Clinical Leadership Committee & Utilization Management Committee

Date: Thursday, July 23, 2020
Time: 1-2pm CLC Content; 2-3pm Joint Content; 3-4pm UMC Content
Location: Online/Phone ONLY; No in-person Meeting
Zoom Meeting: https://zoom.us/j/7242810917
Call-In: 1-312-626-6799; Meeting ID: 724 281 0917

Meeting content linked here: UMC July Meeting Materials CLC July Meeting Materials

CMHSP	Participant(s)
Bay-Arenac	Joelin Hahn; Janis Pinter
CEI	Shana Badgley; Tamah Winzeler; Tim Teed; Elise Magen, Gwenda Summers
Central	Julie Bayardo; Renee Raushi
Gratiot	Kim Boulier; Taylor Hirschman
Huron	Natalie Nugent; Levi Zagorski
Ionia-The Right Door	Julie Dowling
LifeWays	Gina Costa; Dave Lowe, Kaitlin Burnham
Montcalm Care Network	Julianna Kozara; Adam Stevens
Newaygo	Denise Russo-Starback; Annette VanderArk
Saginaw	Kristie Wolbert; Erin Norstrandt
Shiawassee	Crystal Eddy; Jennifer Tucker, Craig Hause
Tuscola	Julie Majeske; Michael Swathwood
MSHN	Skye Pletcher, Todd Lewicki
Others	

CLC

I. Welcome & Roll Call

II. Review and Approve June Minutes, Additions to Agenda

III. Jail Diversion

A. Background: The Jail Diversion Guideline notes that the following should be Included in CMHSP data gathering: "the unique consumer ID as assigned by the CMHSP and the date of diversion, the type of crime, and the diagnosis. The CMHSP must be prepared to share its jail diversion data with the department upon request." How do each of the CMHSPs gather diagnosis data? Is it the broad category, I.e. adult with MI, or is a specific diagnosis kept?

B. Discussion: Since data is pulled from EMR the specific diagnosis for the individual is available as part of the record. There does not seem to be a reason to record only disability category when diagnosis is available and part of the record. Observations from multiple CMHs that there seems to be a lot of variance and lack of clarity around what

type of activities are defined as pre and post booking. Suggestion to develop regional guidance in order to establish shared understanding and agreement about what type of data to collect

C. **Outcome:** Skye will draft jail diversion procedure incorporating principles of the sequential intercept model. Will bring to August or Sept CLC meeting for first reading; CLC can further refine. Please send and feedback or resource materials to Skye to incorporate in draft procedure.

IV. Annual Policy/Procedure Review

A. **Background:** The Service Delivery Chapter of policies and procedures are due for review.

B. **Discussion:** Reviewed/Revised policies and procedures are due to the policy and procedure committee in August.

C. **Outcome:**

CLC & UMC Combined

I. Waivers and Service Ranges

A. **Background: During the MDHHS site review of the waivers,** they specified that it would impact waiver services only, but under all three waivers (CWP, SEDW, HSW). Previous state reviewers allowed service ranges in plans and the state has now indicated they expect to see specific service amounts identified. Since ranges were previously allowed, they are not citing the CMHSPs but will provide technical assistance, to be scheduled.

B. **Discussion:** Reviewers provided rationale that use of ranges does not always accurately indicate what the person's true intensity of needs is. It is not realistic or consumer-friendly to require an authorization anytime a person's needs fluctuate. Reviews and addendums should be completed when there are significant changes in functioning/needs, however there should be some ability to account for typical fluctuations in need and engagement with service. Requiring an extreme level of granularity for amount/scope/duration on IPOS is not person-centered. Using appropriate ranges of amount/scope/duration allows the person being served some autonomy to direct their own services and increase or reduce supports as they experience periods of higher or lower need. Additionally, there are parity concerns if IPOS addendums will be needed each time services are adjusted in relation to a person's needs. There is no comparable example for physical health services; it's typical for physical health benefits to also be defined in terms of a range, ie: up to 12 sessions of physical therapy

C. **Outcome/Action Steps:** MSHN will compile concerns and talking points to share with the group for advocacy with MDHHS throughout the site review cycle. QIC is also addressing these concerns and will provide recommendations for further advocacy with MDHHS

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II. COVID-19 Updates & Successes

A. **Background:** Status updates on CMHSP re-opening activities and any successes in addressing COVID-19 related changes

B. **Discussion:** Concerns for persons who do not have telephone access, or for whom access is limited. There are also challenges with the efficacy of treating individuals with SPMI with telehealth only; anecdotally some CMHSPs reporting uptick in psychiatric hospitalizations
C. **Outcome/Action Steps:** No further actions.

