Date / Time of Meeting	September 7, 2018 10:00 AM – 2:00 PM Dial in: 866-906-9888 Access code: 7258371 Conference Room: 3A, 450 W State St, Boise
Meeting Purpose	Interagency Governance Team
Host	Treena Clark, Division of Behavioral Health

Voting Members	Att'd		Voting Members	Att'd		Participant	Att'd
Ross Edmunds – DBH			Lael Hansen – County Juvenile Justice	X		Cindy Day – DBH	X
Candace Falsetti – DBH	X		Lynn Thompson – DBH/CMH	X		David Welsh – Medicaid	
Carol Dixon – Advocate			Maria McConnell – Advocate			Holly Riker – DBH	
Dave Sorensen – Provider	X		Matt McCarter – State Dept. of Ed	X		Lynn Thull - Consultant	
Kim Hokanson – Parent	X		Matt Wimmer – Medicaid	X		Venecia Anderson – Medicaid	
George Gutierrez – Medicaid	X		Michelle Weir - FACS			Rhonda House – DBH	X
Jason Stone – IDJC	X		Roxanne Printz – FACS			Tiffany Kinzler – Medicaid	
Jennifer Griffis – Parent	X		Vanessa Morgan – Parent	X		Treena Clark – DBH	X
			Pat Martelle – St. Luke's	X		Valorie Leirmann – DBH	
						Suzette Driscoll – Medicaid	X
						Cameron Gilliland – DD	
						Sabrina Griffis – Youth	X
						Ruth York – Idaho Federation of Families	X
						Brady Nixon – Optum	x

AGENDA

#	Time	Length	Topic	Topic Owner	Discussion	Decisions
1	**8:00 a.m.**	**120 min**	Subcommittee Breakouts	Carol Dixon Kim Hokanson	Notes documented separately.	
2	**10:00 a.m.**	**5 min**	Welcome and Roll Call Approve minutes from last meeting	Dave Sorensen		Notes from last meeting were accepted as written.
3	**10:05 a.m.**	**5 min**	Review Follow Up Items	Treena Clark	RASCI chart action item to be discussed later in this meeting.	

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					The provider subcommittee is still waiting on the statement of purpose. The QMIA Council has not yet reviewed the statement, but the recommendation is that it does not meet the QMIA plan. The QMIA plan was to identify problems with the way things were currently working, which was not the target of that subcommittee, though it may arise there. The determination will be made if the provider subcommittee is still necessary.	
4	**10:10 a.m.**	**20 min**	Centralized Complaints Update	Candace Falsetti	According to the Settlement Agreement, a centralized complaints process is required. The proposal is that there be a short-term proposal and a long-term solution. The short-term solution is to utilize the methods already in place at each agency and enhance them as possible. A cross-system subcommittee would be used to identify barriers and develop improvements. Parent involvement is already being included in addressing complaints. A complaint report including information from each system is being drafted. The long-term solution the goal is to look at having a single door contract entity to handle incoming complaints and acting as a navigator to help the family through the process. This will involve budget, contracting, and evaluating potential changes to rule. Complaints are coming in to DBH currently, and they are being addressed by Candace's team. A report is being shared with Jennifer (parents) and it has been very helpful. Early trends are being able to be identified – regional struggles have been an early example. It is important to recognize that this is not a centralized process at this time and is currently just focused on DBH specific issues.	Early trends identified through the centralized complaints have been requested to be brought to the IGT for review.

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					The biggest challenge currently is the issue that it is not yet centralized. Issues that have already been identified are currently being worked on through QMIA. Feedback Received to Date: Medicaid is currently looking at their short-term options and considering the federal regulations that are applicable to contractors. Feedback is also being taken back to QMIA regularly. Early trends identified through the centralized complaints have been requested to be brought to the IGT for review. Information could be included for the IGT in the quarterly reports. Another option would be to send a copy of the current complaint report that goes to the parents to the IGT as well. Resolutions will likely come out of the QMIA subcommittee. It would also be helpful to identify trends by region as well. It would be helpful to bring cross system trends to the IGT specifically.	
5	**10:30 a.m.**	**15 min**	Medicaid/DBH Update on PCP and Case Management	Dave Sorensen	George shared that, based on some of the feedback that had been received, additional options to incorporate new recommendations are being considered. Ways of utilizing the current provider network to do PCP and Case Management are being considered. At this point in time, details cannot be deeply discussed in the event that this goes forward for a contract bid.	

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					Case Management has been currently launched under the Optum network. The transformation to the new requirements is targeted for March 1. In terms of PCP, Candace shared that we have received 914 referred. It is currently taking an average of 64 days from start to finish, though this timeline has improved recently. The range has been between 12 and 50 in a week for referrals. Average is 5 or 6 referrals for PCPs each day. A huge majority have come from region 7. The number approved each week has also improved and is currently at about 30 each week. The hold-up has been scheduling, and that is improving. The question was asked why region 7 was seeing such high numbers, and that region serves more children in general in comparison to the other regions. There are substantially more resources available in region 7. Historically, respite has been highly utilized in this region as well. Total number of children and youth served in 2018 was approximately 2400, with about 25% of those coming through the court system. Suzette shared that on the current PCP document, a lot of feedback and lessons learned are being absorbed and a new template is likely to be rolled out in the near future that is much improved. This is close to being finished.	
6	**10:45 a.m.**	**10 min**	Proposed Statute and Rule Changes for the 2019 Legislative Session	Treena Clark	The CMH Rule is being updated to remove the Axis 1 language and replacing it with mental health. The question was asked if it should read DSM 5, as there will be a newer version in the near	

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					future, and yes, it is required to include a version. The rule concerning the requirement to report parents to Child Support is being removed. Alternate methods of incorporating the child support formulary are also being considered for addition. The question was asked why the initial language was included stating that parents would not be charged more than the actual cost, and it is really to protect the parents. The CMH Act is being updated so that the definition of serious emotional disturbance is more in line with the definition being used everywhere else. Additional language is being included to help standardize the CANS. The question was asked if there was anticipated pushback on these changes, and at this point in time there has not been. Jennifer shared that it is important from a parent perspective that it be understood it's not about the money, but more about the court cases. Medicaid has two rule dockets that are YES related coming up in this session. Draft documents have been sent to Cindy and can be shared. Language is being changed in the school-based services to make rule language compliant with YES requirements. CBRS requirements are also being updated so that they are the same. The other docket is in regards to the 1915i requirements in assessing eligibility. This would provide the groundwork to allow that if	

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					compliance with the requirements are not met, eligibility can be rescinded. Medicaid has public hearing scheduled for both in October at the Elder Medicaid office. SDE has done a lot to inform the districts about YES, and have sent out documents and electronic links as well and has received a lot of interest back.	
7	**10:55 a.m.**	**20 min**	TCOM Implementation	Candace Falsetti	Transformational Collaborative Outcomes Management must happen at every level of the system, and that is why it comes to the IGT. Candace provided an example of how an overall rating is obtained for services and create the shared vision, which is integral to the TCOM process. There are multiple phases throughout the TCOM implementation plan, and progress is being made through these. One of the aspects of the exploration phase of the TCOM implementation is ensuring that TCOM training is provided for the appropriate YES system partners and stakeholders, which would include the IGT. The TCOM suite of reports may be something to have as a future IGT item for review and further discussion. Candace will bring TCOM status updates to the IGT on at least a quarterly basis going forward. Work with Praed, the QMIA Council, and others will continue through these phases. The numbers in the second column are tied to a Praed document that helped identify where the	

