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

Board of Directors

MINUTES

July 19, 2018   1pm-4pm
Ontario County Training Facility, Canandaigua

1:00 – 1:10pm

1. **Call to Order & Welcome** — **George Roets**

   Mr. Roets called the meeting to order and welcomed everyone.

2. **New Board Members** — **George Roets**

   a. **MCO – Curt Swanson, MVP Health Plan**

3. **Introductions (Name, stakeholder group, agency/organization)** — **Board**

4. **Youth Advocate Nominee – Julie Vincent** — **George Roets**

   Mr. Roets reported that we have received a nomination for a Youth Advocate Board member. Julie Vincent recently served as a Youth Advocate RPC Board member in the Western region but has recently moved to our region. Board members received her nomination information are asked to approve her as a Youth Advocate member. Hearing no objection, Mr. Roets declares her appointed to the Board.

1:10 – 1:50pm

Stakeholder Group Meeting Reports — **Beth White**

Ms. White reported that the following stakeholder groups met in the last month to discuss issues for referral to the State CoChairs meeting. Participants of these groups reported on their discussions. See each group's attached meeting summary for details of their discussions.

a. HHSP **Ellen Hey**

This stakeholder group identified two issues regarding telemedicine regulations that they believe merit discussion at the State CoChairs meeting:

ISSUES IDENTIFIED

- OMH is not permitting LSW's to practice via telemedicine, though they are permitted by DOH to do so
- There is great variability from payer to payer regarding reimbursement for telepsychiatry services. This is a parity issue when medical patients can benefit from this technology and BH patients cannot.

RECOMMENDATIONS

- 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. While this impacts providers, the greatest impact is on clients who are denied access to service via this technology.

b. Peer/Family/Youth **Keisha Nankoosingh**

This stakeholder group elected to discuss and support two issues identified by fellow stakeholder groups:

ISSUES DISCUSSED

- Telepsychiatry Implementation Challenges
- Unintended Consequences of OASAS Residential Redesign – Stress in Supportive Living Settings

RECOMMENDATIONS

- Remove daily cap of 60 miles staff travel reimbursement for HCBS services. Limit is unrealistic given the reality that many of these services are only available regionally vs. in every county. Peers frequently travel out of county in support of their HCBS clients.

c. CBO **Marty Teller & Sally Partner**

FLACRA and CFC staff offered background information regarding the changes and the eventual impact that has occurred at the supportive living level of care. They provided this outline:

ISSUE IDENTIFIED - Residential Redesign-Reintegration-Supportive Living

- Residential Redesign brought about the excellent opportunities for Stabilization- approximately 14 days, Rehabilitation- approximately 28 days, Reintegration- approximately 6 months.
- Supportive Living is part of Reintegration, reintegration is non-Medicaid reimbursable
- Supportive living is a non-deficit funded program entirely reliant on DSS Congregate Care payments, which have barely increased year-to-year for *decades.*
- Unintended consequences of Residential Redesign
  - Residential Redesign is an excellent opportunity to meet the needs of the increasing complexity, severity, chronicity of illness that persons with addiction suffer.
  - Stabilization and Rehab under one roof provide that opportunity. Supportive Living is a separate entity that is often, in scattered sites, a catch all for persons exiting Stabilization and Rehab. Individuals continue to suffer high complexity and severity after Stabilization & Rehab with shorter lengths of stay than Community residences requiring greater support than Supportive Living can offer.
- Congregate Care as sole resource of funding barely allows for payment of rent on behalf of the resident, with very little left available for the services needed to support this population.
- Efforts to address this challenge have included utilization of Health Homes Care Managers, yet, Health Home Care Management staff ratios do not allow for the necessary attention to meet the severity of client need.
- In Community Billing and Outpatient Clinic Service are insufficient to meet community need financially and programmatically, especially in rural areas where In Community Billing is cost ineffective.

RECOMMENDATIONS

- 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.

d. DCS **Jim Haitz**

ISSUE IDENTIFIED

- OMH does not permit Physician Assistants (PA's) to practice within the scope of their license without imposing significant hurdles in the form of extra training and/or experience. DOH does not impose these restrictions on PA's. A PA in a primary care practice can diagnose and prescribe medication for a behavioral health condition but cannot do so in a mental health clinic.

RECOMMENDATION

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

1:50 – 2:30

Breakout Groups to Assess Issues **Beth White**

Ms. White broke the group into 3 breakout groups whose charge was to assess the issues identified by the stakeholder groups using the "RPC Inquiry" questions provided. They were to advise as to whether each issue should go forward to the State CoChair meeting and if it has been well enough developed to present a compelling case for State action.

2:30 – 2:40pm: Break **All**

2:40 – 3:45pm

1. Breakout Group Reports **Groups #1-3**

Group #1

- All three issues are actionable and should go forward.
- Highest negative impact is felt to be in telemedicine and OASAS redesign issues.
- There was discussion about whether/how to get preliminary data from pilots that are going on regarding health home caseloads. Group decided that it is unlikely that administrators of pilot would release data in advance of completion and analysis.
- For the PA issue, it was felt that guilds' resistance may be a barrier, but PA's being able to dx and rx would increase services and support to clients.

Group #2

- PA issue should go forward. It would help address long wait times for clients to receive medication evaluation and service.
- Telemedicine issue re LCSW's should go forward, also unified regulations across State agencies.
- OASAS Redesign – the Peer group's recommendation regarding expanded reimbursement of staff travel for HCBS services should go forward. Group was strongly influenced by peer group's description of impact.

Group #3

- Yes, all should go forward, but are they ready? For PA issue, yes, case is made.
- For telehealth issue, agreed that disparity exists, but recommendations should be structured differently, with justifications stated more clearly.
- For redesign issue, CBO and PFY groups should combine their issues and recommendations into one.

