RPC - FINGER LAKES REGION
Chemung Livingston Monroe Ontario Schuyler Seneca Steuben Wayne Yates

FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

AGENDA

December 14, 2018 1pm-4pm

St. Bernard's School of Theology & Ministry, Rochester

1:00 – 1:10pm

1. Call to Order & Welcome — George Roets
2. Confirm Quorum — Beth White
3. New Board Members — George Roets
    a. HHSP - Deborah Salgueiro, Executive Director HHUNY
    b. Key Partner - Nathan Franus, Sr. Program Manager – Behavioral Health, FLPPS
    c. Family Advocate - Ken Sayres leaving
4. Introductions (Name, stakeholder group, agency/organization) — Board & Guests

1:10 – 1:45pm

5. RPC Special Events Summary — Beth White
    a. Resource Sheet
6. Workgroups - Quarterly Summary — Beth White
    a. Clinical Integration
    b. Education re Peer Role
    c. SUD Bed Access

1:45 – 2:00

7. Bylaws – requires Vote — George Roets

2:00 – 2:30

8. CoChairs Meeting & Presentation of PA Issue — George Roets
9. Status of other Referred Issues — Beth White
    a. Telementalhealth
    b. OASAS Redesign

Finger Lakes RPC Board – December 14, 2018 Agenda

2:30 – 2:40 **Break**

2:40 – 2:55

10. MCO Information — Beth White
    a. RCA's Contracted &
    b. Reasons for Clients Declining HCBS Services

2:55 – 3:20

11. Look Ahead – the RPC in 2019 — Breakout Groups

3:20 – 3:45

12. 2019 Discussion – Groups Report — Breakout Groups

3:45 – 3:55

13. Key Partner Seats — George Roets

3:55 – 4:00pm

14. Next Board Meeting — Beth White
    a. Friday, March 15th, 1-4pm, St. Bernard's
    b. Upcoming Meetings – workgroups TBD

15. Wrap Up & Motion to Adjourn — George Roets

Board 2019 Meeting Schedule:
Q1: March 15 - St. Bernard's
Q2: June 14 - Ontario County Training Facility
Q3: Sept 20 - Ontario County Training Facility
Q4: Dec 13 - St. Bernard's

Questions about this process? Contact:

RPC Coordinator, Beth White, at *bw@clmhd.org* or (518) 391-8231 or
George Roets, RPC CoChair at *groets1@rochester.rr.com*

FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

MINUTES

December 14, 2018 1pm-4pm

St. Bernard's School of Theology & Ministry, Rochester

George called the meeting to order at 1:15PM. Motion to approve the minutes made by Kim Hess. Seconded by Sally Partner. Unanimously approved.

New Board Members Introduced:

- HHSP - Deborah Salgueiro, Executive Director HHUNY
- Key Partner - Nathan Franus, Sr. Program Manager – Behavioral Health, FLPPS
- Family Advocate Open Seat - Ken Sayres leaving – got a position in Rochester City Schools and cannot fulfill both duties. Looking for nominations for family and youth positions. Please send to Beth – she will talk with whomever has interest.

Members of the Board and guests introduced themselves

1. RPC Special Events Summary
    - **BHCC's** presented to community – very dynamic and good dialog; United Way also presented as a community partner, looking at some of the same things and there is some overlap.

    - **Child & Family Subcommittee** – at request of subcommittee members, delivered presentation in November about new services, transition to MMC. Review of current system (start with what is, what will remain, and what is coming). New CFTSS services available January 1. Resource Sheet (attached) includes valuable resources regarding the Children's Transition.

    - **The RPC, HHUNY and GRHHN** hosted the RPC's 2nd large networking event for HH, HCBS, MCOs, CMAs. Had over 70 in attendance. Great opportunity for CMAs to network with provider agencies and MCOs. Excellent feedback from attendees.

Questions about this process? Contact:

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George Roets, RPC CoChair at *groets1@rochester.rr.com*

2. Workgroups - Quarterly Summary (see attached summary)
    a. **Clinical Integration** – has met twice since last BOD meeting. In October RRH did a presentation on their clinical integration efforts in 20 service sites. How they did it, what is going on, incremental changes. Good discussion. In December URMC presented about their CCBHC, their approach, barriers and hurdles, initial findings of their work. Group will next meet and discuss what will be the next step for this committee – so many are working on clinical integration – does it make sense to continue on the same path. Will continue as a planning group for their symposium in May 2019. St. John Fisher Department of Nursing is sponsoring the RPC's use of their auditorium. Speakers are confirmed.

    b. **Education re Peer Role** - met in November. Work at that meeting was to take previous identified issues and decide to what to work on next, decided to focus on education resources for employers and coworkers of peers. This group determined that they do not need to recreate educational materials re peer services, as so many already exist. Beth is receiving resources from many stakeholders – a subgroup of the workgroup will review, catalog, and determine what is best to send to employers. Will be doing a survey of employers of those who employ peers and see what they find most useful and helpful re information and education.

    c. **SUD Bed Access** – working on development of pilot web app re bed availability. Looking at having more detailed and up to date information and being more user friendly. RRH has its staff working on the app with group. Some issues re moving ahead with public access or just having for providers. This to be discussed at next meeting. Need to look at original intent of this group – taking a step back. Group is looking at demo of project. Also going to do education re over-referral issue. Provide information on what problems this causes in the system. One agency has a referral form that has education re referral process embedded in the form.

3. **Bylaws**: George opened this discussion. Due to not having a voting quorum present, gave group the option of deferring to next Board meeting or suspending quorum rules for voting. Jill Graziano moved, Sally Partner seconded to suspend voting quorum rules. George asked if there were any questions or discussion on format or bylaws as presented? No questions or concerns. All in favor – all, none opposed. Bylaws approved as written.

4. **CoChairs Meeting**:
    - shared about issues other regions brought to meeting (transportation – Southern Tier – open access centers – resolution that MAS agrees to work with RPC to identify BH programs with same day appointments so that they will put into their system to facilitate transportation to these programs). Lively discussion including problems faced in rural areas. Some suggestions came from meeting and DOH will follow through.

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- Informed Dialog – access to transportation for pharmacy needs. MAS indicated this as a challenging area due to fraud concerns, but that they will consider authorizing stops at the pharmacy on a return trip from a treatment visit. Heard regional updates about what they are working on. Update on C&F committees from RPC perspective. North Country region discussed the general unaffordability of housing that impacts clients.

- Workforce issue re Article 31 clinics and use of PAs. Certification people were at the table. We do have a major issue with access to prescribers. Did not come to agreement on how this might be amended. OMH has some concerns re education level of PAs with regard to BH. Will look at in more detail. May look at PA training programs in NYS and see if there can be advisement on how to include more BH training.
- Sense that the state and RPC liked the change in the CoChairs meeting process. Dialog will continue and intensify. Jill asked if the state gave responses at the meeting; George explained that there will be formal minutes that will codify their responses and recommendations.
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5. **Status of other Referred Issues**:
    a. Telemental Health – formal conference call with state OMH in November. Ready to move on review of telemental health regulations. Comment period coming soon. Psychologist, social workers, and LMHCs will be authorized to provide services. Psychiatrists & NPs in PROS can participate. Psychiatrists can prescribe if licensed in NYS even if located out of state. Young adults can receive services if away at college. If have a hub can add spokes through field office. Will be a document released that identifies differences between OMH and OASAS regs. Jill shared that she was frustrated with call: wanted more clarity on timeline for implementation. She described the disadvantage to having OMH regulations re telemental health as opposed to DOH telemedicine. Big differences in level of flexibility. Question re oversight and regulation re service provision and who is paying for services? Payers had their guidelines; OMH wants different guidelines for how services are provided even if they are not paying for services. Need clarity re how telepsych can be provided into private homes. Dave Putney brought up that regulators have a specific role and cannot be eliminated from the discussion. Are problems related to service provision or payment? Have billing requirements in a separate document from service provision suggested by Jill. Beth noted that there was some good news – there are some things that have been requested are coming. State OMH did engage in collaborative discussion with RPCs. Chris Smith shared that technology requirements are changing. ACT is also included re having psychiatrists and NPs able to participate by telemental health. There is a statewide telehealth learning collaborative – January 14th next call. Beth will send email to BOD with more info.

b. OASAS Redesign – complexity was not suitable to co-chairs meeting. FL RPC will have call with OASAS about this issue. Will be able to present new information about 820. Board members can be on the call – contact Beth if you are interested in being on this call. Will probably occur in January.

6. **MCO's Report on RCA Contracting**:

RCA's Contracted- see info in packet. Andrea H-L gave a list of who is contracted for RCAs. She shared that she tracks reasons for declining HCBS but did not have any details at this time. Her reasons are similar to what other plans report. Fidelis is using RCA's as part of outreach calls to clients. Finding that these are effective, it is getting faster to get POC turned around.

Curt Swanson from MVP shared that clients are asking why they need these additional services (health homes or HCBS) – recurring theme he is hearing from his staff. Deborah from HHUNY has looked at why people are refusing services – need to look at how information is being presented – this impacts people's interest and willingness to have assessment and accepting services. Might be looking at marketing training for HH managers on how to present the service.

Chris Marcello noted need to look at difference between refusing assessment or getting assessment and refusing the service. Colleen from Excellus reported that RCAs are looking to employ engagement specialists. Margaret Morse asked about how much education is being given to providers of physical health care re engaging in HCBS? Jennifer Earl shared that they have specific training to physical health providers re engaging in HCBS. Curt shared that they do quarterly visits on educating physical health providers on this. Hank asked about having HCBS provider accompany care manager to discuss HCBS with client.

7. **Look Ahead – the RPC in 2019**: break into 3 group. Identify any new issues. Prioritize 1-2 most significant. Also look at how BOD could be more effective, how can RPC better work for you? Do you want to move some of Key Partners into ex officio status? Will have 2 seats open for key partners – can't be stakeholder group members but should be an organization what works with our clientele.

8. **2019 Discussion – Groups Report** Breakout Groups
Group 1 (Room C) – PFY Group. 1st issue identified – turnover in peer representation on RPCs. If not employed in peer programs have difficulty in attending meetings. How can we go about

recruiting new peer members and support them to maintain attendance. How do we develop a list of people who are interested in being on the Board? Peers may reach out to NAMI and MHA to recruit new members. 2nd issue – IT infrastructure – some providers do not have the ability to send encrypted emails. BHIT does not cover costs of software and support. Difficult to find IT people who understand the field. Expensive to develop software to support documentation. Care Managers needing to support multiple platforms – how can we utilize RHIOs in this discussion. What is value of BH providers to upload info to RHIO. Vision of what they want versus reality of what can be. Encouraged to look at Mid-Hudson confidentiality training on RPC website. Could be helpful to have a resource directory/site to find information. On-Boarding for RPC Board members – especially for peers. Sometimes don't know different kind of systems that are involved – diagram mapping. Key partners – educational system tapped into. State Ed? Early intervention also a potential.

Group 2 (Room D) – HHSP Group - Mary Vosburgh reported that housing an overarching issue. Great challenges in discharge planning for some OPWDD clients, also those facing criminal charges. Resources aren't there. Need help from RPC looking at innovative resources. Documentation – in conjunction with hospital EDs – legal implications. Can NP/PAs sign as well? Takes time if MD needs to sign the form and are not easily available. Documentation is taking a lot of time and contributes to people leaving the field. Timing of documentation is what is found on audits, not problems with care. Need to partner with state to develop what is needed to document quality care, not write to write.

Children's transition – some are worried about this coming soon – how does this step down into what the concerns are. New referral from Article 28 to the state psych centers for BH clients – how many people are referred and how many admitted into state hospitals. Referral through health commerce system. Needs to be hospitalized for 14 days before state PC will examine. More review at higher level and standardized rather than relationships between existing partners. This issue covers several hospital groups. Not sure if RPC is the right venue to address this concern – Dave Putney will take to CLMHD Mental Health Committee to see if they can discuss with state OMH. Key Partners – OPWDD or someone from faith based community.

Group 3 – CBO's - Children's transformation needs to have a place holder to discuss these concerns. OASAS transformation re 820. VBP preparation – lots of work going on. Need to focus on communication, demonstrating value. Colleen – BHCCs – looking at value of them in this process. Need to have this conversation continued. What are they doing to educate their providers. How are they relating to hospitals and MCOs? Key Partners: parole/probation – some organization from community corrections, Drug Courts. How to utilize some already existing BOD members – Villa of Hope, etc.

Jill – question re VBP. How to ensure during contracting that savings are distributing to partners. Right now dollars are sitting with state and MCOs. What is incentive to get to providers? There is

an expectation that money is encumbered and will go to providers. Need to renegotiate attribution to include new providers If MCOs do not use the money they will need to give back to the state. Beth suggests a special meeting to discuss this issue and have MCOs bring in those most appropriate to participate in this discussion.

9. **Next Board Meeting** Beth White
    a. Friday, March 15th, 1-4pm, St. Bernard's
    b. Upcoming Meetings – workgroups TBD

10. **Wrap Up & Motion to Adjourn** George Roets

    Mary Vosburgh moved and Jody Walker seconded to adjourn at 3:30pm. Passed unanimously.

Questions about this process? Contact:

RPC Coordinator, Beth White, at *bw@clmhd.org* or (518) 391-8231 or
George Roets, RPC CoChair at *groets1@rochester.rr.com*

FINGER LAKES REGIONAL PLANNING CONSORTIUM - BOARD OF DIRECTORS MEETING
BOARD MEMBERS SIGN IN - DECEMBER 14, 2018

22+ MC+BD
24 BOD
8 Guests
32

Group	Name	Sign In
LGU	George Roets	
LGU	David Putney	
LGU	James Haitz	—
LGU	Shawn Rosno	—
LGU	Hank Chapman	
LGU	Margaret Morse	
CBO	Sally Partner	BW
CBO	Martin Teller	
CBO	Jodi Walker	
CBO	Greg Soehner	—
CBO	Chacku Mathai	—
CBO	Jeannine Struble	—
Peer	Jennifer Storch	
Peer	Keisha Nankoosingh	—
Family	Sue Mustard	BW
Family	OPEN	
Youth	Julie Vincent	BW
Youth	OPEN	
HHSP	Jill Graziano	
HHSP	Carole Farley-Toombs	—
HHSP	Mary Vosburgh	
HHSP	Mike Leary	—
HHSP	Ellen Hey	—
HHSP	Deborah Salgueiro	BW

Group	Name	Sign In
MCO	Colleen Klintworth	BW
MCO	Curt Swanson	BW
MCO	Kim Hess	BW
MCO	Jennifer Earl	BW
MCO	Andrea Hurley-Lynch	
MCO	Well Care	
EX OFFICIO	Christina Smith	
EX OFFICIO	Christopher Marcello	BW
EX OFFICIO	Colleen Mance	BW
EX OFFICIO	Dana Brown	—
EX OFFICIO	~~Lori Lubba~~	
EX OFFICIO	Debbie Meyer	—
KEY PARTNER	Kathy Muller	—
KEY PARTNER	JoAnn Fratarcangelo	—
KEY PARTNER	Nathan Franus	
KEY PARTNER	Melissa Wendland	
KEY PARTNER	Jon Miller	—

[redacted]

FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

MINUTES

September 14, 2018 1pm-4pm
St. Bernard's School of Theology & Ministry, Rochester

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1. **Call to Order & Welcome: George Roets called the meeting to order at 1:10PM**
2. **A quorum was present to conduct Board business.**
3. **George introduced new Board members Kim Hess from YourCare Health Plan and Youth Advocate Julie Vincent.**
4. **Board Members and Guests introduced themselves.**

5. **Beth White encouraged Board members to attend workgroups or send staff members to relevant groups. A list of meeting follows at the end of the agenda or contact Beth for the calendar invite for a particular meeting.**
   Workgroup Meeting Reports
   a. **Children & Families Subcommittee:** Most recently, the subcommittee discussed designations for SPA (now known as Children & Families Treatment Support Services or CFTSS) and HCBS. The lists for designated agencies are posted on the state OMH website. The subcommittee also discussed support and readiness funds for starting up these services – there is no time line or application for these as of this date. There is some confusion on how to refer a child to managed care programs; some guidelines were shared about how to work through this process. The subcommittee is working on prioritizing issues including the HCBS launch, conflict free referrals, lack of services in some areas, how to help care providers know how to access services. It was thought that trainings around accessing services were needed. There will be a training October 19th (in-person training) regarding available services, new services and working with SPOAs.

   b. **Clinical Integration:** The workgroup had requested that two organizations present regarding their experiences with clinical integration. Helio Health from Syracuse, a CCBHC, presented information on how they deal with staffing needs, planned for services, and on-going challenges. Rochester Regional will be presenting at the next meeting. After these presentations are completed, the group will be working on an educational symposium to be scheduled for some time in 2019. The previous plans for this fall were changed in order not to conflict with an upcoming conference in October. The goal of the symposium is to educate providers on 42CFR, how to share information, and how to integrate behavioral health services into primary care practices. The University of Rochester has also requested to present to the workgroup in mid-

November regarding their CCBHC. After the presentations are complete, this group will take a pause to decide how they will aggregate this data and determine next steps.

c. **Education re Peer Role:** this workgroup met in August -the focus of the discussion was how to integrate peers into different providers The group did an exercise ranking issues and concerns; the top issues included developing competency standards for organizations employing peers, developing a model for organizations to contract with peer run organizations for peer services, and staff education regarding the value of peers within programs. The group is researching what materials are already available that address these issues rather than duplicate efforts.

d. **SUD Bed Access:** this workgroup was formed to address a referred issue from the Finger Lakes Consortium of Substance Abuse Services and has met three times. The question is whether some regional coordination for SUD beds might result in more efficient access to and use of these beds. A survey was conducted of 15 providers bedded programs. Question re how are wait lists used? Responses included every type of licensed bed provider. Locadtr is being utilized correctly. OASAS does have a website re bed availability but it is not user friendly. Group has decided to conduct a pilot to look at development of a regional resource to find information on bed availability – agreed to move forward to see if this pilot would work on a more extensive basis – how can it be scaled to the region. Also worked on identifying other issues and barriers including: over-referring, what level of care to people need to be referred to, how long is actual wait list.

6. **HARP/HCBS Data Update: Chris Marcello from the OMH WNY Field Office gave an update on quarterly data.** FL has 9600 enrolled in HARP. Has most enrolled in ROS. 38% of those are enrolled in a health home. Current data does not reflect RCA impact. In HH 58% have been assessed for HCBS. 90% are eligible. 53% eligible plans have received a LOSD. Of those, 20% have gotten an authorization from an HCBS provider. Claims paid are catching up. Peer support services are most utilized. Question: is there data on services requested but not able to be filled due to lack of peer support services? There are barriers as to why clients may not want to go out of county to get services. Now can look at referral patterns – could use infrastructure funds to expand services into neighboring counties. Question re current providers expanding services – can reach out to OMH or OASAS re expanding service array or counties being served. Are numbers a reflection of what is available or what is needed? George Roets noted difficulty of providing some of these services in smaller counties. Try to utilize what they can and cobble together services to meet client needs. How to leverage funding to provide services? HARP eligible and enrolled is the highest in the state. Have gotten people "unstuck" from the exchange so may be seeing an uptick in the number of people receiving services. RCA data will also be showing up during the next quarter. Fidelis & Excellus have gotten referrals through RCAs. Your Care & MVP are sending out info to RCAs re HARP eligible individuals. Need to look at those who are eligible for services (HH) but decline to follow through. MCOs do capture why people decline to engage in HH or other services. Often decline due to lack of understanding of what a HH is. Requested that MCOs bring data on why clients decline services – they will look

into and see what data they can share at a next meeting. Are clients in a CCBHC assessed but then declining services part of this data collection process? Is this partly why the number of people being served are low?

7. **Summary of July Board Meeting - Issue Development:** Beth gave a summary of the July Board Meeting (optional meeting). Four stakeholder groups met after the May BOD meeting and discussed three (3) major issues at length.

    a. The **Residential Redesign** Workgroup shared that there has been an unintended consequence in the redesign process (see attached CBO Issues document): one agency indicates that they have seen a 95% decrease in reintegration/CR level bed days since their conversion to 820, as the result of the intense front door demand for stabilization and rehabilitation level services. Reintegration work is not being completed while individuals are occupying a bed. Agencies are seeing more individuals with behavioral challenges in supportive living programs than in the past. Programs are seeing that releasing clients earlier from the reintegration level has reduced the ability to rely on more "experienced" clients to assist with newcomers. More acute clients are coming into these programs. Question: can HCBS be assessed while in reintegration? Are these identified problems a warning sign to the state re how 820 is being implemented? Beth clarified that the first two levels of 820 programs are paid by MMC while the 3rd (reintegration) is still paid under congregate care funding. The group believes that there is little incentive for programs to go under the 820 regulations and that there are questions re viability – can agencies continue to provide these services?

    Request to the State:

    - Develop and implement deficit financing resource, system, structure and opportunity for Supportive Living Service.
    - Enhanced Care Management resources or reduced Care Management caseload based on severity of individuals served to assist.
    - Enhanced Community Billing rates for Supportive Living
    - Enhanced Peer Recovery Coach rates for Supportive Living
    - Remove daily cap of 60 miles staff travel reimbursement for HCBS services. This limit is unrealistic in light of the fact that many of these services are only available regionally vs. all services available in all counties. Peers frequently travel out of county in support of their HCBS clients.

    b. **PA Scope of Practice** - The DCS Group discussed the PA Scope of Practice Issue (see attached DCS Issues document). The group identified the need for additional professionals to utilize for prescribing. There is an issue with OMH re scope of practice for PA's – they are not allowed to assess or to prescribe medication in mental health clinics, though they can do so in programs licensed by DOH and OASAS. Regulations need to be examined to determine relevance and allow PA's to practice under their licensure. Several participants linked this issue to Timothy's Law. Questioned if expansion of prescribing privileges can cover NPs (NPPs are already able to prescribe).

Request to the State:

- Permit Physician Assistants to perform in OMH licensed clinics within their State Ed/DOH defined scope of practice with no additional waivers, experience or training.

c. **Telehealth** (see attached HHSP Issues document). LMHCs are being considered to be included as eligible to provide teleservices as well as LCSWs. OMH has very specific technology requirements that are not relevant to all circumstances. The individual receiving services needs to be located in a Medicaid approved facility; different regulations are required for the practitioner to be located in an off-site facility. Article 28 facilities have a waiver for psychiatrists – looking to see if this can be explored for other BH licensures. Chris Smith, Director OMH WNYFO, indicated that OMH is working on clarifying Telepsychiatry regulations. She shared that OMH is working with the other "O" agencies to have regulations consistent across disability areas.

Request to the State:

- Permit LCSW's and other licensed BH providers to practice via telemed.
- Require MCO's who utilize telemedicine to authorize it for BH services.
- Eliminate the discrepancies between DOH and OMH regulations regarding telemedicine use, i.e. which licensed providers may use it and what types of equipment are required, and how provider sites are screened. While this impacts providers, the greatest impact is on clients who are denied access to service via this technology.

8. Evaluate New Information and Readiness of Issues for Possible Referral to State CoChairs Meeting: Summaries of each issue were sent out prior to this meeting for review.

a. Unintended Consequences of OASAS Residential Redesign – Stress in Supportive Living
   i. Data
   ii. HARP Algorithm
b. Inability of Physician Assistants to Assess, Diagnose and Prescribe in MH Clinics
   i. RIT reports that no other medical specialty limits PA scope of practice
c. Inconsistency of State Agencies' Telemedicine/Telepsychiatry Regulations
   i. Recent State legislative action requires State agencies to have all of the various telemedicine regulations in one place

9. Vote to Approve Issues for Referral to State CoChairs Meeting

Stakeholder groups discussed each issue and cast their vote to determine if an issue would be referred to the state co-chairs meeting.

Issue 1 (OASAS Redesign) – 4 of 5 stakeholder groups voted yes to refer to the co-chairs meeting. MCO's voted "No."

Issue 2 (PAs) 5 of 5 stakeholder groups voted yes to refer to the co-chairs meeting.
Issue 3 (Telepsychiatry) 5 of 5 stakeholder groups voted yes to refer to the co-chairs meeting.

Beth will tabulate ranking order for issues and will relay that information to the Board.

10. **Bylaws:** George requested that original and new set of bylaws be reviewed by the Board. He asked for volunteers to look at these and develop a revised version. The bylaws will be on the agenda at the next meeting. BOD to read in advance and be prepared to discuss at next meeting.

11. **Next Board Meeting**
    - **a.** Friday, December 14th, 1-4pm, Site TBD
    - **b.** Upcoming Meetings – Board members wishing to join a workgroup for the first time should contact Beth to receive the meeting invite
        - **i.** Clinical Integration - Tues Oct 2 – 1-3pm, Site TBD
        - **ii.** C&F Subcommittee – Education Session re Children's Services – Oct 19, 1-4pm
        - **iii.** Education re Peer Role & SUD Access workgroups will be scheduled in Oct-Nov

12. **There being no objection, George declared the meeting adjourned at 4:05pm.**

Board 2018 Meeting Schedule:
First Quarter: February 9th
Second Quarter: May 18th*
Third Quarter: September 14th
Fourth Quarter: December 14th

CoChairs Meeting in Albany
April - CoChairs Meeting - cancelled
November 30th- CoChairs Meeting

Questions about this process? Contact:

RPC Coordinator, Beth White, at *bw@clmhd.org* or (518) 391-8231 or
George Roets, RPC CoChair at *groets1@rochester.rr.com*

Finger Lakes Regional Planning Consortium

RPC Special Events - Quarterly Summary

December 14, 2018

BHCC's Present to Community – October 26 - 67 Attendees

All three of the Finger Lakes region's BHCC's provided updates on their plans and progress.

- **Finger Lakes and Southern Tier BHCC**
- **Hillside-Catholic Charities BHCC**
- **Integrity Partners for Behavioral Health/Genesee County BHCC**

Special Guest - United Way of Greater Rochester discussed their System Integration Project.

C&F Subcommittee Children's Services Overview – November 9 – 47 Attendees

Education Session re Children's Services (see attached presentation)

Now & Future

Join us as we review services available to children now and new ones on their way!

What Services are Available Now?

SPOA – Role & Resource

CFTSS Services as of Jan 2019 and Expanded Eligibility

Overview of Managed Care

Update on Transition & HCBS Services

HCBS/HH/CMA/MCO Networking Event - December 4 – 71 Attendees

- Jointly sponsored by RPC, HHUNY, Huther Doyle & GRHHN
- Care Managers met some of our region's HCBS providers and learned about the services they offer.
- Networked with area MCO's.
- Multi-stakeholder group discussions to identify critical questions and issues to address to improve HCBS referral process.

Questions? *Contact Beth White, RPC Coordinator at bw@clmhd.org or 518-391-8231*

FINGER LAKES REGIONAL PLANNING CONSORTIUM

WELCOME

Goals For Children's Design

- Provide a greater focus on prevention and early intervention and Identify needs early on in a child's life.
- Allow interventions to be delivered in the home and other natural community-based settings where children/ youth and their families live.
- Maintain the child at home and in the community with support and services.
- Prevent the onset or progression of behavioral health conditions and need for long-term and/or more expensive services.
- Be available to all Medicaid eligible children under the age of 21 who meet medical necessity criteria.
- Increase the delivery of services utilizing the six core principles.

Core Principles

- Child Centered
- Family Focused
- Community Based
- Multi-System
- Culturally Competent
- Least Restrictive/Least Intrusive

Current HCBS Waiver Services

Allows Medicaid to pay for some services not normally provided through Medicaid:

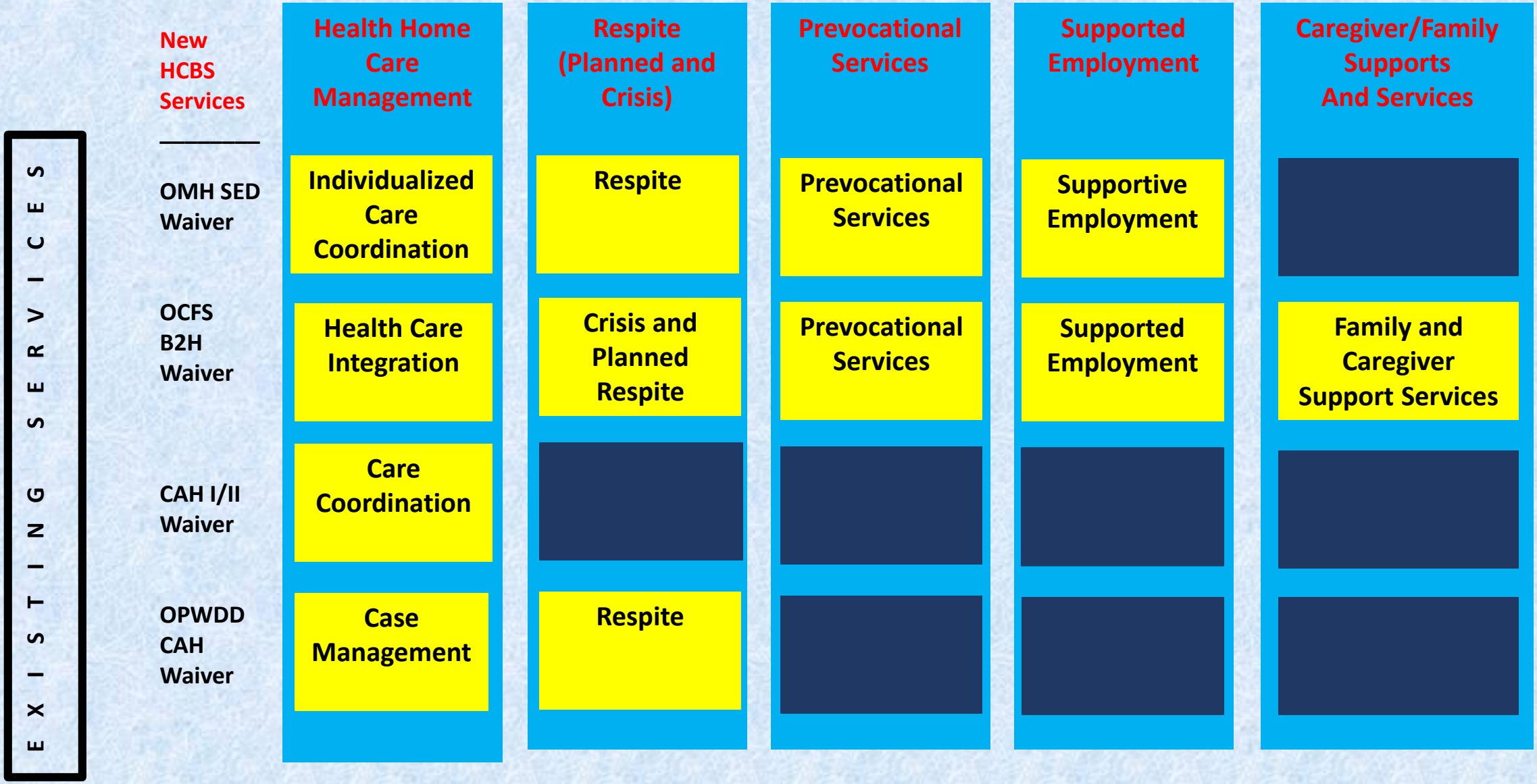
- Care coordination
- Respite
- Family support services
- Intensive in-home services
- Crisis response
- Skill building services

E X I S T I N G S E R V I C E S

OMH SED Waiver	Individualized Care Coordination	Respite	Prevocational Services	Supportive Employment	
OCFS B2H Waiver	Health Care Integration	Crisis and Planned Respite	Prevocational Services	Supported Employment	Family and Caregiver Support Services
CAH I/II Waiver	Care Coordination				
OPWDD CAH Waiver	Case Management	Respite			

E X I S T I N G S E R V I C E S

OMH SED Waiver							
OCFS B2H Waiver	Community Advocacy Training and Supports	Day Habilitation	Adaptive and Assistive Equipment	Accessibility Modifications			
CAH I/II Waiver				Home and Vehicle Modifications	Palliative Care		
OPWDD CAH Waiver			Assistive Devices Adaptive Technology	Environmental Modifications			


EXISTING SERVICES
New HCBS Services
OMH SED Waiver
OCFS B2H Waiver
CAH I/II Waiver
OPWDD CAH Waiver
Health Home Care Management
Individualized Care Coordination
Health Care Integration
Care Coordination
Case Management
Respite (Planned and Crisis)
Respite
Crisis and Planned Respite
Respite
Prevocational Services
Prevocational Services
Prevocational Services
Supported Employment
Supportive Employment
Supported Employment
Caregiver/Family Supports And Services
Family and Caregiver Support Services

EXISTING SERVICES

New HCBS Services	Community Advocacy Training and Supports	Habilitation	Adaptive and Assistive Equipment	Accessibility Modifications	Palliative Care	Customized Goods and Services	Non-Medical Transportation
OMH SED Waiver							
OCFS B2H Waiver	Community Advocacy Training and Supports	Day Habilitation	Adaptive and Assistive Equipment	Accessibility Modifications			
CAH I/II Waiver				Home and Vehicle Modifications	Palliative Care		
OPWDD CAH Waiver			Assistive Technology Adaptive Devices	Environmental Modifications			

NEW ARRAY OF HCBS SERVICES

- Health Home Care Management
- Respite (Planned and Crisis)
- Prevocational Services
- Supported Employment
- Caregiver/Family Supports And Services
- Community Advocacy Training and Supports
- Habilitation
- Adaptive and Assistive Equipment
- Accessibility Modifications
- Palliative Care
- Customized Goods and Services
- Non-Medical Transportation

Current Children's Services

Waiver

Non-MA Care Coordination

Family Advocate Support

- MHA or
- FLPN

Mobile Integration Team (MIT)

- Southern Tier MIT (Adult and Youth)
- Western NY MIT (Youth)
- Rochester MIT (Adults)

Crisis Respite

- Hutchings
- EPC Crisis Respite

ROLE of SPOA-LGU

- Children's Mental Health services contact/lead for county
- Troubleshoot for assisting with challenges for access to services
- Serve as access point for families with/without Medicaid to best "match" them with available services based on their level of need
- Identify of available county resources for families and providers and identification of gaps/needs
- Navigate, refer, and identify services for Non-Medicaid population

Before and After Children's Transformation

Before Transformation

- Current State Plan services
- Care Coordination is limited to six 1915c Waiver Programs and OMH TCM Program, programs include slot limitations
- Limited array of Home and Community Based Services (HCBS) available only to 1915c Waiver - children services depend on and vary by waiver
- Children's delivery of services is siloed
- Behavioral health and physical health services are not integrated
- Care planning is not integrated
- Transitional care across children's system is lacking

After Transformation

- ✓ ***Health Home care management for children with two or more chronic conditions, serious emotional disturbance (SED), complex trauma, HIV (Children Health Home launched in December 2016)***
- ✓ Current State Plan services PLUS
  - ✓ ***Six new state plan services***
- ✓ ***Expanded array of 12 HCBS based on expanded target, risk, and functional criteria with Health Home care management***
- ✓ ***Integrate and transition behavioral health benefits to managed care plan***
- ✓ ***Transition foster VFCA population to managed care***
- ✓ ***Foster transitional care and continuity of care across children serving systems (education, child welfare, juvenile justice)***
- ✓ ***Shift focus to quality, monitoring, and tracking and reward quality outcomes (value based payments)***

Draft, Preliminary Timeline* Subject to CMS Conceptual Agreement and Approvals	Current Date	Preliminary Draft Date*
Implement three of six new Children and Family Treatment and Support Services (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports)	January 1, 2019	Unchanged
Transition to Health Home Begins	October 1, 2018	January 1, 2019
1915(c) Children's Consolidated Waiver*, new array of HCBS in Managed Care, remove exemption and exclusion for 1915(c) Consolidated Waiver children from Managed Care	January 1, 2019 (achieved w/1915 to 1115)	April 1, 2019
Implement Family Peer Supports State Plan Service	July 1, 2019	Unchanged
Three year phase in of Level of Care (LOC)	July 1, 2019	Unchanged
Behavioral Health Benefits to Managed Care	July 1, 2019	Unchanged
Foster Care Population to Managed Care	July 1, 2019	Unchanged
Implement Remaining New State Plan Services - Youth Peer Support and Training and Crisis Intervention	January 1, 2020	Unchanged
*Subject to availability of Global Cap Resources and timely CMS and other State Approvals All Foster Care Children will move to Managed Care in July		

Source: **Children's Medicaid Health and Behavioral Health System Transformation Update, Issue #3** – July 2018

Children's Implementation Timeline For Children & Family Treatment Support Services

State Plan services will become part of the Managed Care benefit on their implementation date

State Plan Service	Effective Date *draft dates pending CMS approval*
Other Licensed Practitioner	**January 1, 2019**
Psychosocial Rehabilitation	**January 1, 2019**
Community Psychiatric Treatment and Supports	**January 1, 2019**
Family Peer Support	July, 1, 2019
Youth Peer Support and Training	January 1, 2020
Crisis Intervention State Plan	January 1, 2020

Source: [Utilization Management for CFTSS: OLP, CPST, PSR] - Webinar - September 18, 2018

FINGER LAKES REGIONAL PLANNING CONSORTIUM

BREAK

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services | Office for People With Developmental Disabilities

Overview of CFTSS:

Other Licensed Practitioner
Community Psychiatric Treatment and Supports
Psychosocial Rehabilitation

For this and the following slides:
Source: **Utilization Management for CFTSS: OLP, CPST, PSR** - Webinar - September 18, 2018

Pathways to Care

- **Referral:** when an individual or service provider identifies a need in a child/youth and/or their family and makes a linkage/connection to a service provider for the provision of a service that can meet that need.

- **Recommendation:** when a treating Licensed Practitioner of the Healing Arts (LPHA) identifies a particular need in a child/youth based on a completed assessment and documents the medical necessity for a specific service, including the service on the child/youth's treatment plan.

Important Managed Care Terms

- **Medical Necessity**

Medical necessity is the standard terminology that all healthcare professionals and entities will use in the review process when determining if medical care is appropriate and essential.

Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. (N.Y. Soc. Serv. Law, § 365-a).

Important Managed Care Terms

- **Notification, Authorization and Prior Authorization**

  Notification to an MMCP allows the plan to update their care management and claims systems with the information a child is eligible for HCBS and will be accessing services. This also permits the named provider to claim for the initial period.

  Authorization is a general term that indicates the MMCP has "opened" the claim window for the child to receive services from named provider. It can also refer to any approval in the MMCP's systems for the child to receive services.

  Prior Authorization provider must request permission from the MMCP before delivering a service in order to receive payment

  - **NOT Required for OLP, CPST or PSR services**

Authorization Summary

- The first 3 service visits with OLP, CPST and Psychosocial Rehabilitation do not require authorization. However providers must notify MMCPs before providing services to ensure proper payment
- If more services are needed and individual meets medical necessity, must perform concurrent review and MMCPs must provide a minimum of 30 service visits
- 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.

Example of Obtaining Concurrent Authorization

- Referral
- Recommendation from LPHA with medical necessity documentation
- Up to 3 visits to determine the need for ongoing services
- Conducting concurrent review: Before the 4th visit, provider must request authorization from MMCP to continue providing services.
- If medical necessity is met, MMCP will authorize 30 visits.
    - MMCPs must make a service authorization determination and notify the provider/enrollee of the determination by phone and in writing no more than three business days after receipt of the request

Other Licensed Practitioner

Other Licensed Practitioner (OLP) Overview

- OLP services include: Licensed Evaluation/Assessment, Treatment Planning, Psychotherapy, Crisis Intervention Activities
- OLP services may be provided to children/youth in need of assessment for whom behavioral health conditions have not yet been diagnosed.
- These non physician licensed behavioral health practitioners (NP-LBHP) include
  - Licensed Psychoanalysts, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Licensed Masters Social Workers when under the supervision of licensed clinical social workers (LCSWs), licensed psychologists, or psychiatrists
- These practitioners must operate within a designated agency

Medical Necessity: Admission Criteria

Criteria 1 or 2 must be met:

The child/youth is being assessed by the NP-LBHP to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:

1. Corrects or ameliorates conditions that are found through an EPSDT* screening; OR
2. Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

*Early and Periodic **Screening**, Diagnostic, and Treatment (**EPSDT**) The Early and Periodic **Screening**, Diagnostic, and Treatment (**EPSDT**) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21

Other Licensed Practitioner (OLP) Overview

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- These practitioners must operate within a designated agency

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services | Office for People With Developmental Disabilities

Community Psychiatric Treatments & Supports

Community Psychiatric Supports and Treatment (CPST) Overview

- CPST is intended to assist the child/youth and family/caregivers to achieve stability and functional improvement in daily living, personal recovery and/or resilience, family and interpersonal relationships in school and community integration. The family/caregivers is expected to have an integral role.

- Service Components: Intensive Interventions, Crisis Avoidance, Intermediate Term Crisis Management, Rehabilitative Psychoeducation, Strengths Based Service Planning, and Rehabilitative Supports

Medical Necessity: Admission Criteria

All criteria must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the child/youth is at risk of development of a behavioral health diagnosis; AND
2. The child/youth is expected to achieve skill restoration in one of the following areas:
    a. participation in community activities and/or positive peer support networks
    b. personal relationships;
    c. personal safety and/or self-regulation
    d. independence/productivity;
    e. daily living skills
    f. symptom management
    g. coping strategies and effective functioning in the home, school, social or work environment; AND

Medical Necessity: Admission Criteria Continued

3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND
4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License: Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physicians Assistant, Psychiatrist, Physician, Registered Professional Nurse OR Nurse Practitioner

Psychosocial Rehabilitation

Psychosocial Rehabilitation (PSR) Overview

- PSR is designed to restore, rehabilitate and support a child's/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of their family and community

- Service Components: Building Personal and Community Competence through Social & Interpersonal Skills, Daily Living Skills, and Community Integration

Medical Necessity: Admission Criteria

All criteria must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND
2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth's functional level to facilitate integration of the child/youth as participant of their community and family AND
4. The services are recommended by the Licensed Practitioners of the Healing Arts (LPHAs) operating within the scope of their practice under State License

Authorization Requirements Pre-Services for OLP, CPTS, & Psychosocial Rehabilitation

- Services are able to be provided both on and off site.
- Providers bill the following:
  - Medicaid fee-for-service rate code
  - Valid CPT code(s)
  - CPT code modifiers (as needed)
  - Units of service

No Prior Authorization required

Getting Ready for Change

What should you be doing now?

- Trainings
- Learn who your CFTSS Providers Are
- Internal Process Reviews/Staff Training
- Claims Testing

FINGER LAKES REGION CFTSS PROVIDERS starting Jan 2019 – OLP, CPST & PSR (as of Nov2018)

	OTHER LICENSED PRACTITIONER		COMMUNITY PSYCHIATRIC TREATMENT & SUPPORT		PSYCHOSOCIAL REHABILITATION	
CHEMUNG	Children's Home WC Glove House Hillside Pathways		Children's Home WC Glove House Hillside Pathways		Children's Home WC Glove House Hillside Pathways	
LIVINGSTON	Glove House Hillside Pathways		Glove House Hillside Pathways		Glove House Hillside Pathways	
MONROE	Cayuga Centers FLACRA Hillside	Liberty Resources Pathways Unity Hospital/RRH Villa of Hope	Cayuga Centers FLACRA Hillside	Liberty Resources Pathways Unity Hospital/RRH Villa of Hope	Compeer Rochester FLACRA FLPN Hillside	Liberty Resources Pathways Villa of Hope
ONTARIO	Cayuga Centers FLACRA Glove House	Hillside Pathways Villa of Hope	Cayuga Centers FLACRA Glove House	Hillside Pathways Villa of Hope	FLACRA FLPN Glove House	Hillside Pathways Villa of Hope
SCHUYLER	Children's Home WC FLACRA Franziska Racker Cntrs	Glove House Hillside Pathways	Children's Home WC FLACRA	Glove House Hillside Pathways	Children's Home WC FLACRA Glove House	Glove House Hillside Pathways
SENECA	ARISE Ch&Fam Service Cayuga Centers Children's Home WC FLACRA	Franziska Racker Cntrs Glove House Hillside Pathways	ARISE Ch&Fam Service Cayuga Centers Children's Home WC FLACRA	Franziska Racker Cntrs Glove House Hillside Pathways	ARISE Ch&Fam Service Children's Home WC FLACRA FLPN	Franziska Racker Cntrs Glove House Hillside Pathways
STEUBEN	Children's Home WC FLACRA Glove House	Hillside Pathways	Children's Home WC FLACRA Glove House	Hillside Pathways	FLACRA FLPN Glove House	Hillside Pathways
WAYNE	Cayuga Centers FLACRA Hillside	Pathways Villa of Hope Wayne CAP	Cayuga Centers FLACRA Hillside	Pathways Villa of Hope Wayne CAP	FLACRA FLPN Hillside	Pathways Villa of Hope Wayne CAP
YATES	Cayuga Centers FLACRA Glove House	Hillside Pathways	Cayuga Centers FLACRA Glove House	Hillside Pathways	FLACRA FLPN Glove House	Hillside Pathways

Upcoming Trainings

November 2018
Children and Family Treatment and Support Services Billing Webinar – 11/6
Children and Family Treatment and Support Services UM/Billing office hours – 11/15
Children's Readiness Funding Trainings (for Identified Providers only)
CANS NY for Health Home Care Managers and Supervisors
1915c Provider In-person Transition Trainings – statewide

Resources and Key Documents

- Billing Manual: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_manual.pdf
  - Supplemental billing guidance: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_supplement.pdf
- CFTSS Provider Manual: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf
- HCBS Provider Manual: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-10-06_draft_hcbs_prov_manual.pdf
- MCTAC Children's Website: https://ctacny.org/childrensystemtransformation

FINGER LAKES REGIONAL PLANNING CONSORTIUM

THANK YOU

www.clmhd.org/rpc/

CLMHD Regional Planning Consortium

Resources Related to Children's Health and Behavioral Health Transition to Medicaid Managed Care (Compiled 11/20/18)

Overview

- *Children's Managed Care Design*
- *Provider Designation*
- *Children and Family Treatment and Support Services (CFTSS) Provider Manual*
- *Draft Children's Home and Community Based Services Provider Manual*
- *Children's Health and Behavioral Health Billing and Coding Manual (Includes both CFTSS and Home and Community Based Services (HCBS))*
- *Supplemental Billing Guidance (Transitional period)*
- *Billing Guidance and Rates*

Helpful Trainings

- *Children and Family Treatment and Support Services (CFTSS) – Service Review*
- *CFTSS Refresher*
- *CFTSS FAQ*
- *CFTSS Billing and Revenue Cycle Management*
- *CFTSS Utilization Management*
- *Aligned Home and Community Based Services*
- *Find a Designated Provider*

Receive Updates and Submit Questions

- ***Subscribe to the children's managed care listserv***
- ***Subscribe to the DOH Health Home listserv***

- ***NYS OMH Managed Care Mailbox:*** OMH-MC-Children@omh.ny.gov
  - Please include Kid's system/managed care in the subject line

- ***Provider Designation:*** OMH-Childrens-Designation@omh.ny.gov
- ***OASAS:*** picm@oasas.ny.gov
- ***DOH:*** managedcarecomplaint@health.state.ny.us
- ***Email DOH about Health Homes through their bureau mail log or call 518-473-5536***

- ***MCTAC Mailbox:*** Mctac.info@nyu.edu
  - Logistical questions usually receive a response in 1 business day or less.
  - Longer and more complicated questions can take longer.

Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access additional resources

Finger Lakes Regional Planning Consortium

Workgroup Activity - Quarterly Summary

December 14, 2018

Clinical Integration Workgroup – met October 2 and December 7

Group hosted presentation on October 2 from Rochester Regional Health regarding their clinical integration efforts in over 20 service sites (see attached presentation).

On December 7, URMC presented their CCBHC program (see attached presentation).

Both presentations were extremely well received and generated significant dialogue.

Plans continue for the spring symposium addressing the sharing of clinical information between behavioral health and other providers. Tentatively scheduled for Wednesday, May 8, 2019. Melissa Zambri and Andrew Philip conformed presenters. St. John Fisher College has informally agreed to host the event. Tour of proposed site is scheduled for December 18.

Having received information regarding tremendous amount of clinical integration activity occurring, workgroup will meet in the first quarter to determine the group's focus going forward.

Education re Peer Role Workgroup – met November 2

Group met to prioritize which of the three previously identified critical topics to address first and how best to begin that work.

It was decided to combine two of them into one area of focus: Competency Standards for Organizations Employing Peers and Staff Education re the Value Peer Coworkers Bring to BH Programs.

Participants had been asked to forward known resources relevant to these efforts and Beth reported that she received hundreds of pages of resource material. All agreed that it is not necessary to create new resources, rather to select the most pertinent and evaluate how best to have it available to those in need of it.

It was agreed that a subgroup would take on the task of going through all the resources, catalogue it and report back to the group on now best to use it. Several participants volunteered to undertake this task.

Group also agreed that employers of peers should be surveyed to determine if they welcome the education efforts that are being discussed and what they feel are their most critical needs. Beth will perform the survey.

SUD Bed Access Workgroup - November 16 meeting deferred

Group had been scheduled to receive a demo of the proposed pilot website for accessing regional information regarding SUD bed availability, but due to the requirements of having the site viewable to the public, a different group of developers were needed and more extensive work done prior to being able to demo the site.

Beth met with the Rochester Regional development team on December 6 to further refine the requirements and answer questions that had come up. Plans are to have the demo ready in the first quarter of 2019.

Beth also met with the Consortium of Alcohol and Substance Abuse providers to update them on the project and invite them to the demo when it occurs. During the discussion, it was shared by 820 providers that they are seeing an issue coming up where clients admitted to their programs who accessed their Medicaid benefit through the NYS exchange end up being changed to local enrollment. This is resulting in a week of no insurance coverage during their stay, with no reimbursement available for that time period. This will be added to the discussions with OASAS about the residential redesign.

All workgroups will be scheduled to meet again in the first quarter of 2019. Board members wishing to attend any of these groups for the first time should contact Beth to be added to the invite list.

Rochester Regional Health

Behavioral Health Integrated Care

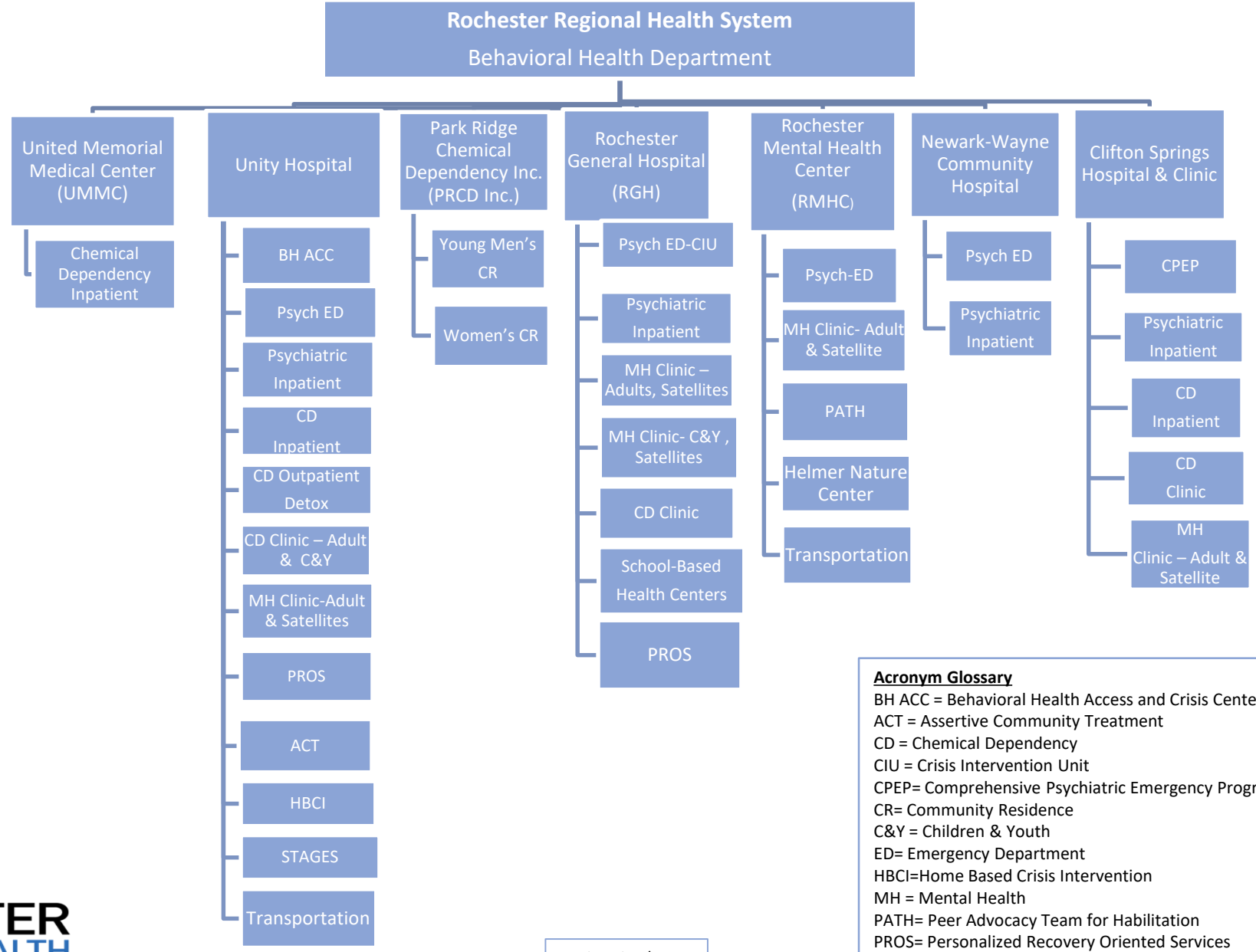
October 2, 2018

AGENDA

- RRH Behavioral Health Department Overview
- Integrated Care Models
- Integrated Care Core Components
- Integrated Care Impact

Behavioral Health department

BEHAVIORAL HEALTH OVERVIEW: LEGAL ENTITIES



Acronym Glossary

BH ACC = Behavioral Health Access and Crisis Center
ACT = Assertive Community Treatment
CD = Chemical Dependency
CIU = Crisis Intervention Unit
CPEP= Comprehensive Psychiatric Emergency Program
CR= Community Residence
C&Y = Children & Youth
ED= Emergency Department
HBCI=Home Based Crisis Intervention
MH = Mental Health
PATH= Peer Advocacy Team for Habilitation
PROS= Personalized Recovery Oriented Services

ROCHESTER REGIONAL HEALTH

Updated: 6/2017

BEHAVIORAL HEALTH OVERVIEW: KEY SERVICES & STATISTICS

14 Behavioral Health Locations; 4 Counties

4

Emergency Department Access Points (includes CPEP)

370,000

Annual Outpatient Clinic Visits

800+ Staff Members

2

Chemical Dependency Residential Programs
24 Woman's Beds & 18 Young Men's Beds

2,000+ Individuals Enrolled in Home Health Care Management

DSRIP - Mental Health Embedded in 7 Primary Care Practices & 5 SBHCs

$75M+

Annual Revenue

75 Active Psychiatric Inpatient Beds

86 Addiction Beds

5 School Based Health Centers

INTEGRATED CARE CORE MODEL

DSRIP Project 3.a.i.
Three Models of Integration

Model 1) Behavioral Health integrating into a Primary Care site

Model 2) Primary Care integrating into a Behavioral Health site

Model 3) IMPACT model of Collaborative Care for Depression

- IMPACT - **I**mproving **M**ood – **P**romoting **A**ccess to **C**ollaborative **T**reatment for late-life depression

Integrated Care Models

NYS Office of Mental Health Satellites - apply for clinic satellite sites for all staff embedded in primary care sites

- ***Staffing*** – permits billing of variety of Master's Prepared Staff in primary care setting
- ***Billing*** – bill for services of staff utilizing existing mental health clinic CPT structure/rates
- ***Regulatory*** – requires staff to be in compliance with all NYS OMH regulations

Collaborative Care Model – utilized collaborative care model in primary care settings

- ***Staffing*** – Masters Prepared Medical Social Workers – only staff type to provide this service
- ***Billing*** – Staff have dual purpose- medical social worker- billing preventative care CPT codes & collaborative care codes – split service opportunity = sustainable revenue model
- ***Regulatory*** – staff experience more flexibility, intervention is targeted at specific Dx

INTEGRATED CARE CORE COMPONENTS

MT

Integrated Care Core Components

- **Clinical Documentation in One EMR**
- **Behavioral Health Screening**
- **BH Crisis Intervention & Social Determinants of Health**
- **Psychiatric Consultation to Medical Providers**
- **BH Treatment**

Low Acuity – patients with minimal needs

Medium Acuity - patients with mental health needs

All components occur within primary care office setting

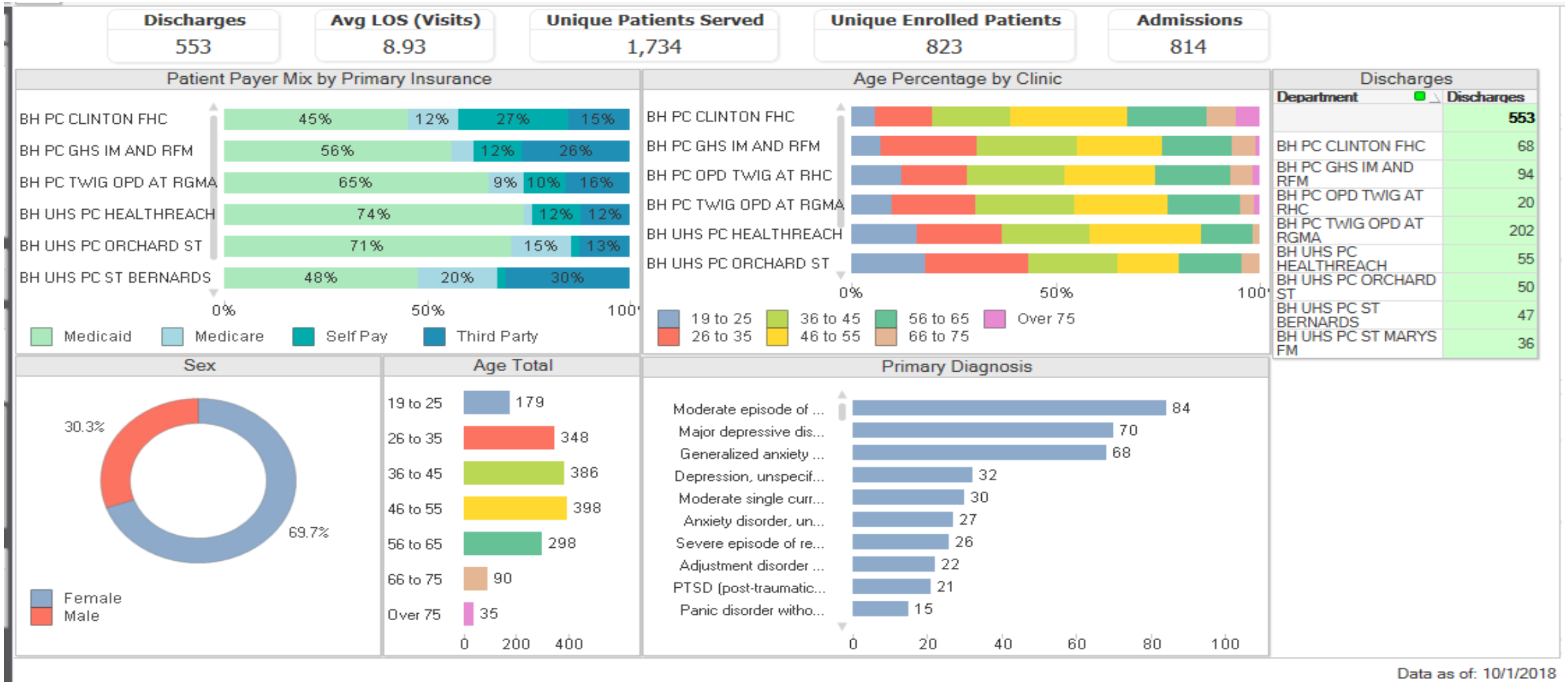
High Acuity- Individuals with a Serious Mental Illness (SMI), complex care – MH Services in MH Clinic Long-Term Goal- embed primary care in MH Clinic

Integrated Care Core Components

Component	Description	Lessons Learned
Clinical Documentation in One EMR	RRH – Utilizes CareConnect (Epic) Currently Physical Health providers – need to "break the glass" to see Behavioral Health Documents	• Education – training to all staff regarding what is viewable and what requires "break the glass" • Culture- cultural shift for providers to feel comfortable "breaking glass"
Behavioral Health Screening	PHQ2-PHQ9 SBIRT	• Initiated Screening Tool at all primary care sites (65+ locations)- total patients screening rates vary by practice • Specialty Clinics- utilize various screening tools
Clinical Intervention	• Psychosocial Assessment • Individual Psychotherapy – access to groups at MH clinics • Brief Intervention Models	• CareConnect Workflow to identify patients • Warm hand off possible within practice • Triage- psychotherapy versus collaborative care
Psychiatric Consultation to Medical Providers	Psychiatric consultation to practitioners in primary care settings. Support in determining patients that should be treated in a mental health clinic setting.	• Education- opportunity to review clinical cases with psychiatric prescriber expertise • Psychiatric Evaluations /Consultation – primary care physicians report willingness to prescribe medications

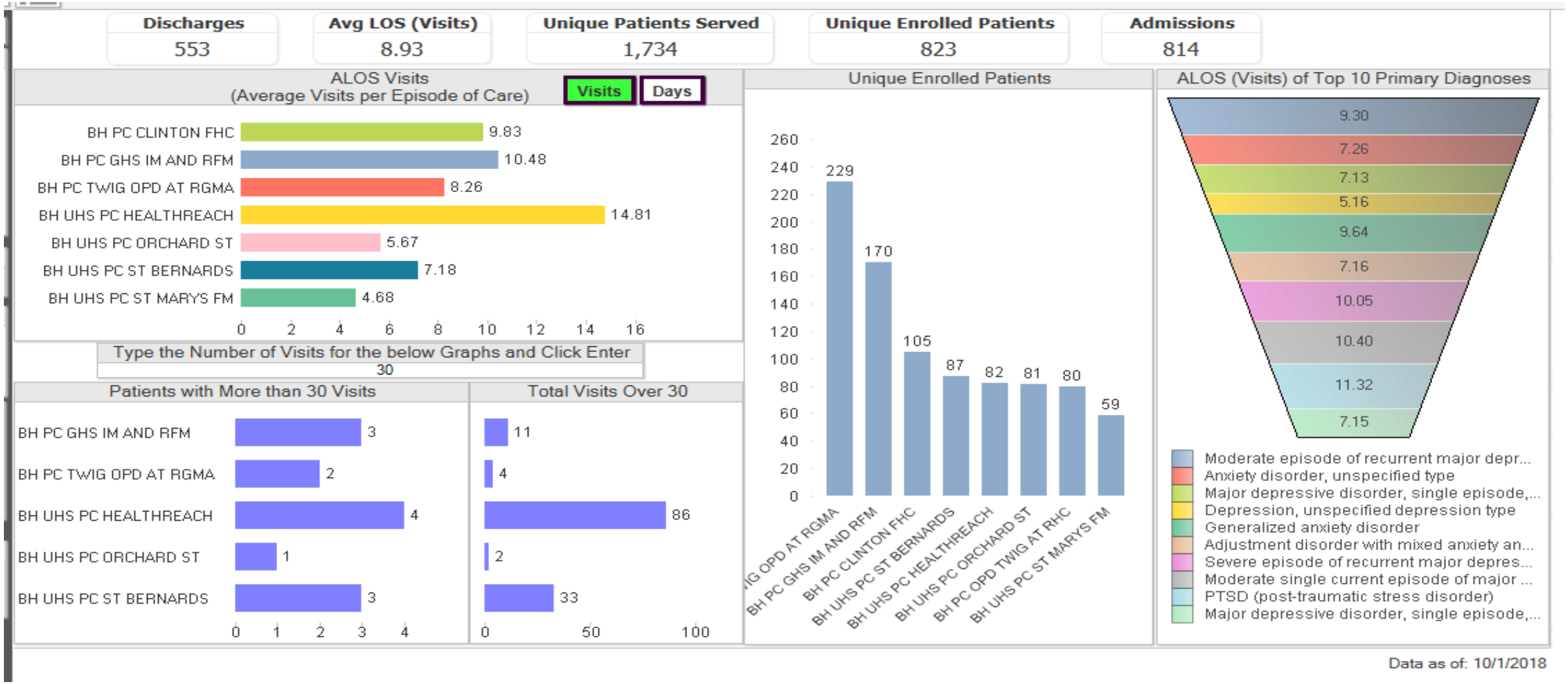
INTEGRATED CARE IMPACT

RRH BH Integrated Care Patients Discharged



ROCHESTER REGIONAL HEALTH

RRH BH Integrated Care Patients Discharged



ROCHESTER REGIONAL HEALTH

Thank You

Strong Memorial Hospital

Certified Community Behavioral Health Clinic
2 Year Demonstration Pilot

Testing Outcomes from
Transformational Clinical Delivery Models

CCBHC

Program activities aim to:

- **Integrate** behavioral health with physical health care
- Increase **consistent** use of evidence-based practices
- Improve **ACCESS** to high-quality health care

CCBHC

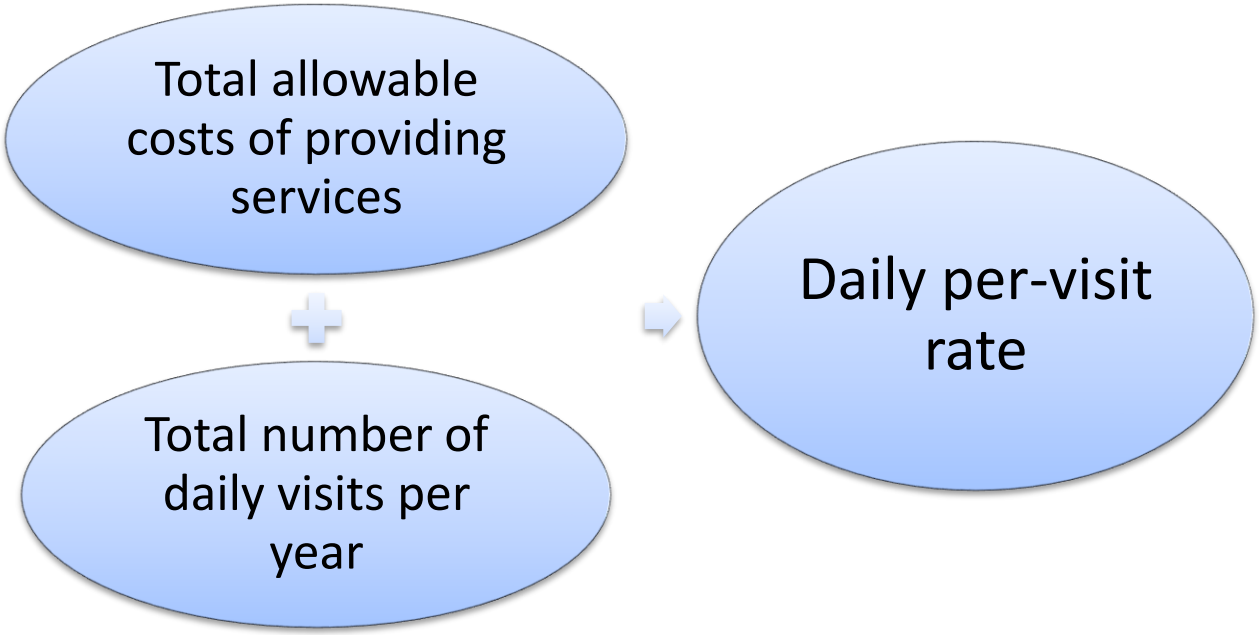
- Engaged in planning activities with New York State in November 2015 in order to be a part of the state's application
- Of the submitted 24 state applications, 8 states were selected for a two year demonstration pilot program
- Pilot Project Years: July 1, 2017 – June 30, 2019

Prospective Payment System

- CCBHC's receive a fixed daily reimbursement per visit
  - Based on the FQHC PPS approach used nationally
- Payment is the same regardless of intensity of services
- Carved out direct to Medicaid vs. through MCOs.

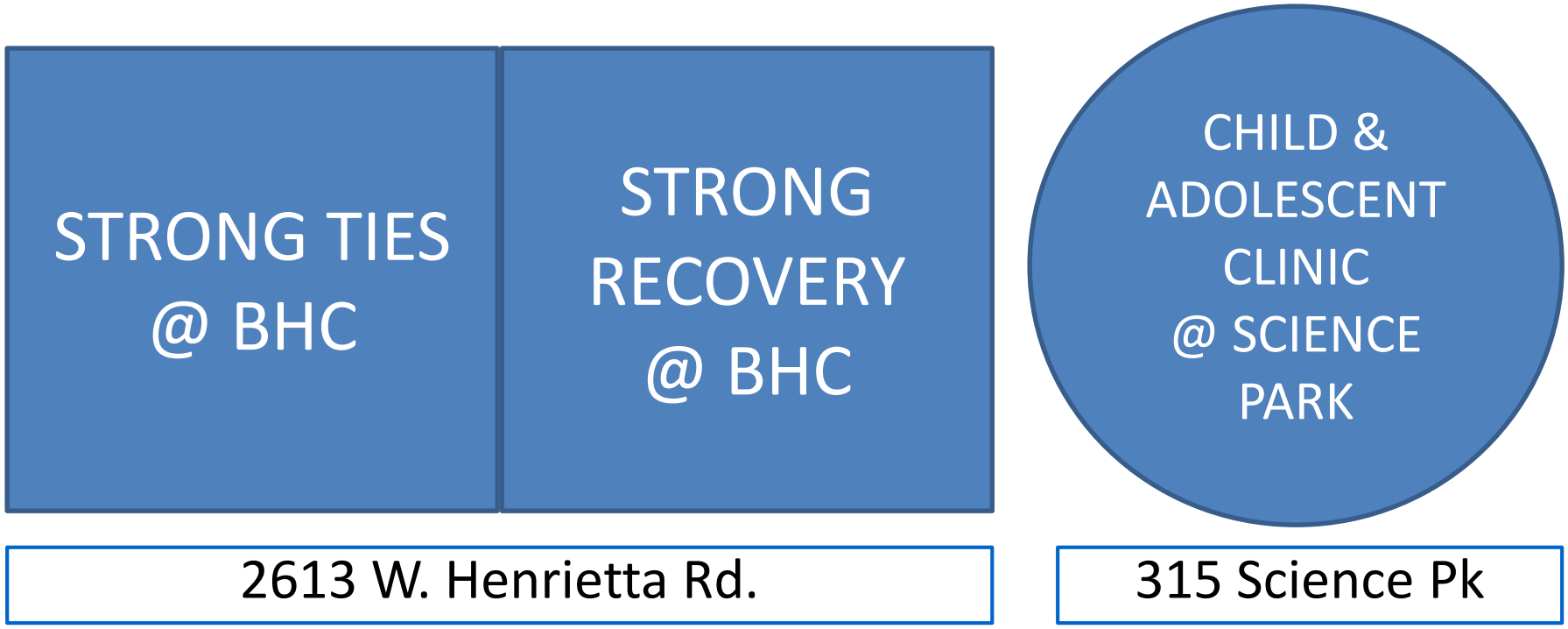
Prospective Payment System

- Cost report included current and anticipated costs

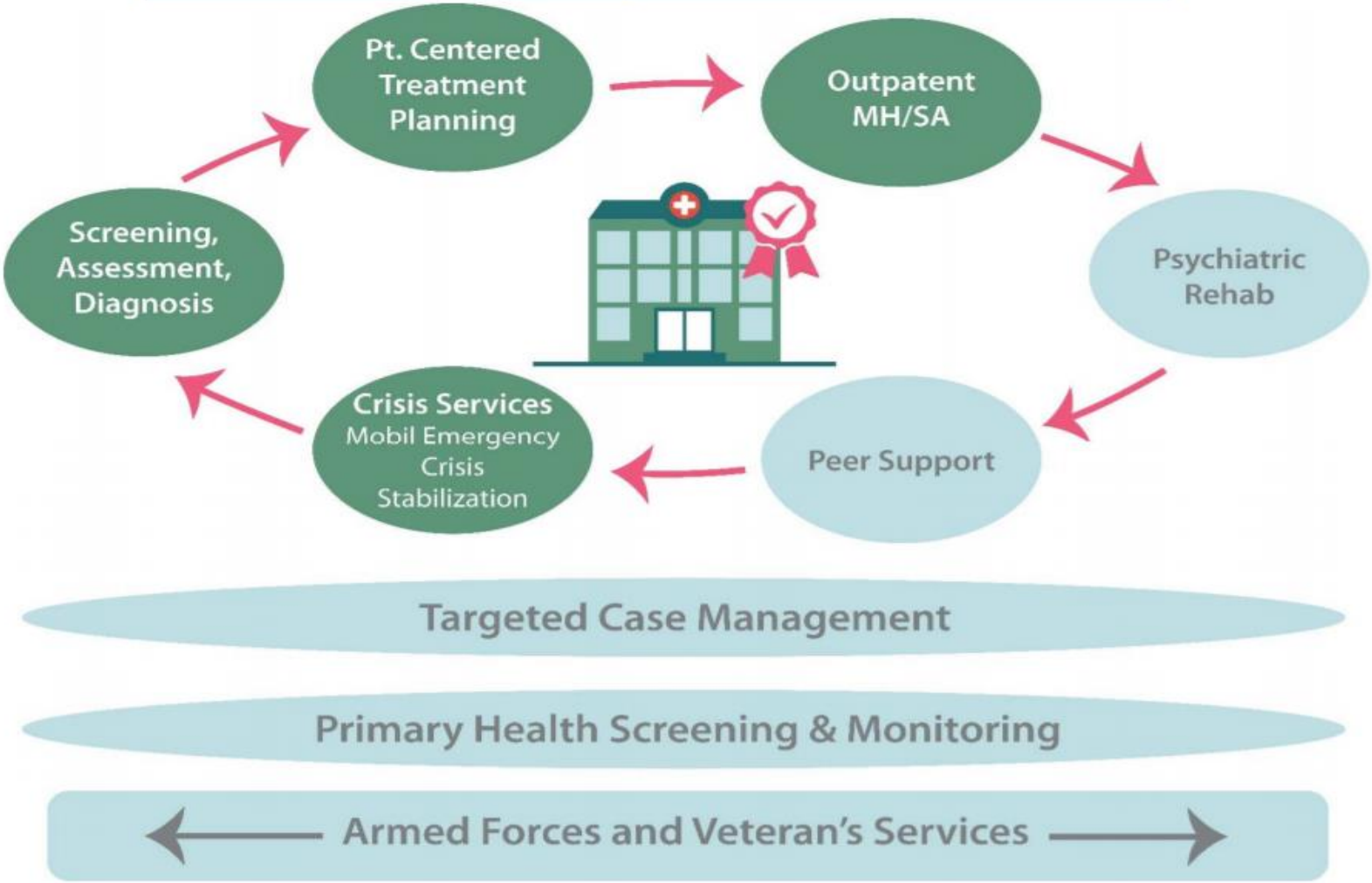


Demonstration Outcome Goal

Demonstrated CCBHC success in improving the health of the SMI, SUD and SED patient population as measured by clinical and quality metrics will reduce high cost/low gain utilization to effect real cost savings for CCBHC sustainability through value-based purchasing models.


STRONG TIES @ BHC
STRONG RECOVERY @ BHC
CHILD & ADOLESCENT CLINIC @ SCIENCE PARK
2613 W. Henrietta Rd.
315 Science Pk

CCBHC Scope of Services



Additional Key Requirements

- NYS OMH Integrated Licensure Approval for all CCBHC sites
- Medically Managed Withdrawal and Stabilization
- Participation in OMH Continuous Quality Improvement Initiatives: Suicide Prevention and Care Transitions

Transforming Vision to Practice

- Education
- Implementation
- Operations
- Optimization

Flexibility and Creativity

- Crisis Therapy Services in Child and Adolescent Clinic and Strong Ties
- Triage of calls for intake to assess need for crisis services within 24 hours
- Seeing patients in the community
- **Integrated services in each of the clinics**

Services DRIVEN by the Treatment Plan

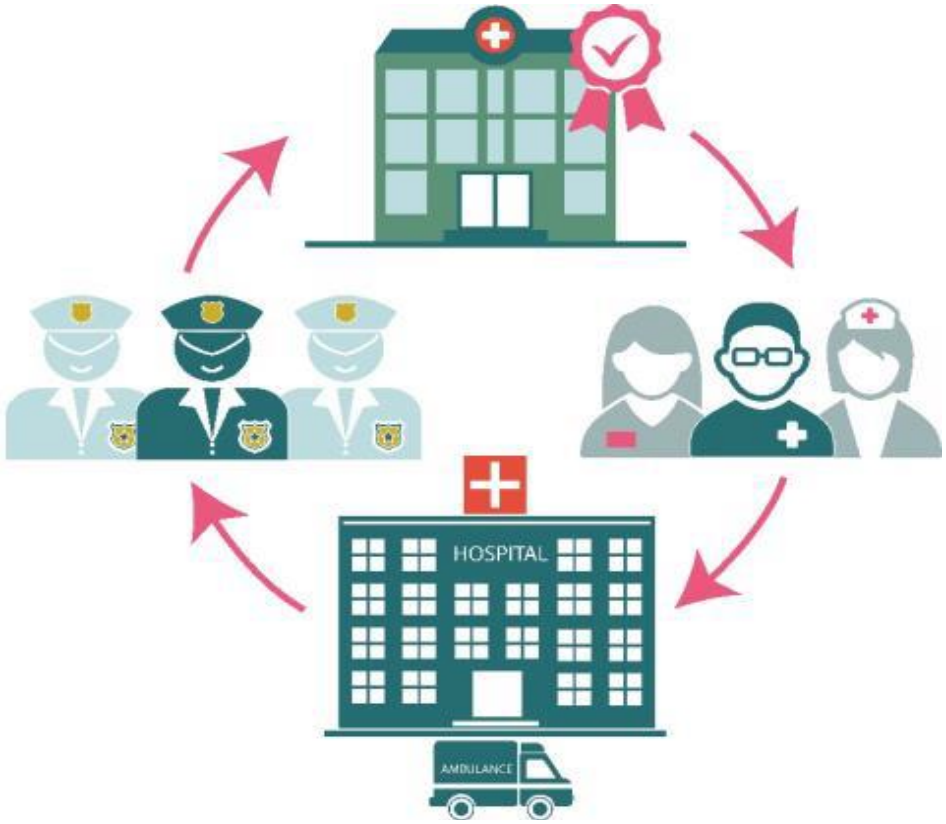
This is crisis driven patient population with multiple psychosocial and socioeconomic stressors on a daily basis.

Individualized road map focused on crisis prevention, crisis intervention and crisis stabilization.

The treatment plan dictates what CCBHC services to offer the patient and evaluates response.

Care Coordination

Expanded care coordination with other health care providers, social service providers and law enforcement, with a focus on whole health and comprehensive access to a full range of medical, behavioral and supportive services.



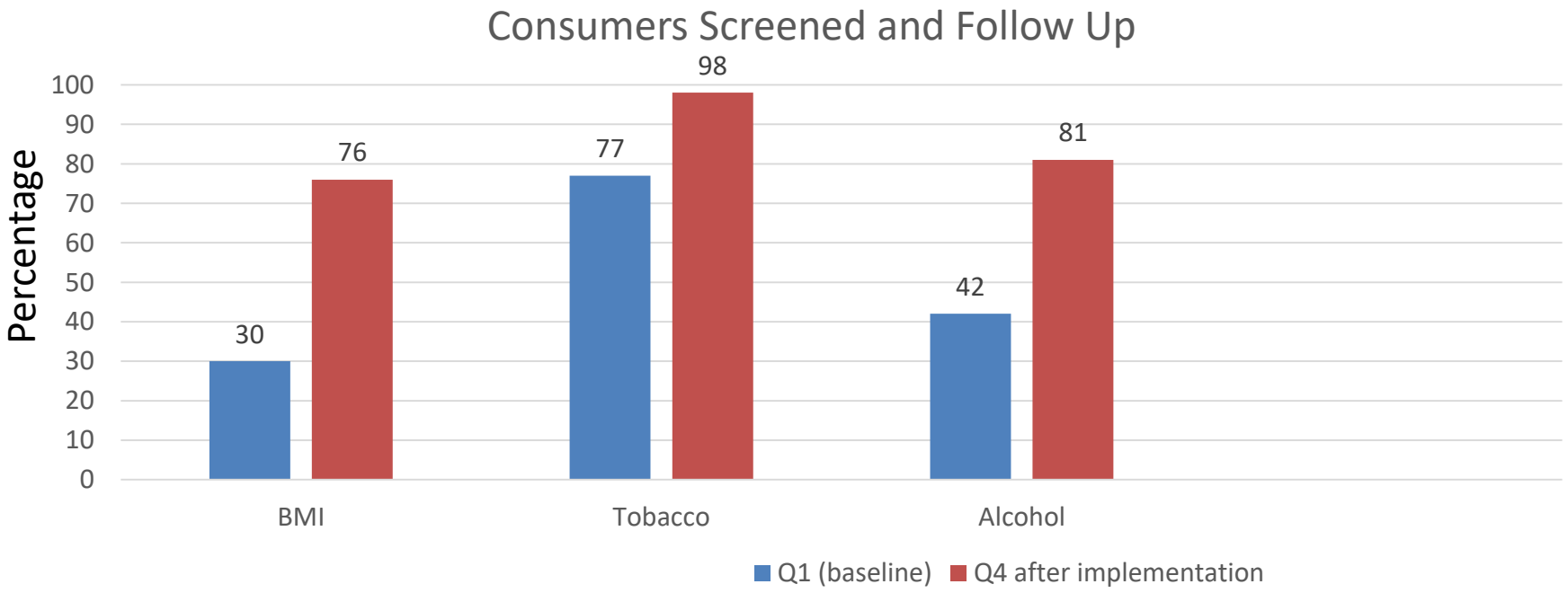
Staff Training

- Trauma-Informed, Motivational Interviewing (MI)
  - Overview & Refresher (1/2 Day)
  - MI for Supervisors (1/2 Day)
  - MI Supervisor Coaching Sessions (Monthly 90 minute sessions x 9 months)
- Veteran Mental Health Needs
  - General training from our VA colleagues to all CCBHC staff on “Understanding Military Culture”
  - Additional clinical training to CCBHC colleagues with a special interest to be our resident “experts” (5 thus far)
- Safety & Violence in the Community Education Training: SAVE Curriculum
  - ½ Day Workshops x 4 for all CCBHC Staff
- CCBHC Integrated Care
  - For CCBHC Leadership
- Unconscious Bias & Culture Vision Sessions
  - 2 sessions thus far
- Multiple Webinars through SAMHSA & National Council

SUCCESS IN NUMBERS

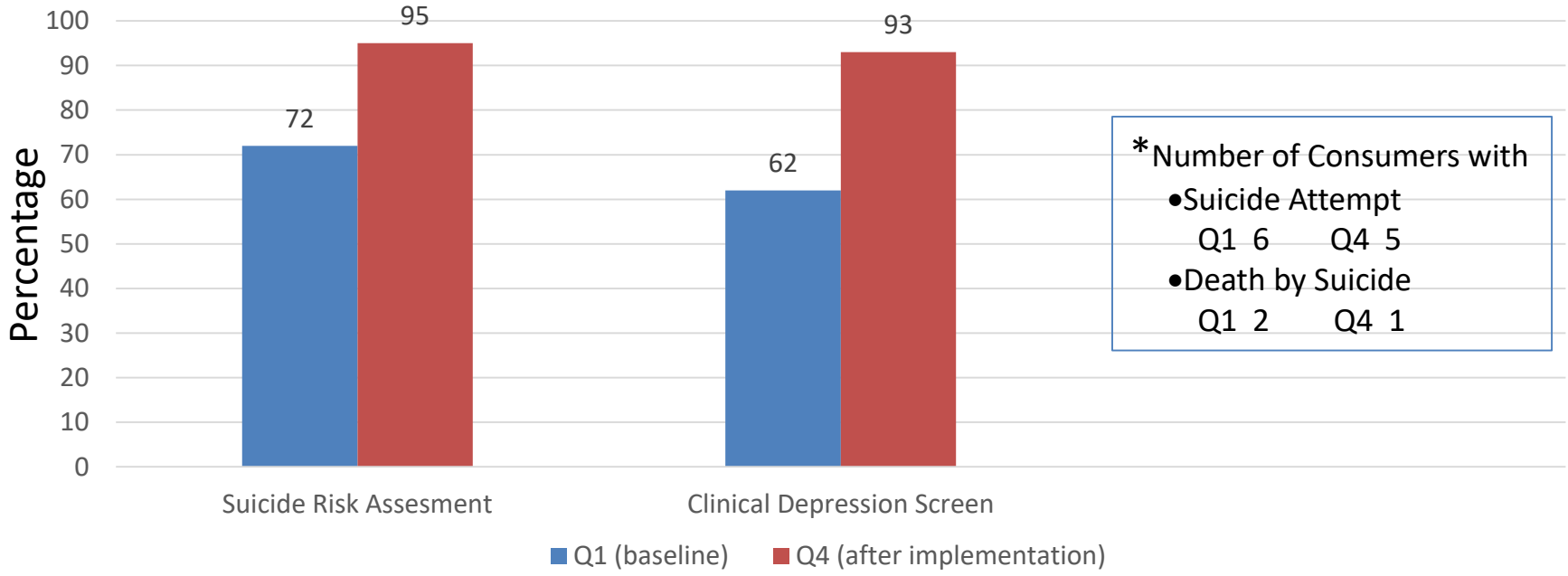
CCBHC Core Services Implementation DY1

Preventative Care Screening



CCBHC Core Services Implementation DY1

Suicide Risk and Depression Screening



SUCCESS IN REAL LIFE!!!!!

Youth PRS Services

- An 18 y/o male who dropped out of school in the spring of 2017 is seen at the URPBH&W outpatient clinic.
- Patient has diagnosis of moderate recurrent major depression, social anxiety disorder and substance or medication induced psychotic disorder with delusions but had desire to seek employment.
- He had a work history including two part time jobs while attending high school but his symptoms progressed to the point where he was unable to continue not only his job, but school as well.
- RT met with him and discussed ACCES-VR services for vocational support.
- Patient really struggles with his anxiety in large group settings so RT transported and attended ACCESS-VR orientation with him.
- Patient stayed for the entire orientation and was able to complete it along with the application following the orientation with minimal help from RT.

SMI TCM Services

- TCM was sent out to see a 34 year old male patient who had been hospitalized for approximately a month after experiencing psychotic symptoms.
- Prior to being inpatient the patient struggled to engage in outpatient treatment resulting in many missed appointments and declining overall health.
- TCM went to the hospital and engaged the inpatient team to assist the inpatient team in securing temporary housing for patient.
- Upon discharge the patient was apprehensive to engage in the clinic and in response TCM went out to the patient's residence and discussed the importance of coming in to his therapy appointment, and taking medication.
- The patient was able to successfully engage with his therapy team afterwards.
- Additionally, the patient and TCM were able to start the process of securing long term permanent housing which he successfully acquired and focusing on important goals such as acquiring replacement identification, and other hard to replace documents that were lost during the incident that resulted in his hospitalization.

SUD PRS Services

Patients new employment while in treatment through PRS:

- -East House, Peer specialist
- -Holiday Inn, Cook
- -Canal Staffing, Warehouse Associate
- -Red Payments, Sales
- -Olive Garden, dishwasher, server
- -Construction worker
- -Field Tec, Warehouse associate
- -stocking at Family Dollar, UPS driver
- -Post office, mail handler
- -Tru Direct/Amazon, van driver
- -Lidestri, Forklift operator

SUD TCM Services

- A 78 year old patient was in a formal process of eviction with his rental company due to financial issues brought on by his addiction
- A court date was set and TCM was able to flex his schedule to accommodate a 5:00 pm hearing time at town court and advocated for a deal to allow this patient to stay in his home of 29 years and developed an agreement to extend his lease.
- TCM also assisted with connection to financial resources to help with backed debt/money management, and financial needs moving forward

SUD PRS Services

- Hi Shlon, it's Martin. I'm sorry for missing our appointment yesterday. I worked my first day at Dollar Tree. And I just got called back from UPS my background check came back good. I'm doing my 4 hour orientation tomorrow and start working immediately! Thank you so much for your help with everything, including my confidence in myself! Everyone is so amazing and caring about helping us addicts find ourselves again! I can never express how thankful I am for all the attention I've received and helping me love myself again. I was so done with life for years because I didn't believe that I was worth living anymore. thank God he didn't call me home

Draft December 2018

Regional Planning Consortiums

Bylaws for Finger Lakes Region

Article I: Purpose

To serve the transformation of the Medicaid behavioral health system the creation of the NYS Regional Planning Consortiums (RPC) were authorized through the Centers for Medicare and Medicaid Services (CMS) 1115 waiver. The RPC is where collaboration, problem solving and system improvements for the integration of mental health, addiction treatment services and physical healthcare can occur in a way that is data informed, person and family centered, and cost effective. *Our goal is to improve the overall health for adults and children in our communities.*

Purpose of the RPC Boards

The function of the RPC is to collaborate, analyze and problem solve issues that arise in the managed Medicaid behavioral health system. The Board identifies, researches, and prioritizes issues, determining viability and actionable steps for regional resolution as well as recommendations and ideas for state partners.

Article II: Membership of the RPC Regional Boards

The Board of Directors of the Finger Lakes RPC shall be comprised of members as prescribed by the NYS Regional Planning Consortium initiative's definition of stakeholder groups and shall follow its directives regarding election of members for said groups.

The RPC Membership is comprised of seven stakeholder types, with both voting and non-voting Board members:

The voting stakeholder groups are:

- **Community Based Organizations (CBO)** – comprised of representatives from the following organization types: Mental Health, Substance Use Disorder, Children's Services, Adult Behavioral Health HCBS Providers, Housing Providers. Some regions have a rural organization from any of the organizations represented on their Board as well. Regions may choose to designate the sixth (6^{th}) seat as a rural or other designation as deemed appropriate by the region. Any organization providing Medicaid billable services and are licensed or designated by either OMH or OASAS are eligible for election to one of these seats.
- **Hospital and Health System Providers (HHSP)** – comprised of two representatives from each organization types: Hospitals and/or Health System Providers, Federally Qualified Health Centers and Lead Health Homes (Adult and/or Children). If there is insufficient interest from an organization type the Board may choose to have an additional representation from another organization type within this stakeholder group.
- **Peer/Family/Youth Advocates (PFY)** –comprised of two peer representatives, two family members, and two youth advocate members. Members of this stakeholder group may work for an agency that provides behavioral

health services but, in their Board member role, they are asked, when possible, to represent their personal experience as a peer or family member rather than their employer's agency perspective. If there is insufficient interest from a member type the Board may choose to have an additional representation from another member type within this stakeholder group.

- **Medicaid Managed Care Organizations (MCO's)** – each MCO organization has a contractual obligation to appoint a staff member to represent their organization.
- **County Directors of Community Services (DCS's)** – each RPC region will select up to six (6) members (if available) to serve on the RPC Board.

The non-voting stakeholder groups are:

- **Key Partners** – Various members elected by the Board due to their related subject matter expertise. For example, members who represent regional PHIP, PPS, LDSS or LHD.
- **Ex Officio** – Members eligible due to their related roles, i.e. State Partners and BHO's
- **Regional Need** – The Finger Lakes RPC Board may elect to move specific Key Partner seats, i.e. LDSS, LHD or PPS to Ex Officio status in order to include additional Key Partners on the Board

CoChairs

Each RPC Board will be facilitated and lead by two RPC CoChairs. One CoChair is a Director of Community Services (DCS) and selected by the regional DCSs. The other CoChair is selected from one of the following stakeholder groups:

- Community Based Organizations
- Managed Care Organizations
- Peer/Family/Youth Advocates
- Hospital & Health System Providers

The non-DCS CoChair is self-nominated and elected by voting Board members.

CoChair role and responsibilities:

Leadership:

- Manage and provide overall leadership to the Board, identifying goals, strategy that advocates regional goals.
- Represent the region at RPC activities and meetings.
- Lead effective and efficient Board meetings, promote effective relationships, open and inclusive communication in meetings and internally mediate contentious relationships.
- Create a culture that allows constructive dialogue, including challenges and varying opinions and consensus decision-making.
- Ensure the Board as a whole is engaged in the identification and development of issues and determination of Board decisions, recommendations and ideas.
- Serve as an ambassador of the RPC, advocating its mission to internal and external stakeholders

Logistics:

- In person attendance at regional Board meetings and state partner meetings.
- On-going collaboration with their CoChair counterpart and RPC Coordinator.
- Develop/organize in concert with CoChair and RPC coordinator the Board's meeting agenda.
- Attend and participate in the RPC CoChairs calls and complete requested surveys.
- Serve as an access point for members of the community who have questions or would like to bring issues to the attention of the RPC
- Enact and uphold the Finger Lakes bylaws

Voting Stakeholders

The RPC Boards each consist of five voting stakeholder parties, they include;

- Community Based Organizations
- Hospital/Health System Providers
- Peers/Family/Youth Advocate's
- Director of Community Services
- Managed Care Organizations

Role and responsibilities:

- Attend quarterly RPC Board Meeting in person, no proxy or call in option is available
- Review Board meeting minutes, to be voted on for approval
- Review meeting agenda and materials prior to each Board meeting
- Represent the collective views of the RPC Board and your stakeholder group in your region
- Identify, prioritize and sort the recommendations/ideas/solutions that have been identified by the region.
- Serve as an access point for members of the community who have questions or would like to bring issues to the attention of the RPC
- Actively participate in Board meetings
- Participate in workgroup/subcommittee levels, or encourage that a staff member from your agency participate when appropriate.
- Deliberate and vote on regional solutions and priority recommendations/ideas to be forwarded to our state partners.

Non-voting Stakeholders

The RPC Boards consist of two non-voting stakeholder parties, they include:

- Key Partners (represent various community organization, including but not limited to PHIPs, PPSs, LDSS, LHD)
- Ex Officio Members
    - State Agencies Representatives (From OMH, OASAS and OCFS)
    - BHOs

Role and responsibilities:

- Attend quarterly RPC Board Meetings in person, and will not send a proxy to the meeting
- Review meeting minutes prior to Board meetings
- Review meeting agenda and materials ahead of each Board meeting
- Represent the collective views of the RPC Board and your stakeholder group in your region
- Actively participate during the Board meetings
- Present on the Board any updates from your represented agency
- Serve as a subject matter expert on the topical areas connected to your organization
- Participate in regional workgroups and/or subcommittee levels, or encourage that a staff member from your agency to participate, when relevant.

RPC Coordinator

The RPC Coordinator collaborates with and supports the RPC CoChairs, Board members and regional work groups/subcommittees to develop, organize and document the action steps taken to address the recommendations/ideas/solutions identified by the region. RPC Coordinator is not a voting member of the Board and will maintain a neutral stance pertaining to the issues/concerns/recommendations and ideas identified at the Board level. They will serve as an advisor to the Board assisting with goals, approach, feasibility and information.

Role and responsibilities:

- Collaborate with RPC CoChairs and subcommittee chairs to develop meeting agendas
- Arrange venue sites for ongoing Board meetings
- Prepare materials for Board meetings
- Update Board membership list as needed and will work with CLMHD communications director to update website with this information
- Document and review meeting minutes, send to Board members for their review
- Facilitate active participation in meetings, working to include all Board members and stakeholder viewpoints.
- Create living documents identifying regional concerns, actions, recommendations, resources and ideas.
- Outreach community organizations as needed when the Board/workgroups expresses an interest in learning more about resources
- Collaborate with RPC Coordinators to align common themes, share best practices, resources intra-regionally
- Assist Board and workgroups in the identification, analysis and development of issues.

Article III: RPC Code of Ethics

The RPC Board is an apolitical Board that represents the collective views of various stakeholders and as such will represent the collective voice of the region.

The members and staff of the RPC are committed to:

- being responsible, transparent and accountable for all of our actions
- accountability and responsible stewardship of our financial and human resources
- avoiding conflicts of interest and removing themselves from meetings or activities that jeopardize the integrity of the RPC
- treating every individual with respect, fairness and dignity
- being mindful of stigmatic language and references
- advocating for access to and quality of Medicaid Managed Care Services for recipients and not for any specific organization member or non-member needs.
- maintaining a neutral political stance when acting as part of the RPC
- ensuring vendors/key partners who present their subject matter expertise at RPC sponsored events do not use the forum for self-gain through marketing and sales. All vendors/key partners will be informed of this limitation prior to any RPC engagement.
- respecting and maintaining confidentiality regarding the organizational, personal or proprietary information shared by other RPC members in the course of RPC business.

Article IV: RPC Board Member Elections and Terms

Length of Board member term and election structure:

<u>CoChairs</u>

- CoChair terms are for 3 years. CoChairs are eligible to serve a second term.
- DCS CoChairs will be selected by and from the DCS stakeholder group.
- Non-DCS CoChairs will be elected by their voting Board members according to the NYS RPC election guidelines.
- CoChairs may resign at any time by submitting written or emailed notice to the fellow CoChair or RPC Coordinator.

- CoChairs missing two out of the four most recently scheduled meetings shall have been determined to be not sufficiently available to serve in the role, the office deemed vacant and filled in accordance with established procedure.

Voting Board members

- Board members will be elected by their community stakeholder members to a 3 year term according to the NYS RPC election guidelines.
- If a Board member decides not to serve a full term, the seat for that stakeholder position is considered open and the organization has 30 days to fill that position with another appropriate organization member. This process does not require another vote.
- If the agency does not respond within 30 days, then requests for nominations will be solicited and an election will be held for the open seat. Eligible voters are members of the corresponding stakeholder group.
  Exception: Managed Care Organizations and DCS's are contractually obligated to participate in the RPC and are not bound by elections/terms but rather assigned by their respective organizations.
- Board members may resign at any time by submitting notice in writing to a CoChair.
- Board members missing two out of the four most recently scheduled required meetings shall have been determined to be not sufficiently available to participate productively in the RPC, and the seat deemed vacant and filled in accordance with established procedure.
    - CoChairs have the discretion to review the individual circumstances and determine next steps regarding removal or reprieve of Board members.

Article V: Meetings, Subcommittees and Work Groups

Board Meeting Quorum

- A quorum of 50% plus one of current voting Board members, including at least one member of each voting Stakeholder group, must be present.
- In order to vote, a quorum of at least 3 members of each voting Stakeholder group must be present.

Meetings

RPC Boards:

- will meet each quarter per calendar year. Additional meetings may be scheduled as needed.
- are open to Public to observe; seats may be limited according to space limitations.
- may conduct their meetings according to their regional needs and preferences.

Subcommittees and Work Groups

- Subcommittees and workgroups are authorized by and accountable to the RPC Board
- The topics, terms, goals and objectives of the workgroups are determined by the region and workgroup leadership and members.
- Workgroups must be led by either a member of the RPC Board or the RPC Coordinator.
- All RPCs will establish a Children and Families Subcommittee to meet a minimum of 4 times per year effective Q3 2018.

