Clinical Leadership Committee & Utilization Management Committee

Date: Thursday, April 23, 2020
Time: 2-4pm
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 April Meeting Materials CLC April Meeting Materials

CMHSP	Participant(s)
Bay-Arenac	Janis Pinter; Joelin Hahn
CEI	Elise, Tim,
Central	Renee
Gratiot	Kim, Taylor
Huron	Levi, Natalie
Ionia-The Right Door	Susan, Julie
LifeWays	Dave Lowe, Gina Costa
Montcalm Care Network	Julianna, Adam
Newaygo	Denise, Kristen
Saginaw	Erin, Kristie, Vurlia
Shiawassee	Crystal, Jennifer
Tuscola	Michael
MSHN	Skye Pletcher, Todd Lewicki
Others	

I. **Review and Approve March Minutes, Additions to Agenda**

II. **COVID-19 Regional Response Planning/ Updates/ Concerns**

A. **Background:** Discuss current issues including Residential Homes Crisis Plan and Managed Care Program Coordination Contact List for Regional Hubs. There is also some confusion around verbal versus physically signed consents requiring further discussion.

B. **Discussion:** Regional Hubs-to transition from long term care settings to a regional hub to present transmission of coronavirus. It appears that this would only affect individuals transferred from another nursing facility. When will identified staff hear something about the coordination function? Struggling with admissions to hospitals even when the person is showing no symptoms, also trouble with discharges requiring planning, like placements. Positive side-Shiawassee-two residential facilities have set up video conferencing to assist residential providers. Verbal versus physical consents-hearing conflicting information. Do they need to be followed up with physical signatures? You should be seeking physical consent. PCE users can access their PIN electronic signature

module. There is also the issue of obtaining the signature of the guardian or caregivers. It should be within a reasonable next face to face visit. Reviewed Residential Homes Crisis Plan and discussed feasibility. A primary challenge is that when individuals in a residential/AFC setting test positive for COVID-19, there is not enough PPE to adequately protect staff and other residents. Guidance is changing so rapidly from CDC, MDHHS, other sources that the content of the document may need to be updated frequently to stay contemporary. Additionally, many contingency suggestions in the document are solely the decision of each CMHSP working together with their local public health office and may not be appropriate for broad implementation across the entire region. Todd will remove reference to regional hubs since MDHHS has ordered that regional hubs can only accept transfers from nursing facilities.

C. **Outcome/Action Steps:** Please provide additional feedback about the Residential Homes Crisis Plan to Todd via email. He will make refinements and if approved by regional medical directors and Ops Council it will be published as regional guidance.

III. ACT Teams in the pandemic

A. **Background:** Because ACT teams needed to adapt quickly and change how they provide treatment, please provide a report on how things are going for the teams and individuals. Curious to know about adaptations in health and safety, team meetings, contacts, medication, harm reduction, and other basics.

B. **Discussion:** Gratiot, Montcalm, Shiawassee and Newaygo do not have ACT services.

BABHA- has prioritized caseload, seeing priority consumers in community each week, other consumers are receiving services via telehealth and team meetings are via telehealth as well. Team reports many consumers are struggling with understanding need to adhere to Stay Home Stay Safe. Does not appear to be a significant increase in BH symptoms at this time.

CEI-Conducting team meetings via zoom, consolidate med deliveries as much as possible, administering meds in community and engaging with social distancing precautions. Daily there are 2-3 staff for consumers who walk in with acute needs. Administering injectibles in office as needed. All other services via telehealth. About 80 current consumers in ACT, many do not understand social distancing and importance.

Central- Psychiatrists reporting telehealth has been helpful and consumers are more engaged, disclosing more via telehealth. ACT team has been doing “creative” med drops such as delivering to porch and then observing from a distance. Administering injections in office when needed with appropriate PPE. Team meetings are conducted via telehealth.

Huron- Team meetings conducted via zoom. Two team members in office each day for med drops and emergency services. Most contacts being conducted via telehealth as clinically appropriate. Running extremely low on PPE. Things are going as well as can be expected given circumstances.