There was extensive general discussion regarding the OASAS redesign issue:

- Observation made that referral to HCBS services prior to discharge to Supportive Living could help address problems, but it was felt that many SUD clients are not eligible for HCBS services.
- It was noted that HCBS eligibility "skews" to MH factors as it is an OMH program.
- Question raised re whether OASAS similarly identifies its most affected clients and how it similarly supports them.
- If not HCBS services, then perhaps increased Health Home care management. Again, questions about eligibility arose, along with discussion of new Health Home Plus vs. high acuity Health Home.

2. Next Steps in Issues Development Process **Beth White**

Sally and Marty will identify available data to support the impacts in Supportive Living that they have described.

Beth will explore what data may be available from OASAS.

Adele will share information regarding eligibility for Health Home Plus and the size caseloads that those CM's carry, compared to Health Home high acuity level of service.

Beth will request the HARP algorithm from the State to determine to what degree it includes people with only substance abuse factors.

3. **Vote or Continue to September Meeting** **All Voting Stakeholder Groups**

Group agreed to continue discussions in September and decide then which issues should be referred to the CoChairs meeting.

3:45 – 4:00pm

1. **Next Board Meeting** **Beth White**
   a. **Friday, September 14th, 1-4pm, Ontario County Training Facility**

   b. **Upcoming Meetings – Board members wishing to join a workgroup for the first time should contact Beth to receive the meeting invite**
      i. **SUD Beds Coordination – August 15, 1-3pm**
      ii. **C&F Subcommittee – August 10, 1-3pm**

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

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
October - CoChairs Meeting

*Rescheduled from original date of May 4th

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 – VOLUNTARY MEETING

BOARD MEMBERS SIGN IN - JULY 22, 2018

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

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

FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

AGENDA

September 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. **MCO – Kim Hess, YourCare Health Plan**
    b. **Youth Advocate - Julie Vincent**
4. **Introductions (Name, stakeholder group, agency/organization)** — **Board & Guests**

1:10 – 2:10pm

5. **Workgroup Meeting Reports** — **Beth White**
    a. **Children & Families Subcommittee** — **Jodi Walker**
    b. **Clinical Integration** — **Ellen Hey**
    c. **Education re Peer Role**
    d. **SUD Bed Access**

2:10 – 2:30

6. **HARP/HCBS Data Update** — **Chris Marcello**

2:30 – 2:40 Break — **All**

2:40 – 3:30

7. **Summary of July Board Meeting - Issue Development** — **Beth White**

8. **Evaluate New Information and Readiness of Issues for Possible Referral to State CoChairs Meeting** **All**

    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**

3:30 to 3:45

9. **Vote to Approve Issues for Referral to State CoChairs Meeting** **Voting Stakeholder Groups**

3:45 – 3:55pm

10. **Bylaws** **George Roets**

3:55 – 4:00pm

11. **Next Board Meeting** **Beth White**
    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**
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CHEMUNG, LIVINGSTON, MONROE, ONTARIO, SCHUYLER, SENECA, STEUBEN, WAYNE, YATES

Finger Lakes Regional Planning Consortium

Bylaws

Bylaws Definition

The rules and regulations enacted by an association or a corporation to provide a framework for its operation and management.

Bylaws generally provide for meetings, elections of a board of directors and officers, filling vacancies, notices, types and duties of officers, committees, assessments and other routine conduct. Bylaws are, in effect, a contract among members, and must be formally adopted and/or amended.

A Beginning

The Finger Lakes RPC will develop and adopt bylaws as the process unfolds and the manner of the group's work is defined.

- Purpose
  - As the Medicaid behavioral health system undergoes transformation, the RPC will work to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend priorities for reinvestment of Medicaid savings.

- Membership
  - Resignations and Removals
    - Board members may resign at any time by submitting written or emailed notice to one of the two CoChairs.
    - Any Board member missing two out of any four scheduled meetings shall have been determined to be not sufficiently available to participate productively in the RPC, and the seat shall be deemed vacant and filled in accordance with established procedure.

  - Filling of Vacancies
    - When a representative of an organization leaves the Board for any reason, that organization may assign another of its employees to fill the seat, providing that the replacement Board member is knowledgeable about the RPC process and will be able to speak on behalf of the organization.

        - When an organization or Board member no longer can participate on the RPC Board, that seat, if an elected one, is to be filled by the second or next place Stakeholder group finisher in the most recent Board election. If that person or organization is not available or willing, recruitment will occur and seat may be appointed by mutual agreement of both CoChairs or, if no agreement can be reached, election by the full Board.

    - Quorum
        - In order to meet, a quorum of at least 50% plus one of current voting Board members, including at least one member of each voting Stakeholder group, must be present.
        - In order for an action (a vote) to be taken, a quorum of at least three members of each voting Stakeholder group must be present.

    - Compensation
        - The Board of Directors shall receive no compensation for their services as RPC Directors.

Proposed January 30, 2017
Adopted January 30, 2017

Finger Lakes Regional Planning Consortium

Children & Families Subcommittee – August 10, 2018

St. Bernard's School of Theology & Ministry, 1pm – 3pm

MEETING SUMMARY

Welcome and Introductions - 5 min **Jodi Walker**

RPC Board has opening (1) **Beth White**
for Youth Advocate Board Member – 2 min

Eligibility: Ages 18 to mid-20's with lived experience receiving child services

Those wishing to nominate a candidate should contact Beth.

