MSHN
Mid-State Health Network

Council, Committee or Workgroup Meeting Snapshot

Meeting: Utilization Management Committee

Meeting Date: 4/27/2017 (1:00PM-4:00PM)

MSHN Representatives:

Bay-Arenac: Janis Pinter
CEI: Stefanie Zin, Tamah Winzeler, Joyce Tunnard, Tom Lam
CMHCM: Kara Laferty, Janelle Lynch
Gratiot: Michelle Stillwagon
Huron: Levi Zagorski
The Right Door: Susan Richards, Emily Betz
Lifeways: Shannan Clevenger, Michael Cupp
Montcalm Care Network: Adam Stevens
Newaygo: Brian Russ
Saginaw: Linda Tilot, Vurlia Wheeler
Shiawassee: Craig Hause, Jennifer Tucker
Tuscola: Michael Swathwood

TBD Solutions: Josh Hagedorn

MSHN Staff: Todd Lewicki, Nicole Jones, Joe Wager
RED= Call-In

KEY DISCUSSION TOPICS

1. Welcome and Introductions (T. Lewicki)
2. Previous Meeting Snapshot
3. Prospective Utilization Review
   a. Decision Points
   b. Action Steps
   c. Information
   d. Communication
   e. Parking Lot
4. Concurrent Utilization Review
   a. Decision Points
   b. Action Steps
   c. Information
   d. Communication
   e. Parking Lot
4. Retrospective Utilization Review
   a. Decision Points
   b. Action Steps
   c. Information
   d. Communication
   e. Parking Lot

KEY DECISIONS/DIALOG

- Snapshots & Updates: Group reviewed; no changes made;
- Suggestion that the data report due dates be included as a column on the agenda. Once the reports are fully ready, they will appear in the agenda folder. The UMC would like to have this extra column added for the purpose of knowing when the report will be covered. The full templates need to be fully completed so that the set of reports have fully completed templates.
- SUD staff-MSHN SUD staff put a proposal together (for penetration rate for SUD). Could the SUD staff at MSHN put together a proposal regarding what the SUD penetration rate would like for the purpose of the metric, i.e. should we use the same methodology that the state is using? The methodology has been developed, we are just looking for a target in this data. Should we use the same percent expectation of 10% for SUD? What was the logic that was used for the original percent expectation? Should we determine the percent target and then take to Operations Council because they were originally involved? Operations council should be informed about the trends. It is a question of a

	richer benefit to fewer persons versus a thinner benefit to more persons. Cost per case in combination to number served could be the point of analysis. UMC feels that this could be given to Ops Council. Looking at a cost of care metric to look at how much resource is used per client. If we do this (cost related) then we should get CFO buy-in. Share with Leslie and the CFOs for reaction. The UMC is in support of looking at cost related data in relation to penetration rate. This is in relation to maximum spending and budgets. ▪ Decision Points 3a: Does there appear to be inconsistency with regional service eligibility and/or medical necessity criteria? Percent of instances in the MSSV file where actual eligibility determination matches the anticipated eligibility profile? Did their eligibility determination match what we thought it would be? If found to be eligible were the fields filled out (see consistent application of criteria)? If the person is eligible and that person is in a population, does that person have developmental disabilities as a "yes" as well as three or more functional impairments? As compared to the final eligibility determination? There is not a lot of confidence in the integrity of the data just yet and we should go through this vetting first. We will be doing this for all three populations. We will need to include the SUD population as well. This should be added to the list above. There is a field called "substance" and if it is a "yes" then would we want to see three or more functional impairments as well? Recommended the LOCUS sub-domains to address these areas. We will just look at substance abuse now and not functional impairments elements. Josh will add a new tab to look at this element. UMC should review the shinyapps database to help look at and get familiar with the data and to look at the metrics and to look at them in light of the metrics we have developed. This should be homework prior to the next meeting. What should this homework look like? Consistency of Application of Criteria-have an interim working session for an hour to have Josh train on the MSSV app to provide more detail and have a question-answer session. Meeting to be scheduled. Any time after May 5 could be scheduled. ▪ Decision Points 3a: Clubhouse. The UMC reviewed the Clubhouse proposal that it be recognized as a standalone service. The UMC agreed and regionally supported that it is a standalone service, provided there is a "caseholder" that manages the paperwork aspects because of the required elements (i.e. person-centered plan). ▪ Information discussed: Inpatient LOS Report draft-Direct questions to Joe Wager. ▪ MSSV Reports-CMH Submission Status: All CMHSPs are reporting with the exception of the following updates: LifeWays-scheduled to submit a file in May; Newaygo-indicate that Streamline is gathering it, but there is a problem on the back end and will be cost prohibitive to fix. Will need to check with IT to see if there is another way to submit the data. MSHN should seek a solution with Newaygo; Tuscola-has submitted the changes to PCE and is awaiting the result.
▪ **ACTION/INPUT REQUIRED**	Action Points-will be addressed in this area for the prospective, concurrent, and retrospective areas of the agenda. Questions to address in this area are: 1. Do we need to verify the data? 2. Do we need to request further analysis? 3. Do we need to request change strategies from stakeholders (see MSHN Change Strategy Form)? 4. Do we need to provide regional training? 5. Do we need to modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy? 6. Do we need to re-evaluate required credentials for access/intake staff? ▪ Draft Requirements for "Follow Up after Hospitalizations": Inpatient Admissions data submission. UMC discussed MSHN's need to receive inpatient psychiatric hospitalization data. The need is for MSHN to receive admissions data

	within 24 hours of the admission. There was vocal debate against the CMHSPs providing this data due to the work implications. MSHN asserted that the data still needs to be received due to the contract with the state relating to PIHP/MHP collaboration. The data does not have to specifically be within 24 hours, but should be within no greater than 48 hours to ensure it is properly processed. The UMC requested to see the elements in the contract. It was pointed out that this was shared in January. The topic ended with opposition against providing the data (suggested to provide in Box and is only temporary until all hospitals can be brought to submit psychiatric inpatient ADTs). UMC members asked to discuss with their CEOs (who have discussed the issue in Operations Council already).
▪ **KEY DATA POINTS/DATES**	▪ DA Workgroup/Data Lab Meeting scheduled for 5/9/2017, 12pm-3pm ▪ Next UM Committee meeting 5/25/2017, 1-4pm, GIHN