III. Case Management/ Supports Coordination Workgroup

A. **Background:** Continuation of discussion from last month. A proposed workgroup charter was submitted to Ops Council for review/approval. Thank you to all who have indicated interest in participating; once approved by Ops Council more information will go out to the group to schedule first meeting. Skye covered interested participants. Kaitlin (LifeWays), Taylor (LifeWays), Joelin (BABH), Julie D. (Rt. Door), and Dawn Herriman (MCN) both requested to be a part of the group.
B. **Outcome:** Informational Only. Skye will send out some meeting times in the next few weeks. Charter in meeting material.

IV. MDHHS Memos/BHDDA Guidance

A. Letter L 20-43 Extension dates for LOC Determinations
B. BHDDA Guidance Resident Freedom of Movement
C. BHDDA Guidance COVID-19 Testing Consent for Individuals with Decision-Making Challenges
D. BHDDA Guidance Infection Control Issues in Behavioral Health Clinic Settings
E. Electronic Visit Verification Implementation (Wieferich Communication 7/8/20)
F. BH Communication Essential Virtual and F2F Services COVID-19 Guidance (7/8/20)
G. Discussion: Included in meeting folder due to how many are affecting CMH functioning. Focusing mainly on: BH Communication Essential Virtual and F2F Services COVID-19 Guidance (7/8/20): Can we expand on what we already have for telehealth to ensure that we are not adding more forms? *Consent to treat* is a place where this could be addressed, this was recommended. Some CMHSPs are documenting in the consent and some are doing in the consent and in every progress note. Also, another option is to include individual preference in the person-centered plan. It could be specified in the PCP attesting that telehealth could be part of the service delivery. Should also account for what gets done should an emergency arise during telehealth. How should we go about justifying telehealth, or not, and why? We should defend why we are doing it as opposed to defending why we were not offering it. Also, EVV implementation has no update, but some CMHSPs have considered moving forward. CIO Forum has discussed and may have further insight.

UMC

V. Implementation of CLS 2015 Code

A. **Background:** MDHHS intends to transition CLS services currently being provided in an unlicensed setting under HCPCS Code H0043 to H2015 effective 10/1/20. EDIT created a sub-workgroup to answer questions from the field and provide technical guidance. Q&A document produced by EDIT is included in meeting materials

B. **Discussion:** This will be a challenge and Central will be sharing their perception of the issue. CMHSPs are going through the details and trying to absorb what the transition means and what should happen. Central shared that with the new modifiers, it will be difficult to figure out what is exactly going to be needed. There will be discussions with PCE. These changes will also involve staff trainings and new processes. Ratios are very confusing especially for incorporating this into the individual's plan of service. This ratio of activity to define the "preponderance" of units also further confuses the issue of specificity in using the exact number of units in an individual's plan (for the waivers). The term preponderance is vague and confusing. The state said they will be making their tools available soon. Oakland had also worked on a tool and they may be willing to share.

C. **Outcome:** This will be kept as an agenda item for ongoing discussion to gather ideas, resources, and solutions. Skye will share the tools as they become available as well.

VI. HSAG CAP for UM Findings

A. **Background:** Refer to items #31, 34, 35, 36 on draft CAP for UM-specifications. MSHN Regional UM Policy was amended to add clarifying language around expectations for timeframes of issuing ABD notices. MSHN will monitor during the FY21 DMC site reviews to ensure adverse benefit determinations are being issued with consistency in regard to the HSAG areas of finding.

B. **Discussion:** What tracking mechanisms does each CMHSP have in place to ensure timeframes are met? What additional steps might need to be taken as a region to ensure our process is standard and fully complies with requirements? After auth decisions, ABD notices are handled in a different department. There are inconsistencies in comparison to other CMHs. Most echoed an interest in making sure that it is done consistently. Because there are different departments, it lends to greater confusion and uncertainty as to updates and where the decision is in the process.

C. **Outcome:** QIC and Customer Service Committee are handling the formal CAP responses to HSAG and have implemented formal. Staff should remain aware of this issue and QIC is doing a lot of work on it and to be sure to link with them to ensure the best local process.

VII. Penetration Report

A. **Background:** MSHN migrated this to the REMI system.

B. **Discussion:** Penetration is down since COVID, not surprisingly. Engagement is down and that seems connected to COVID, especially for new persons in getting them into services. Broken down by HMP and Medicaid. Detail report was also included. Medical Directors recommended including race and ethnicity in the penetration rate report.

C. **Outcome**: No further thoughts or recommendations.

Parking Lot/Upcoming:

Follow up on status of MCG reports and generating data.