Transition Timeline Update (attachment) – 10 minutes **Melissa Hayward**

Designation List Released – 5 min **Jodi Walker**

Beginning July 1, 2018, providers must be designated through this process to provide newly aligned Children´s SPA/HCBS services under the NYS Medicaid program (both fee–for–service Medicaid and Medicaid Managed Care):

Children and Family Treatment and Support Services: Other Licensed Practitioner, Crisis Intervention, Community Psychiatric Supports and Treatment, Psychosocial Rehabilitation, Family Peer Support Services, Youth Peer Support and Training

HCBS: Caregiver Family Supports and Services, Crisis Respite, Planned Respite, Supported Employment, Community Self–Advocacy Training and Support, Habilitation, Palliative Care, Prevocational Services

It was observed by several that the OMH list has some problems in its sort function, the main one being that, when sorting by County, the results only show providers who deliver services *only* in that county. Providers who deliver services in multiple counties are not part of the search results for any of their individual counties. Beth will share this feedback with OMH.

Readiness Funds (attachment) - 5 min **Beth White**

Beth shared information regarding upcoming Children's Behavioral Health Readiness Funds. No timeline has been announced yet for the application process or distribution of the funds, but providers can benefit from reviewing the categories of funding that will be available to plan for how they might best use these new resources.

SPOA Workgroup Update – 5 min **Melissa Hayward**

Melissa shared with the group that there is a statewide SPOA workgroup led by the Conference of Local Mental Hygiene directors looking at the role of SPOA's as the children's transition occurs. She emphasized that the goal and intent of "Single Point of Access" remains, including for referrals to health homes. She will keep the group updated regarding the SPOA workgroup's discussions and findings.

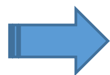
Process for Referrals to Health Homes & CMA's – DOH Standards (attachment) – 10 min **Beth White**

Following up on one of the discussions from the last meeting, Beth shared information regarding 'Referral of Children to Health Home and or Care Management Agency.'

Referring a child/adolescent with a Managed Care Plan (MCO)

- If a referred child/adolescent has a Managed Care Plan (MCO), the referral through the MAPP Referral Portal will be sent to the MCO assignment file. The MCO will have up to 3 business days to assign the referral to a Lead Health Home.
- The Lead Heath Home then has up to 3 business days to assign the referral to a Health Home Care Management Agencies (CMA) for a care manager to be assigned.
- Once a CMA is assigned, the care manager should be assigned no more than within 24 hours.

See attachment for more detailed information.



Today's Focus: *Create Message*

Breakout Groups – 35 min **Beth White**

- Break Out by Multi-Stakeholder Group
  - Health Homes/CMA's
  - MCO's
  - Counties – SPOA
  - Other Child & Family Serving Providers
  - State Partners and Others
- Introductions
- Identify Scribe & Reporter – scribe's notes will be turned in to RPC Coordinator
- Referring to provided definitions of Health Homes and CMA's,

  i. "Design" a flyer – come up with tag lines or other means of breaking information down into simple and compelling language to connect with families around these services
  ii. Think outside the box
  iii. Have fun with it!
  iv. Discuss how/where we can get "testimonials" from families who have benefitted from these services

Breakout Groups Report **Jodi Walker**

Jodi asked each group to report out their suggested tag lines and critical recommendations regarding messaging for families.

- Group #1 – Came up with two tag lines.
    i. "All about You"
    ii. "What We can Do"
    iii. Suggested that families review draft of proposed brochure as part of process

- Group #2 – Actually drafted a complete brochure!
    i. Tag Line – "We want to keep you where you are"
    ii. Recommends that cover of brochure feature Care Management, not Health Homes, as more people understand what care management is vs. what health homes are

- Group #3 – Had three recommendations
    i. Emphasize community supports available to clients
    ii. Include description/interpretation of services so clients understand what the services actually can do for them
    iii. Focus on care management being a service where an actual

Discussion - 10 min **Melissa Hayward**

Melissa opened the discussion asking the group "What is important to look at right now?"

HCBS Launch – providers are not ready to deliver these services

The conflict free policy is important but difficult to manage – there is a seemingly universal issue of "guided" referrals by agencies, hospital systems and counties, which affects and limits family choice.

Unavailability of HCBS services vs. SPA services

Transition has increased the number of children eligible for HH care management, and through that, access to skill building and respite services, but there has been no increase in the system's capacity to deliver these to more children.

Most/many CMA's are new to the child serving system, not familiar with children' services

Next Steps **Beth White**

Schedule training date for care managers and children's service providers regarding:

- What services are available now and whether they will continue or transition
- What new services will be available and when
- Detailed information about all of these services to provide more than a title to CM's
- Collaboration with SPOA's

<u>Next Meeting Date</u> - Training will be scheduled for Friday, Oct 19, 1-4pm. Location TBD.

Finger Lakes Regional Planning Consortium
CBO Stakeholder Group
Issue Development Discussion – June 27, 2018

Present: Sally Partner, Marty Teller, Chacku Mathai, Jeannine Struble, Beth White

The CBO group decided to bring forth a new issue:

Unintended Consequences of OASAS Residential Redesign - Stress in Supportive Living Settings

Discussion

FLACRA and CFC staff offered background information regarding the changes and the eventual impact that has occurred at the supportive living level of care. They provided this outline:

I. Issue- Residential Redesign-Reintegration-Supportive Living
   A. Residential Redesign brought about the excellent opportunities for Stabilization- approximately 14 days, Rehabilitation- approximately 28 days, Reintegration- approximately 6 months.
   B. Supportive Living is part of Reintegration, reintegration is non-Medicaid reimbursable
   C. Supportive living is a non-deficit funded program entirely reliant on DSS Congregate Care payments, which have barely increased year-to-year for *decades.*
   D. Unintended consequences of Residential Redesign
      1) Residential Redesign is an excellent opportunity to meet the needs of the increasing complexity, severity, chronicity of illness that persons with addiction suffer.
      2) Stabilization and Rehab under one roof provide that opportunity. Supportive Living is a separate entity that is often, in scattered sites, a catch all for persons exiting Stabilization and Rehab. Individuals continue to suffer high complexity and severity after Stabilization & Rehab with shorter lengths of stay than Community residences requiring greater support than Supportive Living can offer.
   E. Congregate Care as sole resource of funding barely allows for payment of rent on behalf of the resident, with very little left available for the services needed to support this population.
   F. Efforts to address this challenge have included utilization of Health Homes Care Managers, yet, Health Home Care Management staff ratios do not allow for the necessary attention to meet the severity of client need.
   G. In Community Billing and Outpatient Clinic Service are insufficient to meet community need financially and programmatically, especially in rural areas where In Community Billing is cost ineffective.

