Clinical Leadership Committee & Utilization Management Committee

Date: Thursday, March 25, 2021
Time: 1-2:30 pm Joint Content, 2:30-4pm UMC and CLC Breakout Sessions
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 CLC March Meeting Materials

CMHSP	Participant(s)
Bay-Arenac	Janis Pinter; Joelin Hahn
CEI	Elise Magen; Tonya Seely; Tim Teed
Central	Julie Bayardo; Renee Rauschi; Angela Zywicki
Gratiot	Sarah Bowman; Taylor Hirschman
Huron	Natalie Nugent; Levi Zagorski; Jill Rowland
Ionia-The Right Door	Julie Dowling; Suzi Richards
LifeWays	Gina Costa; Dave Lowe
Montcalm Care Network	Julianna Kozara; Sally Culey
Newaygo	Kristen Roesler; Denise Russo
Saginaw	Kristie Wolbert; Vurlia Wheeler
Shiawassee	Crystal Eddy; Jennifer Tucker; Trish Bloss
Tuscola	Michael Swathwood
MSHN	Skye Pletcher, Todd Lewicki; Kim Zimmerman
Others	

JOINT CLC/UMC SESSION

I. Welcome & Roll Call

II. Review and Approve February Minutes, Additions to Agenda

Addition: An area of focus affecting multiple CMHSPs during the MDHHS site review of the waivers revolved around multiple standards within the Individual Plan of Service (IPOS) sub-section. Within the approved corrective action plan, MSHN committed to developing a regional training plan that aims to work towards compliance of the IPOS standards. BHDDA and The ARC Michigan have combined efforts to offer a monthly PCP Webinar Series that aims to provide and collaborate on training to support populations receiving public mental health services through a PIHP/CMHSP. As part of MSHN's training plan, MSHN would like to offer the opportunity to be invited to this series. Please share with anyone who may benefit from these monthly webinars. Interested parties should send an email to Katy.Hammack@midstatehealthnetwork.org by Friday, April 9th. The invites come out by email monthly. Marie Eagle is willing to add whoever wants to attend to the email list.

Webinars occur every month on the third Tuesday of the month:

Mar 16, 2021 03:00 PM
Apr 20, 2021 03:00 PM
May 18, 2021 03:00 PM
Jun 15, 2021 03:00 PM

Jul 20, 2021 03:00 PM
Aug 17, 2021 03:00 PM
Sep 21, 2021 03:00 PM
Oct 19, 2021 03:00 PM
Nov 16, 2021 03:00 PM
Dec 21, 2021 03:00 PM
Jan 18, 2022 03:00 PM
Feb 15, 2022 03:00 PM
Mar 15, 2022 03:00 PM
Apr 19, 2022 03:00 PM
May 17, 2022 03:00 PM
Jun 21, 2022 03:00 PM
Jul 19, 2022 03:00 PM
Aug 16, 2022 03:00 PM
Sep 20, 2022 03:00 PM
Oct 18, 2022 03:00 PM

III. PCP Training Plan/Toolkit

A. **Background:** Site review by MDHHS in 2020 identified needs with respect to person centered plan drafting and goal/objective writing. To support the CAP process, MSHN completed a plan/toolkit. Kim Zimmerman will present to CLC/UMC for feedback.
B. **Discussion:** Support for the need for regional training resources. Consider training resources that also focus on the philosophy of person-centered planning (the "why"). Additional training resources for supervisors would also be helpful to support implementation and ongoing skill-building with caseholders
C. **Outcome:** Please email feedback to Kim directly in the next 30 days. Todd will provide the draft training resource document via email for review.

IV. Community Transition Program (formerly Direct Community Placement Program)

D. **Background:** CMHSPs are starting to have some of their consumers in this program. There are logistical issues, questions, and concerns being raised. CEI has requested discussion and shared that they have asked the following questions to the state:
   a. How is someone identified for this program?
      i. What qualifies someone?
   b. How is CMH included throughout this process?
      i. So far, CEI is getting notified just prior or after placement occurs; there is little to no other communication occurring
   c. How is placement determined between Hope Network & Beacon?
      i. Are there other residential programs that are options?
      ii. Can they (Hope/Beacon) refuse placement?
   d. What oversight is provided for these placements?
   e. How is success determined/measured?
      i. If success is determined at day 90, what is CMH expected to do and by when?
      ii. Can success be determined prior to day 90?
   f. What is the contracted rate for placement?
      i. Is it assumed/contract that CMH has to take over this contracted rate if alternative placement is not determined at day 90/91?

