MSHN
Mid-State Health Network

Council, Committee or Workgroup Meeting Snapshot

Meeting: Utilization Management Committee

Meeting Date: 6/22/2017 (1:00PM-4:00PM)

MSHN Representatives: RED= Call-In

CMHSP	Participant
Bay-Arenac	None-excused. Meeting was recorded.
CEI	Tamah Winzeler, Tom Lam
Central	Kara Laferty
Gratiot	Michelle Stillwagon
Huron	Levi Zagorski
Ionia-The Right Door	Emily Betz
LifeWays	Shannan Clevenger
Montcalm Care Network	Adam Stevens, Julianna Kozara
Newaygo	Brian Russ
Saginaw	Linda Tilot, Vurlia Wheeler
Shiawassee	Jennifer Tucker, Craig Hause
Tuscola	None
MSHN	Todd Lewicki, Amanda Horgan, Cammie Myers, Joe Wager, Kim Zimmerman
TBD	Josh Hagedorn

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;
  Cost and Unit Comparison Discussion
- Shiawassee, LifeWays and Newaygo received copies of theirs from their CEO. Operations Council have reviewed this data and UM committee is interested in looking at this data as well. In some instances costs are going up but numbers are not. Ops requested what Leslie could produce data in terms of cost per consumer and cost per program. Touch base with Amy and Leslie for what is going to be produced. Amanda and Ops support UM review. Ops to receive a list of what we review.
- DAB and TANF- shift with Healthy Michigan-what are staff seeing locally?
- At Ops Council, LifeWays is following up. Are others seeing a shift of DAB and TANF to Healthy Michigan? Saginaw, LifeWays, and Central are seeing this. People who used to be qualified for DAB/TANF reimbursement is much higher and HMP is lower. A report can be completed out of the MSHN reporting portal and it will break down the list of fund sources by population to get into a comparison. Use last FY(16) to this FY(17). Run the Eligibility report to accomplish this task.
- Does there appear to be inconsistency with MSSV Eligibility Logic?

	▪ Conversation was had relating to disposition of service requests. Montcalm and CEI provided input on their findings. The CMHSPs would like to receive their MSSV extract when each report timeframe comes due for MSSV. The file is currently up to date as of 6/3/17. Closing reports-not every CMH is completing these. There may be issues in the end records. The end records look like every other record expect interval field is an "E" for end. Some changes for End records for some CMHs were not hard-coded. PCE said they do not think anyone is actually sending an end record at this time. Demographic and disposition pieces are in there. End records are being submitted but it may be an issue of mapping the data. So, the discharge form in PCE may not have fields mapped (or that they can be) to trigger the end record. It is harder to determine when an actual end record needs to occur. Are end records being submitted when there is a discharge, even if certain fields are blank? If some are filling out this field, how is this working for those CMHs? There are instances where there are two functional impairments and not three. Members could select the number of functional impairments as a way to look at how each level breaks down. It will default to three, but this could be changed. Can look at, at assessment, or at point of screening. Question around number of functional impairments to accept someone in for services. It was suggested to set eligibility at Two, but with the opportunity to toggle among one, two, or three. Historically, the criteria was three for adults and two for children. This origin was the contract between the state and the CMHSPs. UMC agreed to review the data relative anticipated eligible to be the three or more for adult and two or more for children. At Shiawassee, LifeWays, Saginaw and Central are reporting discharges. The other CMHs in the region do not appear to be. So this may not be cross-walked with the current fields or maybe not coded in. Each CMH should check with their EMR vendor project manager to make sure this has been coded into the system. ▪ **Concurrent Decision Points** ▪ For review of Variation in the Use of Intensive Services, are the ACT and Home-Based utilization data reports ready for regular review in the UM schedule. (Presentation in meeting). The purpose was to discuss the development of appropriate targets for ACT and Home Based reports. ▪ What are the performance thresholds to be for ACT and Home-Based utilization reports? This will be regional data to be used as a benchmark for further discussion. There is the issue with COB recoding as it comes to Medicaid from Medicare. In Box, there is a note from Maggie via the EDIT group explaining some of this issue. ▪ **Retrospective Decision Points** ▪ What should the threshold or performance expectation be for the region? UMC discussed use of state comparison data-Joe W. indicated there is state data and will share a benchmarking sheet with UMC. Joe W. will look into the thresholds in the KPIs to determine if we are already exceeding. The logic to come up with a target: look at barriers, lower performers, give health plans feedback, what barriers are we trying to move? Break down performance by health plans in our region. Add to agenda for Data Analytics workgroup. ▪ Clinical Leadership Committee has created clinical protocol guidance related to the portfolio measures all noted it the retrospective section above. What initial steps should be taken to implement these? These need to occur relative to the balanced scorecard measures (i.e. what a staff does when there is a particular outcome with Access to Primary Care-Child or Adult). The plan is to present the clinical protocols in more depth in the July meeting. ▪ Outcome Assessment Data-CAFAS Update (i.e. What are our next steps for the measure: Percent of Children whose CAFAS Results Meet SUD Criteria?)

	▪ Waiting until there is a chance to do a webinar to present analyses have been created and sit down to ask questions. Waiting for a response from Forest G. to schedule the presentation. Looking at Gratiot as the location.
▪ **ACTION/INPUT REQUIRED**	▪ **<u>Concurrent Action Steps- No action steps needed this month relative to concurrent UR measures</u>** ▪ Do we need to verify the data? No ▪ Do we need to request further analysis? ▪ The data was reviewed. CMHSPs are not doing the aftercare in every situation, health plans have questioned- the data is comprised of 100% claims data, but not all discharges are the CMHSP's. What process weeds out the consumers that are mild to moderate-continuing stays help determine this. Saginaw reviews 100% of their readmissions. Suggestion: that all readmissions be looked at, case by case. Use this as a justification and discovery around systemic versus individual issues. Suggestion: review the previous quarter. ▪ Do we need to request change strategies from stakeholders (see MSHN Change Strategy Form)? ▪ Not at this time, but the committee would like to obtain a list of the verified representatives from each of the health plans to ensure that these persons are recognized as legitimate when they call the CMHSP to discuss a case. Similarly, the MHPs are reporting the issue with the CMHSPs as well in terms of communication. No conclusions yet, but this appears to be a barrier to the process. How can this process be improved? Use Skye's interface with the health plans to introduce the idea of better coordination between the two groups. ▪ **<u>Retrospective Action Steps</u>** ▪ Do we need to verify the data? No ▪ Do we need to request further analysis? ▪ Plan All-cause Readmissions: The data could be reflective of only acute medical/physical conditions. Of these, how many persons touch both systems? Include number of chronic conditions as a part of the analysis. The data should be reviewed further. Questions around how we use the ADT data and who gets the message in the system-push out alerts to CSMs for the review of the alert in the system. What is the expectation to respond? Who responds? Discussed looking at a procedure regionally for how to deal with this. Example: have nursing respond to ADTs/have them filtered with criteria, for example, more than 6 ADTs in the last 180 days, use a high utilizer teams and come up with a care coordination team. Kara from Central has a documented process and will share this with Todd for the UMC. ▪ Do we need to set utilization thresholds or limits? There is an existing threshold.
▪ **KEY DATA POINTS/DATES**	▪ DA Workgroup/Data Lab Meeting scheduled for 7/11/2017, 12pm-3pm ▪ Next UM Committee meeting 7/27/2017, 1-4pm, GIHN