling was that the state have some accountability as well.
d. Outcome: The topic sparked a larger conversation relating to person-centered planning and concerns.

- UPDATES

Management of Threats to Schools – Subgroup Update

a. Background: In the wake of the latest school shooting in Parkland, Shana wondered if other CMH's have crafted a formal policy about your response when contacted about "clearing" students who make threats/have concerning behaviors, communicating with schools, etc. Update: Decision from 4-19-18 meeting was to form a workgroup including Dani Meier, Linda Schneider, Julie Bayardo, Gwenda Summers (CEI Families Forward Director), and Kim Boulier (GIHN) will meet and develop a draft for consideration.

***Outcome**: The previously mentioned workgroup will schedule a date for meeting. In addition to the members listed above, Julianna Kozara from Montcalm also volunteered to participate as MCN is doing significant work around school safety issues. Emails are currently out to get this meeting scheduled.*

Parking Lot-August

Status of Deaf Mental Health First Aid rotation

Next Meeting: September 27, 2018 at 1-4p at GIHN, Alma