E. **Discussion:** Significant challenge because CMHSPs do not have settings that are HCBS compliant and also able to meet high acuity needs. Individuals are sometimes placed on state hospital "discharge-ready" list however they still require locked/secure settings so the CMHSP is not able to place them appropriately despite pressure from state hospitals and MDHHS to do so.

F. **Outcome:** Please continue to share details of these cases with MSHN for advocacy with MDHHS. MSHN can share concerns with PIHP Directors to see if there is benefit in bringing a statewide approach to MDHHS

V. Update: ACT Reporting Requirements

G. **Background:** Memos issued by MDHHS in November 2020 regarding minimal expectations for average of 120 mins per consumer/per week for ACT services. Review of regional data indicated underutilization throughout the region, even pre-pandemic.

H. **Discussion:** Agreed that ACT Utilization report will be reviewed by these committees quarterly and each CMHSP will follow up internally with its ACT teams/providers as needed

I. **Outcome:** Added to quarterly report schedule (Feb, May, Aug, Nov)

VII. Update: Clinical Determination for Use of Face to Face vs. Telehealth and Future Plans

A. **Background:** Review 3/3/21 MDHHS Memo "Expectation of the Provision of Face-to-Face Services." Last month it was decided that a regional telehealth utilization report will be reviewed by these committees on a quarterly basis. Also, seeking feedback for MSA-2068 Telemedicine proposed policy that focuses on asynchronous telemedicine services.

B. **Discussion:** CMHCM reported that they are building into the PCP documentation of the individual's preference regarding telehealth vs face-to-face. BABHA agrees that it would be helpful to have some regional consistency about how consumer preference will be documented in PCP and progress notes so that there is shared understanding of what MSHN and external reviewers will be looking for to meet MDHHS expectations. Todd sent out a copy of the MSA-2068 Telemedicine proposed policy for review.

C. **Outcome:** CMHSPs can submit feedback directly to MDHHS for the proposed telemedicine policy

VI. Update: H2015 Reporting Memo 2/10/21 (including "preponderance rule")

A. **Background:** Discuss 3/19 Technical Assistance webinar and next steps. Review differences between H2015 and T2027 in light of email from Morgan at MDHHS

B. **Discussion:** All CMHSPs are struggling with implementation of these changes due to lack of clarity from MDHHS and guidance that often seems conflicting. No clarification of Preponderance rule. So, contradictory to the unit reporting/billing. Would like to see MIOHSIG sign off on their guidance to us. It is especially difficult when there is an apartment complex type of situation with shared staffing. Reduces the flexibility to meet consumers' needs. They are essentially pushing people either into just specialized residential or single person homes. What if people want to live together? The problem with straight 15 min unit in the multi consumer context is you have one staff, so you must toggle from two consumers to three, etc., as people leave and come back. The risk of recoup is so high, we are concerned our providers will not want to continue these types of arrangements.

C. **Outcome:** MSHN does not support use of the preponderance rule. The preponderance rule is interpreted as "majority." This is counter to PCP principles. Propose regional workgroup consisting of cross-functional representation; draft workgroup charter will be presented to Operations Council for consideration

VII. Update: Independent Facilitation Proposal

A. **Background:** Proposal for regional contract will go to Operations Council during April meeting (4/19/21).

VIII. LOCUS Training Changes

A. **Background:** Beginning in FY21 MDHHS entered into a contract with Deerfield Systems (maker of LOCUS) which covers statewide use of LOCUS and provides access to the online training system for all CMHSP users. Each CMHSP and contracted provider organization were required to sign zero-dollar contracts for use of LOCUS and EHR implementation. Review the LOCUS Training Update FAQ and

LOCUS Training Questions documents. Each CMHSP or the region as a whole will need to develop a training plan to ensure competency and interrater reliability. FY21 LOCUS Specialty training brochures posted in meeting folder- good resources for advanced skills, quality outcome measures, supervision, etc

B. **Discussion:** Does each CMHSP currently have a local trainer to support the supplemental training/fidelity needs? Is there a regional need to support local trainers in developing their training plans? Transition to the new system seems to be a big leap. GIHN reported some staff recently completed the online training and reported it is nowhere near sufficient to orient users about appropriate use of LOCUS. How will this be maintained if the state is no longer offering Train the Trainer opportunities? Local trainers will be necessary to ensure staff competence. Supplemental trainings seem to be focused on individual CMH plans- this could lead to decreased fidelity if each CMH is conducting their own versions of training.

C. **Outcome:** There is support for additional train the trainer and additional supplemental trainings. There needs to be follow up with regard to the low quality of the trainings occurring through Deerfield. Pass along additional feedback as needed. Skye will share feedback with PIHP LOCUS leads group and MiFAST fidelity team.

