MSHN
Mid-State Health Network

Council, Committee or Workgroup Meeting Snapshot

Meeting: Utilization Management Committee

Meeting Date: 7/27/2017 (1:00PM-4:00PM)

MSHN Representatives: **RED= Call-In**

CMHSP	Participant
Bay-Arenac	Janis Pinter
CEI	Tom Lam, Tamah Winzeler, Joyce Tunnard
Central	Kara Laferty
Gratiot	Kim Boulier
Huron	Levi Zagorski
Ionia-The Right Door	None
LifeWays	Michael Cupp
Montcalm Care Network	Adam Stevens, Julianna Kozara
Newaygo	None-excused
Saginaw	Vurlia Wheeler
Shiawassee	Craig Hause
Tuscola	Michael Swathwood
MSHN	Todd Lewicki, Cammie Myers, Joe Wager, Skye Pletcher
TBD	Josh Hagedorn

KEY DISCUSSION TOPICS

1. Welcome and Introductions (T. Lewicki)
2. Previous Meeting Snapshot
3. Annual Review of UM Plan
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;

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 June meeting). Joe presented the ACT data to the UM Committee. The numbers of patients per 1,000 instead of services per 1,000. Recommendation to do a ZTS enhancement to includes patients per 1,000 served at the CMH.
- What are the performance thresholds to be for ACT and Home-Based utilization reports? Medicaid provider manual does not have a threshold, so why should UMC? Do the CMHs do daily contacts for ACT? Expectation is typically multiple contacts per week. HBS was also reviewed. The same recommendations apply.
- What would the committee like to define for the SUD reports? What questions/data points are we interested in? Detox Recidivism-include primary substance use being reported at that admission to address best level of care for someone repeatedly being admitted. Looking at recommending a 30 day and 90 day timeframes.

	Then look at the category of primary substance next. Admission and Discharge files would be the source of the data for these reports. If someone leaves detox then goes to residential, then does that count? No, it does not. Derek from TBD is working a "step down" report to look at how DC planning is happening. Joyce will check with SUD staff at CEI for further feedback as well. Josh recommends using the last official BH-TEDS file accepted by MDHHS as the data source. ▪ The Acute Services report is services per 1,000. The question has been asked around what should be done having reviewed the data. We should mark measures that are exploratory as such to ensure when action should be taken, or not. Exploratory refers to an action that is more diagnostic. It may tell us that there is an issue to fix, but not how to fix it, or why. Diagnostic is a term that better fits for this process. The Acute Psychiatric data was discussed in depth. Another measure is to look at of those screened, how many were hospitalized. **Retrospective Decision Points** ▪ What should the threshold or performance expectation be for the region for Adult and Child Access to Primary Care? **We are performing above the state and national levels. See proposals below.** ▪ Should these targets be set relative to national health plan standards and Michigan health plan standards? **See proposals below.** ▪ **Proposed Performance Targets:** (Access to Care for Adult/Child measures and All-Cause Readmission measure) ▪ **Proposed Target 1-** Each CMH to perform equal/better to the average MHP performance ▪ **Proposed Target 2-** Each CMH to perform better than the best MHP performance (rationale- we are a specialty benefit, confirm our expertise in this content area). **The UMC's interest is to use this target for review.**
▪ **ACTION/INPUT REQUIRED**	**Annual Review of UM Plan** Due for annual review and input. Please make comments/changes on the copy of the plan and save back to Box (track changes are on). All comments/revision suggestions should be complete prior to the August UMC meeting. UMC has chosen to have a number of measures to track and some of these are action oriented and will require follow up, like the priority measures. Ensure the metric measurement timeframe frequencies and aligned with our current reporting schedule. Verify any MSSV logic changes as needed. Josh to verify. Include change strategy form logic into the UM plan. For MSSV-UM wants to be able to pull the individual case to be able to review and act on each case. Follow-up: what is the format or the details that members want to go into it? The logic is available, but different staff implement different tools to get their data. Joe will discuss with Forest to get further direction. Clinical licenses will roll out for ICDP access and these will be automated and sent to committee members. Todd will follow up by making the indicated changes and send back out to the UMC. ▪ Outcomes assessment and CAFAS data ○ Proposal- refer to CAFAS workgroup for further exploration and to address following:

	▪ Review logic for defining eligibility ▪ Provide feedback on how the definition of eligibility should change/if it should change ▪ Identify potential reasons for unexpected output ▪ Review definitions of levels of care, specifically the "other" category (can or should it be redefined to more accurately capture the scope of services that are currently lumped in under "other"?) ▪ Other specific suggestions for CAFAS workgroup to address? ▪ The initial questions were posed back in November 2016. As we work more with the data, more questions arise. As we develop one balanced scorecard measure, it may warrant getting the group back together to review the logic and thinking around these new questions. Review logic for defining eligibility. The data does not look right and this needs to be determined why before we start acting on it. It would be helpful to be clear on what we are seeing. ▪ Follow-up from June meeting- CMHSPs report out on clinical protocol implementation plans. This will be due on August 11, 2017 to Todd. ▪ Follow-up from June meeting- Verified points of contact at MHPs for care coordination/follow-up after hospitalization. Document found here- HERE . As discussed last month there was a request to get a compiled list of MHP contacts. Skye indicated she has additions to this process. The workgroup (PIHP/MHP) indicated that they want the PIHP to be the first point of contact. The MHPs were taking a few additional steps that were outside of the scope. This will be further defined. If there are calls to your CMHSP relating to care coordination, they should be directed at Skye. ▪ CLC proposal for an Integrated Health workgroup to be comprised of representation from CLC and UM committees for the purpose of addressing some of the following related to integrated health: o Assist with development of a regional population health/care management plan o Create strategies for using ADT feeds to improve care coordination o Develop best practices and provide regional guidance around primary health coordination o Provide procedural guidance with regard to collaboration with MHPs ▪ CLC would like a workgroup to have a shared CLC/UM workgroup to address integrated health activity. Purpose to come up with an Integrated Health Plan with SUD, to address different strategies around ADT feeds, best practices. UMC volunteers: Kara, Skye, Todd, but there will be more follow up between Kim Boulier and Dani Meier to clarify the workgroup, send back to Todd and Todd will send to UMC to obtain the remainder of volunteer participants.
▪ **KEY DATA POINTS/DATES**	▪ DA Workgroup/Data Lab Meeting scheduled for 8/8/2017, 12pm-3pm ▪ Next UM Committee meeting 8/24/2017, 1-4pm, GIHN