COLLABORATIVE GOVERNANCE WITH CONSENSUS DECISION MAKING

The governance structure and consensus decision making process will use the collaborative governance model which is built on the following foundation.

Collaborative Governance

Perhaps the most notable success of collaborative governance with consensus decision making is the National Quality Forum (NQF), which brings together working groups from the public and private sectors to endorse consensus standards for healthcare performance measurement which are evidence-based and valid. The result is high-quality performance information that is publicly available and recognized as the gold-standard for healthcare quality.

Collaborative governance creates the structure and rules under which the RPC will function and carry out its mission. ***The consensus decision making process is critical because if the group is engaging in collaborative problem solving, the need to invoke a formal vote is minimal if not eliminated. The operative word is collaboration.***

There are several critical factors for successful collaboration and consensus building:

1. *Face to face dialogue*
2. *Trust building*
3. *Development and commitment to shared understanding of the interests of other parties*
4. *Shared goals*
5. *Leadership*

<u>Consensus Decision Making:</u>

- is a process that allows a group of diverse and similar stakeholders to come to mutual agreement
- allows for the input and agreement of all stakeholders to arrive at a final decision that is not necessarily agreed upon but acceptable to all
- promotes growth and trust between differing stakeholders and stakeholder groups
- allows stakeholder groups to work through their differences
- values the contribution of all stakeholders
- instills a higher level of commitment to the decision-making process and increases engagement of members
- encourages members to acknowledge other points of view, think more creatively and inclusively
- is a more difficult path than majority rules, takes more patience and skillful leadership.

A group committed to consensus may utilize other forms of decision-making (majority rules voting) when appropriate and agreed upon.

Finger Lakes Region

Issue Presentation: Current OMH 599 Guidance prohibits Physician Assistants from assessing patients and prescribing medications in Article 31 clinics

SUPPORTING INFORMATION

OMH does not permit Physician Assistants (PA's) to assess and prescribe without going through a waiver process

Currently a PA in an Article 28 primary care setting or FQHC can diagnose a behavioral health condition and prescribe medication, but cannot do so in an Article 31 mental health clinic.

SUPPORTING INFORMATION

We verified that State Ed/DOH permit assessment and prescribing to be within scope of practice of PA's

F. Prescriptions

In an outpatient setting, the PA may prescribe all medications, including Schedule II - V controlled substances, if delegated by the supervising physician. PAs may apply to the DEA to obtain their own, individual registration numbers as "mid-level practitioners." Once duly registered by the DEA, they may prescribe Schedules II, III, IV and V drugs, in compliance with Article 33 of the Public Health Law and Part 80 and Part 94.2 of Title 10 regulations. Such prescribing is also subject to any limitations imposed by the supervising physician and/or clinic or hospital where such prescribing activity may occur. PAs shall register with the Department of Health in order to be issued official New York State prescription forms. Official New York State prescription forms issued to the PA are imprinted with the names of both the PA and the supervising physician. If a PA utilizes an official prescription issued to a hospital or clinic, the PA must stamp or type his or her name and the name of the supervising physician on the official prescription.

- https://www.health.ny.gov/professionals/doctors/conduct/physician_assistant.htm

SUPPORTING INFORMATION

The origins of these restrictions were explored with OMH, to determine if they were part of the establishment of outdated regulations,

but it was learned that it is at the discretion of the OMH Medical Director.

Current waiver process is unclear as to the specific additional training and/or experience required in order to be approved.

SUPPORTING INFORMATION

Heidi Miller, the head of the Rochester Institute of Technology's PA program, reported

that she is not aware of any other medical specialty limiting PA's in this manner.

PA EDUCATION BY THE NUMBERS

- **27 months education**
- **75 hours of pharmacology**
- **175 hours in behavioral sciences**
- **400+ basic sciences**
- **580 hours clinical medicine**
- **2,000+ hours in clinical rotations**

Source: Issue Brief - “PA’s in Psychiatry,” American Academy of Physician Assistants

PA EDUCATION BY THE NUMBERS

After Graduation….

- PAs must pass a national certifying exam and obtain a state license.
- To maintain certification, PAs complete 100 hours of continuing medical education (CME) every two years
- Must pass a national recertification exam every 10 years.

IMPACT

Instances have been identified where PA's wished to work at Article 31 Clinics but were not or would not have been permitted by OMH to assess or prescribe.

Belief that a PA’s ability to assess and prescribe at FQHC’s but not in Article 31 MH Clinics could be a contributing factor in the financial viability of Article 31 clinics.

WHAT ABOUT QUALITY OF CARE?

- We all desire quality care for our clients, we believe there are various ways to achieve quality
- Behavioral Health Workforce Concerns
- Can we put in place other ways to address the need to assure quality care?

EMBRACE OPPORTUNITY TO HAVE PA'S AUGMENT THE BEHAVIORAL HEALTH WORKFORCE

- There are 23 Physician Assistant programs in New York State.

- In the face of extreme prescriber shortages in Behavioral Health, these practitioners could be a significant resource in the care of our clients

EMBRACE OPPORTUNITY TO HAVE PA'S AUGMENT THE BEHAVIORAL HEALTH WORKFORCE

A 2017 report, "The Psychiatric Shortage: Causes and Solutions," recognizes PAs as key to expanding psychiatric care.*

*Source: Medical Director Institute. The Psychiatric Shortage: Causes and Solutions. National Council for Behavioral Health. March 28, 2017. Washington, DC. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf Accessed April 12, 2018.

CONSIDERATIONS - HOW TO REPLACE EPISODIC CASE BY CASE WAIVER PROCESS

- Set standards for employment of PA's in Article 31 Clinics:
  - Establish Guidelines on how to shape this practice
  - Credentialing within clinic setting according to experience and training
  - Varying amounts and types of supervision required based on experience
    - Can supervision re assessment include other qualified clinicians in addition to psychiatrists?

LCSW's, Psychologists

- Require employed PA's to receive their required CME's in psychiatric curricula
- Incentivize PA's to acquiring CAQ (Certificate of Added Qualifications) in Psychiatry

PHYSICIAN ASSISTANT ASK

Revisit 599 Guidance to allow Physician Assistants to assess and prescribe in Article 31 Clinics by establishing guidelines that support their full practice and assure quality services.

Finger Lakes Regional Planning Consortium

MCO Information for RPC Board Meeting – December 14, 2018

RCA's Contracted and Reasons that Clients Decline HCBS Services

At the RPC Board meeting in September, members expressed interest in receiving information from the MCO's about the progress of the RCA contracting process and also regarding the reasons that eligible clients end up declining HCBs services.

Information was received from 4 out of 5 of the Finger Lakes region's HARP MCO's:

Excellus, Fidelis, MVP and YourCare

CONTRACTED RCA'S (RECOVERY COORDINATION AGENCIES)

CMA's contracted to provide Health Home Care Management services are now eligible to pursue a contract with MCO's to directly assess clients for HCBS services without requiring them to enroll in a Health Home.

Excellus Contracted RCAs: Finger Lakes RPC Region

BADEN STREET SETTLEMENT
BEHAVORIAL HEALTH NETWORK
CATH CHAR COMM & RES SVC AI M
CATHOLIC CHAR OF THE DIO/ROCHESTER (pending)
CATHOLIC CHARITIES ROCHESTER
CNYHHN INC
DELPHI DRUG ALCOHOL COUNCIL
EAST HOUSE CORPORATION
F L A C R A
GENESEE COUNTY MNTL HLTH SVCS
HCR CARE MANAGEMENT LLC
HUTHER-DOYLE MEM INSTITUTE
IBERO AMERICAN ACTION LEAGUE
IBERO AMERICAN ACTION LEAGUE INC
INTEGRATED COMM ALTERNATIVES
LAKEVIEW HEALTH SERVICES INC
MC COLLABORATIVE LLC
MONROE PLAN FOR MEDICAL CARE INC
NEIGHBORHOOD CENTER INC
STRONG MEMORIAL HOSPITAL (pending)
UCP UTICA MH
UNITY HOSPITAL ROCHESTER
VILLA OF HOPE
WAYNE CO CHAP NYSARC

Fidelis Contracted RCAs: Finger Lakes RPC Region

ANTHONY L JORDAN HEALTH CTR	MONROE
BADEN STREET SETTLEMENT	MONROE
BAYER WILLIAM H	MONROE
BEHAVORIAL HEALTH NETWORK	MONROE
CATH CHAR COMM & RES SVC AI M	ONTARIO
CATHOLIC CHAR OF THE DIO/ROCHESTER	LIVINGSTON
CATHOLIC CHARITIES CHEMUNG-SCHUYLER	CHEMUNG
CATHOLIC CHARITIES ROCHESTER	MONROE
COMM PLACE OF GR ROCH	MONROE
COMMUNITY CARE OF ROCHESTER	MONROE
COMPANION CARE OF ROCHESTER	MONROE
DELPHI DRUG ALCOHOL COUNCIL	MONROE
DEPAUL COMM SER MH	MONROE
EAST HOUSE CORPORATION	MONROE
EPILEPSY ASSOCIATION TBI	MONROE
F L A C R A	ONTARIO
FAMILY SER OF CHEMUNG CNTY MH	CHEMUNG
FINGER LAKES MIGRANT HLTH	YATES
GLOVE HOUSE	CHEMUNG
HCR CARE MANAGEMENT LLC	MONROE
HERITAGE CHRISTIAN-FL	MONROE
HILLSIDE CHILDREN'S CTR	MONROE
HUTHER-DOYLE MEM INSTITUTE	MONROE
IBERO AMERICAN ACTION LEAGUE	MONROE
IBERO AMERICAN ACTION LEAGUE INC	MONROE
LAKEVIEW HEALTH SERVICES INC	ONTARIO
LIFESPAN OF GREATER ROCHESTER DAY	MONROE
LIFETIME CARE	MONROE
LOYOLA RECOVERY FOUNDATION	MONROE
MARY CARIOLA CHILDRENS CENTER INC	MONROE
MC COLLABORATIVE LLC	MONROE
MONROE PLAN FOR MEDICAL CARE INC	MONROE
PARK RIDGE MENTAL HLTH CTR MH	MONROE
PATHWAYS INC	STEUBEN
PERSON CENTERED HOUSING OPTIONS INC	MONROE
PRALID INC TBI	MONROE
REHAB COUNSEL&ASSESSMENT TBI	ONTARIO
ROCHESTER REHABILITATION CTR	MONROE
SCHUYLER COUNTY MENTAL HLTH SVCS	SCHUYLER
SOLDIERS AND SAILORS MEM HSP	YATES
SOLDIERS AND SAILORS MEM HSP	YATES
STEUBEN CHURCHPEOPLE A/P	STEUBEN
STEUBEN CNTY COMM SVCS BD MH	STEUBEN
STRONG MEMORIAL HOSPITAL	MONROE
TRILLIUM HEALTH INC	MONROE
UNITY HOSPITAL ROCHESTER	MONROE
VILLA OF HOPE	MONROE
WAYNE CNTY COMMUNITY SRV BRD	WAYNE
WAYNE CO CHAP NYSARC	WAYNE

MVP Contracted RCAs: Finger Lakes RPC Region

Currently MVP has provider networks in Monroe, Livingston, and Ontario Counties in the Finger Lakes Region.

For Livingston County RCA's contracted:
- Genesee County Mental Health Services
- Venture Forthe

For Monroe County RCA's contracted:
- Villa of Hope
- Venture Forthe

For Ontario County RCA's contracted:
- Venture Forthe

YourCare Contracted RCAs: Finger Lakes RPC Region

Most of YourCare Health Plan's enrollees reside in the Western region.

SDE/RCA Contracts Executed or in Process:

Western NY	Monroe Plan for Medical Care	HH CMA, RCA
Western NY	Evergreen Health	HH CMA, RCA
Western NY	Horizon Health	HH CMA
Western NY	Housing Options Made Easy	BH HCBS Designated Provider
Western NY	Venture Forthe	BH HCBS Designated Provider, HH CMA
Western NY	WNYIL	BH HCBS Designated Provider, HH CMA, RCA
Western NY	Southern Tier Environments for Living	BH HCBS Designated Provider, HH CMA, RCA

Reasons Eligible Clients Give for Declining HCBS Services

Excellus

Members Assessed/Approved/Decline HCBS services: As of 11/27/18, a total number of members *for which we were notified* as assessed, eligible and declined services is ~450 members. This number is likely significantly greater as only a very small percentage of CMA's provide this information to us routinely.

Although most of the reasons noted for members declining services are generic (simply that the member does not want services) some specific reasons include:

- Member is just not interested
- Member is not medically well enough to participate in these services
- Member does not want an additional provider involved in care
- Member speaks no English and there are no services provided in member language (does not wish to have interpreter services)
- Too much going on to add services

Fidelis

Currently Fidelis does not have a tracking mechanism in place to provide data regarding the number of HARP members eligible for Tier 1 or Tier 2 of which have declined the services. This may be an item tracked at the Health Home level.

MVP

In regard to the HARP HCBS services, Beacon does not always get nor track the declination reasons for the HCBS services. Beacon's summary:

For year-to-date 2018, they were notified of 274 members who declined HCBS services. While they do not receive rationale for each manually-tracked case, some of the most common reasons include that the member is satisfied with PROS and/or CPST services, they have significant health concerns to address before engaging in additional services, or that they were simply not interested in the HCBS services offered. Other members have communicated that they do not feel they have needs that can be addressed with HCBS services. Most often the declination is due to the member cancelling the appointment for an undetermined reason and subsequently failing to make a follow-up appointment.

YourCare Health Plan

- 1,941 individuals enrolled in HARP
- As of November 30, 2018 – 43 members have declined HCBS services for the following reasons:

1) Members feels that the service will not be helpful to them and they don't understand the services themselves.

- We are finding that there are certain CMAs who are better educated and deliver this information more successfully to members. We continue to educate HHCM regarding HARP/ HCBS services.

2) Members feel they have too much going on in their life already- for example housing issues, they are working, childcare, engaged in day treatment programs (SUD and PROS) or OP BH services and report not wanting to focus on anything else until that issue is resolved.

Finger Lakes Regional Planning Consortium
2019 Board Meeting Dates

All meetings are on Friday from 1-4pm

March 15 - St. Bernard's
June 14 - Ontario County Training Facility
Sept 20 - Ontario County Training Facility
Dec 13 - St. Bernard's