CLC and UMC Breakout Sessions will begin at the conclusion of joint content agenda

CLC Breakout Agenda Items

I. Transitional Housing (Shana Badgley)

A. **Background:** Shana requested discussion last month and the committee was unable to cover this topic. Carrying forward to the March meeting.

B. **Discussion:** This item is referring to the Community Transition Program discussed in Agenda Item #4 of the joint portion of the meeting. No further discussion required.

C. **Outcome**: N/A

II. Trauma-Informed Assessment

A. **Background:** In addition to assessing organizational trauma competency, what evidence-based trauma screenings/assessments are being used with consumers? How are results of trauma assessment then included in person-centered planning and addressed through treatment? MSHN QAPI team suggested sharing of tools/resources among CMHSPs following requests for best practices.

B. **Discussion:** CATS, UCLA PTSD index, ACES, northshore, young child PTSD checklist, TFCBT, stay away for more in depth assessments. Are any using more in depth? CATS for initial. TFCBT for pre and post measures. UCLA for more in depth. Sag-CTAC at front door. Built into the IPOS process and whether they require a follow up based on findings. CPP-for infant mental health.

C. **Outcome:**

III. CMHSP Tracking for Prescreen and After-Hours Mobile Crisis

A. **Background:** The following questions were posed to members of the CLC: Are any of your agencies using contracted providers or other creative arrangements for afterhours mobile crisis teams and/or prescreening services. If so, could you share the arrangements and how they are working out? Having daytime clinical workforce meet these needs is proving more and more challenging. Responses were compiled for further conversation in the CLC meeting.

B. **Discussion:** Difficult to staff pre-screen and mobile crisis. Trying to ensure that the team remains whole and functional. Central switched to 12 hour shifts to have more days off. Central gave intermittent contracts to crisis staff to pick up shifts as they wanted. They can earn extra money. Need to be careful to help avoid burnout. Incentivizing with less staff has been a good solution. Staff who are eligible are

able to take on hours as appropriate. Central had two pay grades that were included. ICSS data was discussed.

C. **Outcome:**

UMC Breakout Agenda Items

I. **MDHHS Required Reporting- Service Authorization Data**

A. **Background:** In recent months MDHHS has issued 3 separate requests for information in the areas of grievances, appeals, and service authorizations. MDHHS provided a finalized grievance reporting template and we expect finalized versions of the appeals reporting template and service authorization reporting template in the next 1-2 weeks. MSHN has decided to suspend the MSHN Customer Service Timeliness report at this time until all 3 MDHHS reporting templates have been received. We anticipate that most of the same elements will be required by MDHHS and we intend to eliminate any duplicate reporting requirements. UM Committee will be responsible for fulfilling the MDHHS Service Authorization reporting requirements going forward. Collaboration will occur between UMC, Customer Service Committee and Quality Improvement Council to streamline reporting requirements

B. **Discussion:** Support for eliminating elements of the MSHN Customer Service Timeliness report that are duplicative to any MDHHS required reporting.

C. **Outcome:** Skye will distribute the finalized MDHHS Service Authorization Reporting template once it is received (anticipated 4/1). UMC will review and determine if any clarification is needed to ensure all CMHSPs are consistently reporting the data elements in the same way (ie: ensure shared understanding of what constitutes a service request, etc)

II. **FY21 Q1 MCG Retro Reviews**

A. **Background: C**ompiled regional data provided for review

B. **Discussion:** Reviewed Q1 retrospective reviews- no concerns with data. The region is maintaining at or above the target performance of 95% consistency with MCG criteria. Discussion from CMHSPs who are currently conducting prospective screenings. There are challenges with inpatient days not aligning correctly in MCG if a person is not placed on an inpatient unit for >24 hours after pre-screening. Newaygo shared how they are able to change the initial date of episode of care in MCG to align with the actual admission date when it differs from the date of the pre-screen.

C. **Outcome:** No further action required. Newaygo CMH shared information related to MCG data entry which was distributed to the larger group.

III. **Regional LOCUS/CAFAS Outlier Reports**

J. **Background:** TBD previously developed outlier reports in Power BI for both organizational comparison (differences in service provision among CMHSPs) as well as individual outlier detection. There have been challenges in the ability to utilize these reports as intended since they are housed in MSHN Power BI which CMHSPs do not have log-in access to. MSHN IT has been working on solutions so that consumer-level data can be isolated and visible to only the serving CMHSP without exposing the full underlying dataset of all consumers in the region.

K. **Discussion:** MSHN intends to share CMHSP-specific links that will allow anyone with the link to view the data for that CMHSP without being visible to other organizations. This should be available to view without a Power BI login.

L. **Outcome:** MSHN will aim to have this information available for April meeting or provide status update.

Parking Lot/Upcoming: