FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

AGENDA

July 19, 2018 1pm-4pm

Ontario County Training Facility, Canandaigua

1:00 – 1:10pm

1. **Call to Order & Welcome** — **George Roets**
2. **New Board Members** — **George Roets**
    a. **MCO – Curt Swanson, MVP Health Plan**
3. **Introductions (Name, stakeholder group, agency/organization)** — **Board & Guests**
4. **Youth Advocate Nominee – Julie Vincent** — **George Roets**

1:10 – 1:50pm

Stakeholder Group Meeting Reports — **Beth White**
- a. **HHSP** — **Ellen Hey**
- b. **Peer/Family/Youth** — **Keisha Nankoosingh**
- c. **CBO** — **Marty Teller & Sally Partner**
- d. **DCS** — **Jim Haitz**

1:50 – 2:30

Breakout Groups to Assess Issues — **Beth White**

2:30 – 2:40pm: Break — **All**

2:40 – 3:45pm

1. **Breakout Group Reports** — **Beth White**
2. **Next Steps in Issues Development Process** — **Beth White**
3. **Vote or Continue to September Meeting** — **All Voting Stakeholder Groups**

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

*Rescheduled from original date of May 4th

CoChairs Meeting in Albany
April - CoChairs Meeting
October - 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.

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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**

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

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

[redacted]

FINGER LAKES REGIONAL PLANNING CONSORTIUM - BOARD OF DIRECTORS MEETING – VOLUNTARY MEETING

BOARD MEMBERS SIGN IN - JULY 22, 2018

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NO GUESTS

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	
CBO	Martin Teller	
CBO	Jodi Walker	
CBO	Greg Soehner	
CBO	Chacku Mathai	
CBO	Jeannine Struble	
Peer	Jennifer Storch	
Peer	Keisha Nankoosingh	
Family	Sue Mustard	
Family	Ken Sayres	
Youth	TBD	
Youth	TBD	
HHSP	Jill Graziano	
HHSP	Carole Farley-Toombs	
HHSP	Mary Vosburgh	
HHSP	Mike Leary	
HHSP	Ellen Hey	
HHSP	Adele Gorges	

Group	Name	Sign In
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KEY PARTNER	Kathy Muller	
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KEY PARTNER	Sahar Elezabi	
KEY PARTNER	Melissa Wendland	
KEY PARTNER	Jon Miller	

Finger Lakes Regional Planning Consortium

Issues Referred to April 24, 2018 Albany CoChairs Meeting

Approved at the Finger Lakes RPC Board of Directors meeting on February 9, 2018, the following four issues were referred to the Albany CoChairs meeting scheduled for April 24th.

ISSUE	RECOMMENDATIONS
Sharing of Clinical Information between Behavioral Health Providers, Medical Providers and MCO's	1) Develop and deliver training for all providers with actual case scenarios that show how the various regulations apply, and how information can be appropriately shared. 2) FAQ that can be distributed as a reference sheet for providers with information that has been approved by OMH, OASAS and DOH.
Needed Expansion of Eligible BH Billable Provider Categories: this will increase critically needed access to multidisciplinary treatment services and help with recruitment efforts and workforce development.	1) Licensing authorities and regulatory oversight entities should come together to expand the array and types of professional providers, while adhering to professional standards. 2) Examine the issues/barriers that institutions may have ensconced as practice regarding hiring various professionals.
FQHC Co-location restrictions are a barrier to clinical integration efforts. The regs released by DOH in October 2016 prohibit FQHC's from co-locating and/or sharing staff with a behavioral health program during normal business hours without a separate entrance.	Remove this restriction.
Health Home Engagement Challenges	Reduce the redundancies and inefficiencies in the health home assessment and HCBS referral process

Finger Lakes Regional Planning Consortium

HHSP Stakeholder Meeting – Issue Development – June 26, 2018

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

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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.

Finger Lakes Regional Planning Consortium
PFY Stakeholder Group
Issue Development Discussion – July 13, 2018

Present: Keisha Nankoosingh, Sue Mustard, Ken Sayres, Jennifer Storch, Beth White

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The PFY group reviewed the available options for issue development:

- Select any issue(s) approved by the Board in February for further development
- Select any recently identified new issue(s) for further development
- Bring forward a new issue

The group opted to discuss and contribute to the two new issues that have recently been identified:

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

Discussion

One of the system challenges that the group noted that could be impacting the residential issue is that, as clients move through different parts of the system, they can "lose" their peer advocates. Given that the role of the peer is to help people through the various stages of change as they pursue their recovery, this loss works against the stated role of the peer.

There was detailed discussion about the fact that, while in rehabilitation level of 820 programs, clients cannot go into the community unescorted. For them to go from this level of structure to the almost completely unstructured setting of supportive living is jarring and less than optimal for good community reintegration. In addition to changes that may be requested of the State regarding the structure and/or funding of supportive living settings, the group felt that there are some opportunities to locally address the issue:

1. Increase staff capacity to escort clients on community visits with peers to begin the process of community reintegration before they transition to the supportive living setting.

2. Explore possibility of MCO's funding the 820 programs' peer services to clients for 2-3 months post discharge as a means of continuity and additional support.

3. Explore possibility of MCO's employing peers to work as transition supports to clients as they move from one setting to another in the system.

4. Aggressively incorporate the consideration and referral to HCBS services early in the 820 program's discharge planning process.

Finger Lakes Regional Planning Consortium
PFY Stakeholder Group
Issue Development Discussion – July 13, 2018

Regarding the telepsychiatry topic, the group was curious to know how equipment would be provided to clients who used this service in their homes, and what support they would receive in using it. Can/will clinicians provide this support?

Request to the State:

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.

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

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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.

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

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.

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.