Lifeways- Currently have some consumers with high needs who were recently discharged from State hospitals. Safety planning and attempting to educate consumers regarding safety risks associated with COVID-19. Some consumers who have been engaged in ACT for longer periods of time seem to be stabilized and doing well; reduced ED visits and IPH admissions. Doing as many contacts via telehealth as possible but also doing med drops and contacts in community as clinically needed and using social distancing and PPE when doing so

Right Door- No current consumers receiving ACT

Saginaw- Approx 38 individuals in ACT currently, still doing many face to face contacts in community with appropriate PPE as clinically needed. Providing other services via telehealth whenever possible. Some team meetings still occurring face to face others via telehealth. Very new team which is why some team meetings are occurring face to face

Tuscola- Using telehealth for many consumer contacts and team meetings. Also providing phone support when needed, community med drops and face to face contacts as needed. Practicing precautions with screening and use of PPE for any community and f2f contacts.

C. **Outcome/Action Steps:** None needed; informational only

IV. Informational Update: Whole Health Action Management (WHAM)

D. **Background:** Based on feedback from this group, MSHN submitted a proposal for Mental Health Block Grant funding for FY21 to host regional WHAM trainings for peer coaches. This was approved by MDHHS.

E. **Discussion:** Update to the group. MSHN was approved for MHBG funding for this process. This is somewhat tentative due to pandemic and financing. Planning for activity in FY21. Looking at training dates as early as November of this year if is able to progress,

F. **Outcome/Action Steps:** MSHN will provide updates as needed

V. Case Management Service Provision

G. **Background:** Request for discussion regarding provision of CSM. Which CMHSPs offer different intensities of CSM, ie: an “intense” case management program, etc?

H. **Discussion*:*** Subgroup developed to cover CSM measures and different levels of CSM. Are there differences in CSM? There are some programs that are more oriented toward med management, some are more dynamic to react to higher needs. Then there is ACT with 40 consumers on each team and 7 staff on each. LOCUS scores are used in combination with clinical assessment to determine level of CSM. Rt Door does OP, CSM, intense CSM, and meds as a matter of a continuum. OP-when someone comes in, they are assigned to OP with little CSM and adjust on the continuum as needed. How is this working in terms of engagement? It is a critical piece. How about adults versus children? For children-generally family therapy but there can be advantages to CSM in

helping with engagement. Reduced some kids from in home intensive services to CSM and it even resulted in reducing hospitalizations. Gratiot are using HB workers to stay with the same worker for case management. Kids with DD mostly CSM and kids with SED more are HB. Discussion around finding the balance between case management and therapeutic services so that individual needs of consumer are met vs. "standardized" programming (ie: 2 CSM contacts per month, etc)

I. **Outcome:** Continue carrying this discussion into subsequent UMC meetings.

VI. BHDDA "Rounding Rules" Memo & Subsequent Clarification

A. **Background:** Some CMHSPs are experiencing increased authorization requests from providers with the relaxation of telehealth guidelines and generous rounding rules. Strategies for ensuring increased service requests are clinically justified by increased need of consumer and not driven by the provider increasing frequency of contacts?

B. **Discussion:** Some CMHs are seeing increased requests for frequency of contacts.

C. **Outcome:** Continue conversation via email exchange; CMHSPs can share best practice as to how they are working with providers to ensure medical necessity of any increased services.

VII. Devereaux Early Childhood Assessment (DECA)

J. **Background:** Proposal to include DECA on MSHN FY21 Regional Training Grid as it is contractually required assessment tool for Birth-4. MSHN distributed 5-question survey monkey to determine regional training needs related to DECA. If you wish to respond to survey please do so by 4/30.

K. **Discussion:** Is there sufficient regional training needs to support a coordinated training approach? Example: MSHN to host regional train-the-trainer during FY21

L. **Outcome:** Carry to next month.

VIII. Regional Crisis Residential Utilization & TBD Feasibility Study

M. **Background:** With direction from this group, MSHN commissioned TBD to conduct a crisis residential feasibility study for the region. Please review in preparation for an expanded discussion during next month's meeting facilitated by Travis Atkinson from TBD.

N. **Discussion:** The team was asked to ensure a thorough review for discussion next month. CEI will have crisis residential for kids up and running soon as well.

O. **Outcome:** Will continue thorough discussion next month

Parking Lot/Upcoming:

- MCG Retrospective Reviews FY20 Q1-Q2: please send to Skye before June meeting (thanks to those who have already submitted)