Request to the State:

A. Develop and implement deficit financing resource, system, structure and opportunity for Supportive Living Service.
B. Enhanced Care Management resources or reduced Care Management caseload based on severity of individuals served to assist.
C. Enhanced Community Billing rates for Supportive Living
D. Enhanced Peer Recovery Coach rates for Supportive Living
E. 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.

Additional Information since July 19 Finger Lakes RPC Board Meeting

Catholic Family Center – Supportive Living Incidents

Incident report data for our 3 Community Residences and Supportive Living, which is where many clients go after release from the 820 facilities (formerly Intensive Residential Treatment).

The two areas where there are significant increases after the change in Intensive residential are “Client under the Influence” and “Missing Client.” The 820 conversion took place on 1/1/17. Here is the incident data:

INCIDENT TYPE	2016	2017	2018 YTD
Client Under the Influence	8	24	21
Missing Client	9	21	12

No other client behavioral-related incidents have increased significantly.

Data not currently available on how many individuals in the 820s are HARP-eligible or HARP-enrolled.

FLACRA - 820 BED DAYS
July 2018

FLACRA - Maxwell Hall 820													
# of Days													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Stabilization					21	0	20						41
Rehabilitation					503	478	404						1385
Reintegration					43	78	149						270
TOTAL	0	0	0	0	567	556	573	0	0	0	0	0	1696

FLACRA - Otte 820													
# of Days													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD
Stabilization					94	27	1						122
Rehabilitation					411	546	639						1596
Reintegration					136	101	35						272
TOTAL	0	0	0	0	641	674	675	0	0	0	0	0	1990

The most important piece of data we spoke about is how 820 Residential Redesign has reduced available Community Residence (now called Reintegration) beds.

The attached illustrates that since we began tracking closely in May, the bed days for Community Residence stays decreased by up to almost 95% (remembering that the Totals indicated previously represented entirely Community Residence bed days. Therefore, most all of these individuals that were previously in Community Residence are now in Supportive Living, whereas documents submitted indicated, there are insufficient services to meet their complex needs.

FLACRA has 69 Supportive Living beds which always have a minimum of a one month's wait to get into.

Finally, while I do not have exact details, as it relates to meeting High Acuity for reasonable Health Home care Management Caseloads or HCBS/HARP Services, less than half are eligible, and with still transitioning through difficult and new requirements, half of those are not enrolled.

OASAS Total Beds & Supportive Living Data

Yearly break-down: 819/820 beds- Finger Lakes RPC Region

Year	819 Intensive Residential	819 Community Residence	819 Supportive Living	820 Residential Services	Total # Beds
2015	67	234	271	0	572
2016	67	236	271	0	574
2017	0	236	277	67	580
2018	0	182	289	109	580

819 Supportive Living Bed Data - Finger Lakes RPC Region

Year	Utilization (90% standard)	1-month retention rate (85% standard)	3- month retention rate (75% standard)	6- month retention rate (55% standard)
2016	82.5%	91.75%	83.88%	63%
2017	78.09%	93%	77.33%	63.67%
2018	79.72%	93.11%	82%	69.22%

Data sourced from NYS OASAS Western Regional Office – September 2018

Year of service	# of Clients Served	Level of care no longer neede d	D/C due to client arrest	Client death	D/C due to illegal sub use	D/C due to non compliance	Left against clinical advice
2016	322	42.06%	4.35%	1.69%	NA- this option not available on report	34.34%	7.21%
2017	409	46.91%	3.61%	1.32%	4.37%	21%	10.34%
2018 (Jan-Sept)	264	49.21%	2.62%	.19%	6.08%	16.88%	7.11%

819 Supportive Living Disposition Data - Finger Lakes RPC Region

Please note that in 2016, 1 supportive living program's data was unavailable.
Data sourced from NYS OASAS Western Regional Office – September 2018

SUD Clients Eligible for HCBS Services?

During the July meeting, there had extensive discussion regarding whether HCBS services could be more intensively used to support people as they go to the supportive living sites. It is not known how many people who leave 820 sites to go to supportive living are HARP eligible and there was uncertainty regarding SUD clients without SMI diagnoses are even eligible for HARP.

OMH provided the details of the HARP eligibility criteria, frequently referred to as the "HARP algorithm." There are, in fact, several qualifying criteria based on clients' SUD episodes of care:

- Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
- Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
- Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.
- Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.

The complete criteria can be found at the end of this document.

SUD Clients Eligible for Health Home Plus Care Management?

For those not eligible for HARP/HCBS, the question was raised whether they might be eligible for the new more intensive Health Home Plus care management services.

Adele Gorges of HHUNY reports that, for individuals with an SUD diagnosis but not a Serious Mental Illness, they are not eligible for Health Home Plus. They would be eligible for a different level of Health Home Care Management if they have an SUD diagnosis along with a second qualifying chronic condition, and meet the risk requirement. There are two levels for which they could be eligible.

There was also a question about someone in Supportive Housing and whether or not they would be eligible for Health Home Care Management. They are possibly eligible if their housing situation is one in which Medicaid is NOT billed for care management services. Note that it is sometimes the case that a housing program is required to provide care management within the rate paid by Medicaid for the housing program.

The *"HARP ALGORITHM"* is the phrase commonly used to describe the periodic computerized identification from claims data of HARP eligible individuals using the following criteria. These criteria are taken from pages 18-19 of the New York State managed Medicaid RFQ. The full RFQ can be found at:
NEW YORK REQUEST FOR QUALIFICATIONS FOR BEHAVIORAL HEALTH BENEFIT ADMINISTRATION
https://www.omh.ny.gov/omhweb/bho/rest-of-state-final-rfq.pdf

HARP Target Criteria: The State of New York has chosen to define HARP targeting criteria as:

i. Medicaid enrolled individuals 21 and over; *and*
ii. SMI/SUD diagnoses; *and*
iii. Eligible to be enrolled in Mainstream MCOs*; and*
iv. Not Medicaid/Medicare enrolled ("duals"); *and*
v. Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

HARP Risk Factors: For individuals meeting the targeting criteria, the HARP Risk Factor criteria include *any* of the following:

i. Supplemental Security Income (SSI) individuals who received an "organized" MH service* in the year prior to enrollment.
ii. Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
iii. SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
iv. SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
v. SSI and non-SSI individuals discharged from an OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
vi. SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
vii. SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to enrollment.
viii. Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.
ix. Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
x. Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
xi. Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.
xii. Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.
xiii. xiii. Individuals transitioning with a history of involvement in children's services (e.g., RTF, HCBS, B2H waiver, RSSY).

*An "organized" MH service is one which is licensed by the NYS Office of Mental Health.

Finger Lakes Regional Planning Consortium

Clinical Integration Workgroup Meeting – August 22, 2018

St. Bernard's, 1pm – 3pm

MEETING SUMMARY

1. Welcome and Introductions

2. Helio Health Presentation re Clinical Integration

Presenters: Lisa Mancini, Chief Clinical Officer

Kathi Meadows, Outpatient Division Director

Group received presentation regarding Helio Health's clinical integration efforts.

LICENSE – Began with separate SUD and MH clinics, then became Integrated Outpatient Clinic and now are CCBHC with 24/7 Open Access
PATIENT CHART – All records are maintained together in one chart
STAFF – Staff are interspersed with persons with varying disciplines
CASE CONFERENCES – Providing open case conferences for all staff
INTAKE PROCESS – One point of entry for all persons seeking treatment
TREATMENT SERVICES – Patients are able to access all treatment services throughout their treatment

SCREENINGS

- BMI
- Communicable Disease
- TBI Questionnaire
- Alcohol Screening
- Tobacco Screening
- Patients with Schizophrenia and Bi-Polar are screened for cardiovascular disease and diabetes

See attached presentation for more detailed information. Extensive questions and discussions, great appreciation from group for information.

3. Educational Symposium Planning Update

- **Scheduling Conflict**

  Beth reported that there is a major clinical integration conference scheduled in Rochester this fall: "Innovations in Integration: Solutions for Healthcare Reform," presented by the Collaborative Family Healthcare Association (CFHA). Group was asked to determine if this posed a sufficient enough conflict to affect the projected date of its planned event. It was agreed to defer event to the early-mid spring.

- **Site Discussions – St. John Fisher**

  Beth met with the Dean of Nursing at St. John Fisher College and they are interested in collaborating to present this event at their facilities. Dates and projected audience size will be considerations that will be explored to determine if this is a viable venue.

- **Activities for Planning Group**

  i. Establish Planning Group

  For event planning to proceed, Beth is requesting volunteers for a small planning group to work on details in between workgroup meetings. Josh Maldonado, Melissa Wendland and Ellen Hey volunteered to be part of this group.

  ii. Finalize Date & Venue – in process

  iii. Confirm Identified Speakers – will be confirmed as date is solidified
    1. Legal - Melissa Zambri, partner with Barclay Damon LLP. She is considered a HIPAA guru. Profile attached.
    2. Clinical – Andrew Philip Ph.D., Deputy Director of Integration at National Council for Behavioral Health. Profile attached.

  iv. Determine Other Sessions – planning group will develop
    1. RHIO for BH Providers
    2. Culture of Information Sharing – PCP & BH
       a. Informal Facilitated Groups or Panel Presentation?

  v. Pursue CEU's – Beth will contact hospital partners to ID sponsor and submission timeline

vi. Brochure & Communications – planning group will develop
vii. Funding – as plans are finalized, Beth will determine budget and reach out to partners for support

4. Next steps

Rochester Regional Health will present on their clinical integration efforts at next meeting

Beth will schedule Event Planning Group meeting

Project Teach Discussion – Joe Stankaitis suggested that David Kaye be contacted to determine the level of our region's participation in use of the resource.

Finger Lakes Regional Planning Consortium
DCS Group – Issue Development Discussion

DCS Monthly Meeting – June 22, 2018

Present: Jim Haitz, George Roets, Hank Chapman, Margaret Morse, Dave Putney, Beth White

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The DCS Group decided to develop one of the issues approved by the Board in February:

Needed Expansion of Eligible BH Billable Provider Categories – the group focused on the inability of Physician Assistants (PA's) to be able to assess and prescribe in MH Clinics

Discussion

DOH defines the scope of practice for these practitioners, including their ability to prescribe medications, and the manner in which supervision is required.

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

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.

D. Supervision

A physician assistant works under the supervision of a licensed physician who is responsible for the physician assistant's performance as well as the overall care of the patient. The physician assistant may have more than one supervising physician; however, there must be one clearly designated supervising physician who is available at any one time.

In New York State, a physician may employ or supervise no more than four PAs in the physician's practice; in a correctional facility, no more than six PAs; and, in a facility licensed pursuant to PHL Article 28, no more than six PAs. Physicians are not required by law to notify the State Education Department which PAs they employ or supervise.

The supervising physician may delegate to the PA any clinical functions within that physician's scope of practice providing the PA is appropriately trained and experienced to perform those functions. The physician assistant is subject to the limitations set by the supervising physician and to the policies of the employing institution, in addition to state laws, rules, and regulations.

Finger Lakes Regional Planning Consortium
DCS Group – Issue Development Discussion – cont'd.

DCS Monthly Meeting – June 22, 2018

OMH imposes significant hurdles, requiring additional experience and completion of an OMH waiver process order for PA's to fully practice and *prescribe medications*. These requirements aren't needed in other settings. Why does OMH need to impose these extra requirements, particularly given the shortage of psychiatrists and NP's who can prescribe?

OMH documents mention that a waiver can be obtained from the commissioner for the PA to perform psychiatric assessment and medication management, with the requirement for "specialized training." Nothing can be found that defines that specialized training. Reference has been made to the specialized training being 2 years of psychiatric experience. The problem is….how do they get that experience if you can't hire them to practice in their licensed profession? Yes, there are specialized medications used in behavioral health clinics and it is a serious responsibility to prescribe them, but no more so in the behavioral health discipline that in cardiology or any other medical specialty. The supervising physicians perform their oversight responsibilities always with the amount of the midlevel practitioner's knowledge and experience in mind.

It is not feasible for clinics to hire PA's to do less than what the NYS Education Dept. has defined as their authorized scope of practice. They are well paid and it compromises the financial viability of the clinics to have them work in a diminished capacity for 2 years before one can even apply for a waiver.
An analogy to this would be to require clinics to hire an LCSW in an OMH licensed clinic, but prohibit that LCSW from assessing and diagnosing until they first have 2 years of experience - despite the fact that their NYS LCSW scope of practice permits these clinical functions.

The PA must be supervised by the psychiatrist and is a dependent practitioner who can prescribe under NYS Education law & DOH. It should not be necessary to obtain a waiver for something that is already allowed under law and within the professionals licensed scope of practice, and widely permitted throughout NY in many other medical specialties.

Request to the State:

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

Additional Information since July 19 Finger Lakes RPC Board Meeting

Contact has been made with the head of RIT's Physician Assistant program. She was shocked and unhappy to learn that OMH restricts PA's practice and reported that, to her knowledge, no other medical specialty imposes similar restrictions. She noted the irony that PA students do rotations in mental health clinics, so MH clinics help educate these practitioners only for them to go on to other sites due to the restrictions placed on them in the MH clinics.

The Finger Lakes DCS group discussed this topic again in their most recent monthly meeting and decided to write a letter to the Commissioner of OMH regarding this issue.

Finger Lakes Regional Planning Consortium

Workgroup Meeting - Education re Peer Specialist Role - Aug 27, 2018

Ontario County Training Facility, 1pm – 3:00pm

MEETING SUMMARY

1. Welcome and Introductions

Beth welcomed everyone, and people introduced themselves.

2. Info for RPC Newcomers

For those new to RPC activities, Beth gave a brief overview of the RPC and its purpose.

3. Why are We Here?

Beth explained that the RPC Board had identified an issue that there was confusion regarding the role and activities of peer specialist employed by mental health programs. This group is charged with exploring the value and development of education for employers and coworkers regarding the role of peer specialists in treatment programs.

Recruitment Challenges

- At the last meeting, participants had wanted to discuss peer recruitment challenges, but time ran out before the topic could be addressed. Group identified multiple challenges:
- Hard to find peers with one year of recovery who have the required experience working in licensed settings
- Existence of felonies and/or CPS involvement can exclude peers from certain settings.
- Not having a driver's license is significant issue, particularly difficult in rural areas. It was noted that Access VR can assist peers in getting a license.
- There was discussion about how transportation is not just an issue for peers and that a coalition of MH and Aging Services stakeholders is working on this issue. In Rochester, Lyft and Uber are being used.
- OASAS certification process is expensive for peers. It was reported that OASAS has scholarships and pays fees for certain recertification activities. Detailed Information is available here.
- Many peers found to lack basic technology skills, requiring significant support and training.
- Different processes exist for MH Peer Specialists and OASAS Recovery Peer Advocates. There were questions about what the common activities would/should be.

Rank most critical issues identified in last meeting

1. Training Needed for Supervisors
2. Standards for Supervision of Peers
3. Generic Job Description that can be Used for all Peer Positions
4. Develop Competency Standards for Organizations Employing Peers
5. Create a regional model/template for contracting with peer-run organizations and CBO's with experience developing, managing and evaluating peer run programs.
6. Regional approach needed for training supervision and ethics so that peers working in programs can thrive.
7. Staff education needed regarding the value that peer coworkers bring to treatment programs.
8. Opportunities for peer to peer support
9. Creation of a training and development process for peer positions, including workgroups that include peers

Group participated in activity to rank the above issues in order of priority to be addressed. The three top ranked issues were:

1. Develop Competency Standards for Organizations Employing Peers
2. Create a regional model/template for contracting with peer-run organizations and CBO's with experience developing, managing and evaluating peer run programs.
3. Staff education needed regarding the value that peer coworkers bring to treatment programs.

4. Breakout Groups

Prior to breaking out, workgroup discussed if each breakout group will address all three action items or if each group will focus on single issue. Decision was for groups to each focus on one issue, with the people voting for each issue in that respective breakout group.

Groups charged to discuss and identify Action Steps for workgroup to take to address the top three ranked items.

5. Break Out Groups Report

Group #1: *Develop Competency Standards for Organizations Employing Peers* – Sara Passamonte

- Development of non-regulatory guidelines for hiring and supervisory practices related to peers
- Bring available resources to light. Many resources available – explore how to have organizations know about and use them to best advantage.

- Have mandatory training required of all organizations seeking to employ peers. The required training should be basic and pertain to all org's, with inclusion of specialized content specific to the setting/peer role.

Group #2: *Create a regional model/template for contracting with peer-run organizations and CBO's with experience developing, managing and evaluating peer run programs.* – Melissa Wendland

- Convene peer run CBO's to discuss resources each could bring to the table regarding contracting, i.e. MOU, MCO contracting, infrastructure.
- Develop MOU amongst these peer-run CBO's regarding areas of mutual interest and ways in which they can best support one another's work.
- Have this group develop their Value Statement.

Group #3: *Staff education needed regarding the value that peer coworkers bring to treatment programs* – Kris Amos

- Ongoing training from executive level on down through the organization, to ensure that the knowledge and organizational commitment is ongoing throughout inevitable staff changes.
- Update definition of current peer roles.
- Require organizational readiness for hired peers – don't just hire them and plug them into various random roles. Have appropriate roles defined and referenced during hiring and orientation process for peer, supervisor and program team.

6. Next Steps

At next meeting, group will discuss which of the above recommendations to address first and how best to tackle them.

Draft September 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 and are representative of the RPC stakeholders. The Board identifies, researches, prioritizes, and initiates the due diligence process for identified issues, determines 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 _______________ RPC shall be comprised of members as prescribed by the NYS Regional Planning Consortium initiative and shall follow its directives regarding election of members for each stakeholder group.

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 (6th) seat as a rural or other designation as deemed appropriate by the region. Any organization providing Medicaid billable services and are licensed 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

Co-Chairs

Each RPC Board will be facilitated and lead by two RPC Co-Chairs. One Co-Chair is a Director of Community Services (DCS) and selected by the regional DCSs. The other Co-Chair 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 Co-Chair is self-nominated and elected by voting Board members.

Co-chair 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 development, due diligence 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 Co-Chair counterpart and RPC Coordinator.
- Develop/organize in concert with co-chair and RPC coordinator the Board's meeting agenda.
- Attend and participate in the RPC Co-Chairs 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 Co-Chairs, 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 Co-Chairs 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 with the due diligence process for submission of recommendations and ideas.

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>Co-Chairs</u>

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

- Co-Chairs 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 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 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 Co-Chair.
- 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.
  - Co-Chairs 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
- 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.

Article VI: Collaborative Governance

A collaboration between committed regional stakeholders, the NYS Office of Mental Health (OMH), Department of Health (DOH) and Office of Substance Abuse Services (OASAS) in common forum to engage in consensus oriented solution seeking, problem solving and decision-making in order to leverage and build on the unique attributes, expertise and resources of each for the betterment of the NYS Medicaid Managed Care System.

(Note to Board: the above definition of Collaborative Governance differs from that of the original RPC model. The language in the box is the original definition of Collaborative Governance).

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*

Consensus Decision Making:

- 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 Regional Planning Consortium

HHSP Stakeholder Meeting – Issue Development – June 26, 2018

Present: Jill Graziano, Adele Gorges, Ellen Hey, Mary Vosburgh, Beth White

Rochester Regional Health shared its experience implementing telemedicine over the last year. They are pursuing this technology to increase prescriber access, improve efficiency, and better match existing supply of prescribers with customer demand across a broad geographical footprint. Further, there is an ongoing shortage of prescribers as described by the Local Governmental Units (LGUs), Community Based Organizations (CBOs), and health systems. In order to meet the needs of our customers, increased efficiency using technology is an imperative.

While many challenges existed in the implementation process, the issues identified by the group as most critical are:

Staffing; OMH not permitting LCSW's to deliver billable services via telemedicine

Coverage: Variability among payers regarding reimbursement for telepsychiatry

Staffing: Clinical differences identified are NYS OASAS allows all licensed clinicians to perform assessments and evaluations (so it includes social workers) while NYS OMH guidelines allow for physicians, psychiatrists and nurse practitioners only. This variation provides flexibility in service delivery model, permitting various types of clinical staff to utilize telehealth to meet community needs. While NYS OMH reports the plan to permit telepsychiatry for additional clinical staff members, no additional guidance has been received. NYS OASAS also mandates that prescriber be present in person for initial MAT assessment/evaluation while OMH does not have a restriction on in-person first visits for mental health care. Tech variations are described above.

Coverage: While telepsych is approved as equivalent to face-to-face with psychiatrist per CMS, not all payers reimburse for these services (i.e. Optum currently will not reimburse for tele-psych, which is being challenged at this time). The health system is working on getting answers from payers as to whether or not they cover the services for both OMH and OASAS tele-practice.

How Timothy's Law enters into this scenario is unclear. If a payer offers telemedicine for other disciplines of care, shouldn't they also be required to offer it for behavioral health services?

Recommendations to State:

Permit LCSW's and other licensed BH providers to deliver services via telemedicine.

Require all MCO's who utilize telemedicine to authorize it for behavioral health services.

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

Additional Information since July 19 Finger Lakes RPC Board Meeting

Reference has been made to there being new legislative action regarding telemedicine regulations. The Conference of Local Mental Hygiene directors summarized the changes:

Telehealth -The Enacted Budget expands the use of telehealth by including special needs and additional OASAS & OPWDD providers.

• Includes hospitals serving special needs populations; OASAS Credentialed Alcoholism and Substance Abuse Counselors (CASAC); Early Intervention providers; Article 16 clinics, and certified and non-certified day and residential programs operated by OPWDD

• Includes interactive queries conducted through communication technologies or by telephone as remote patient monitoring

• Requires DOH, OMH, OASAS and OPWDD to coordinate on the issuance of a single guidance document that outlines each agency's regulations or policies including reimbursement to address barriers to care.

Regarding questions that have arisen regarding private payers' requirements to cover telemedicine services, the following information was found:

NY State Law Private Payers

A health plan shall not exclude from coverage services that are provided via telehealth if they would otherwise be covered under a policy. Telehealth means the use of electronic information and communications technologies by a health care provider to deliver health services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located.
Source: ***NY Insurance Law Article 32, Section 3217-h.***

Above Information sourced from the Center for Connected Health Policy
http://www.cchpca.org/jurisdiction/new-york

DOH

November 20, 2015 29

Telehealth Provider Definition

- Providers eligible for reimbursement include:
  - Physician
  - Physician Assistant
  - Dentist
  - Nurse Practitioner
  - Podiatrist
  - Optometrist
  - Psychologist
  - Social Worker
  - Speech Pathologist
  - Audiologist
  - Midwife
  - Certified Diabetes Educator
  - Certified Asthma Educator
  - Genetic Counselor
  - Hospital
  - Home Care
  - Hospice
  - Registered Nurse, only when receiving data by means of RPM
  - Any other provider as determined by the Commissioner pursuant to regulation

CURRENT OMH

§ 596.4 Definitions.

(g) *Practitioner* means a physician or nurse practitioner in psychiatry who is providing telepsychiatry services from a distant or hub site in accordance with the provisions of this Part.

§ 596.5 Approval to Utilize Telepsychiatry Services.

(a) Telepsychiatry services may be authorized by the Office for assessment and treatment services provided by physicians or nurse practitioners, as defined in Section 596.4 of this Part, from a site distant from the location of a patient, where the patient is physically located at an originating/spoke site licensed by the Office, and the physician or nurse practitioner is physically located at a distant/hub site.

Above information sourced from Rochester Regional Presentation to FLPPS - 2017

Finger Lakes Regional Planning Consortium

Workgroup Meeting – SUD Bed Coordination – August 15, 2018

Wood Library, Canandaigua, 1 – 3pm

MEETING SUMARY

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1. Welcome and Introductions

2. Why are We Here?

For those new to the RPC's activities, Beth gave a brief overview of the purpose of the RPC. Workgroups are established when specific issues are identified and participants agree that regional collaboration may result in solutions or system improvements. This workgroup was established when the Finger Lakes Consortium of Alcohol and Substance Abuse Services asked the RPC to determine if regional coordination might result in more effective access to and utilization of SUD beds in the area.

3. Review Survey Responses (attachment)

Based on prior group discussions, a survey was sent to 15 OASAS licensed programs to gather information regarding the process for accessing their beds. Though only 6 programs completed the survey, these programs represented a broad cross section of bed types. Beth reviewed the results of the survey with the group.

Majority of survey respondents expressed interest in participating in pilot addressing better ways to receive information re bed availability.

4. Rochester Regional Health – Demo of beta web resource for SUD Bed Information

Joe Majauskas and Amy O'Keefe previewed a WordPress designed website that would allow people looking for SUD beds to receive more current and sortable information than is currently available. They will be putting it in place for their system's beds and have brought it to the group to see if it would be of interest to be used by other/all bedded programs in the area.

Extensive discussion touched on the following items:

- Website projected to be updated 3 times per day
- Identification of Key Info needed on site – Date & time of Update, gender of Beds, Hours Open for Admission, Beds on Hold as well as open
- Pop Up's could describe admission process for each facility
- Discussion of OASAS Site and their potential reaction to this site
- Public should be able to view site
- Solution might be scalable and able to eventually include OP program slots
- Alerts re newly available beds may be possible
- Excellus willing to help with training/webinar creation for providers/users
- Some wondered if providers would keep this updated any better than they do the OASAS website. Discussed the incentives for use of a more user friendly and timely method.
- If pilot is successful, it was suggested that OASAS be approached with a waiver request relieving participating providers from having to update the OASAS website. Noted that there would need to be an indicator there linking to the regional website.
- The group acknowledged OASAS' efforts to provide this type of information on their website, but consensus was that the State's sites are based on outdated technology with no timeline for change to more productive and user friendly platforms.

Group was generally in favor of pursuing this possibility in the form of a pilot. Beth will meet with Amy and Joe before the next workgroup meeting to look at workflow for potential implementation.

5. Review/Discuss Barriers Identified in Mapping Process (attachment)

During the May 22 meeting, the group had performed a system mapping process, led by Nathan Franus. The result of that exercise was the identification of some of the barriers to effective bed utilization. Beth asked the group to select one of the barriers that the group feels it could address and discuss how to approach finding solutions.

The issue of "Over-Referrals" was selected. Highlights of the discussion:

- The survey results showed that many people put on programs' waitlists are never admitted to the program. There is a tremendous amount of activity fielding requests and assessing people to the point needed to enter them onto the waitlist.

- Too many providers, clients and families believe that detox is needed when, clinically, it may not be the appropriate level of care.

- Some people are going on waitlists too soon as the result of providers attempting to plan for the next level of care.
- Providers must have contingency plan for times when they do not get "the" bed that they want for their client. This leads to multiple referrals.
- One residential provider shared that they include "education" and guidance in their referral form to attempt to mitigate the over-referral activity.
- Need Community Education
- Need Provider Education

6. Next Steps

Beth will meet with RRH staff re workflow for pilot.
At next meeting, group will discus how to begin to address "over-referrals."