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					accomplishments are within the process of TCOM implementation. The training that was provided early on was very good, though not attended well. Discussions in the clinical and training subcommittee involved the idea that this training should be replicated with a better explanation of who should attend. Along these lines, a TCOM conference, supported by Praed, will be coming up here in May. This will include training aimed at providers including information about how to build TCOM into your services. There are only 150 seats available for the TCOM conference here, so this will just be a start for training, as parents, providers will both want to attend. The exploration phase is mostly finished and work is currently being done on the second and third phases.	
8	**11:15 a.m.**	**15 min**	YES Implementation: Provider Experience	Dave Sorensen	The question was asked if there was still a provider feedback group being put together. Some written concerns have come in from providers, but no other major input has come in to DBH. Optum shared that they receive a lot of questions and feedback through their YES inbox and they review them and make changes as possible. These are often very specific about CANS. Dave S. shared that one of the things that has been noticed by providers is that communication is not consistent from all parts of the system and it is resulting in miscommunication being shared, even from region to region. This has been shared with Optum as well. As an example, in an audit, an agency was audited on a certain service definition, being	Dave S. will share examples of these issues with Suzette/Medicaid. Waiting list issues, including type of service and area, are to be brought to the attention of Medicaid.

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					told one thing, and in a different region, they were told the complete opposite, even though it was the same case management service. One of the challenges is that providers may be going to different sources and should be directed to Optum for information. As an example, a training was attended where partially inaccurate YES information was presented, and corrected on site, causing concern. It has also been noticed that there are inconsistencies with the provider manuals and materials, which causes concern, because ultimately, the provider is held accountable for that information. Medicaid and Optum are reviewing documents on a daily basis as they are aware of this issue. As the Practice Manual is being worked on there is constant cross-walking being done constantly to address this. Changes are being made for the next October roll-out, and provider alerts are being sent out as changes are made. Optum has been great about open communication and working with the providers. The fear comes from audits and being held accountable to potential misinformation. Conversations with Optum are being held to address how to audit as roll-outs are not being done simultaneously. There have also been concerns with Liberty and some providers (region 4) are being told that they are backed up and not taking new appointments. However, this seems to be region to region, as region 7 shared that there hasn't been a delay. This may be potentially related specifically to DD evaluations rather than YES evaluations.	

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					It is also being reported that information has been difficult to get from Liberty, though this has also been reported to be improving. There are some concerns about the diagnosis and who is conducting them, as a clinical or master's level diagnosis is superseding a higher level diagnosis. This is causing frustration and concern. Medicaid shared that these are always done by a licensed clinician, and encouraged these specific examples to be shared with the Liberty contract monitors. Overall most providers are really liking the CANS and are finding the process and the information valuable. One concern with the CANS is getting everyone trained. It is a costly process to getting everyone trained, and this is why it is taking a little bit of time to get everyone trained. Providers are asking for this understanding. Optum has a phased training approach and has Praed contracted out through next spring for ongoing trainings. Evaluation will be done to determine additional training needs. More on-demand options will be coming through Praed. The use of social security numbers to identify clients is causing a lot of concern with families and providers are receiving a lot of pushback where families do not want to share the SSN. This is becoming a roadblock to the process. Another concern that has been shared with Optum is the coordination of getting everyone together for the coordination of care as the logistics of it is becoming an administrative burden as providers try to get a hold of all the involved parties. The question was asked if that	

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					should ultimately be the case manager's responsibility; right now, it is falling on the provider, though it may improve going forward. Not everyone has case management services. With CBRS services in particular, the request is being made to have the parties come together prior to knowing if the services are even authorized. Optum is looking at this and the process of switching the meeting to after the authorization has occurred. Another concern is workforce shortage, and the volume is not able to be served. It is becoming more of an issue to find master's level clinicians willing to work through the process. Clinicians are frustrated by the burdensome process. Clinicians are dropping out because they no longer want to work with Medicaid. It is also a challenge to find paraprofessional staff to work within these processes as well. Paraprofessionals will fit the need for a lot of the coming services, and rates will likely be built in to address that. Peer support is a good example of how this sort of service improves over time. The providers appreciate that there have been some rate increases and some new billable services. Providers would appreciate the ability to have paraprofessionals bill for consultation. Master's level can, but paraprofessionals and peers cannot. Agencies either pay or don't, but it is required. Additionally, the reimbursement rate for tele services is very low. Medicaid expressed interest in waiting list concerns and would like to be notified as soon as possible if waiting list issues are occurring. There is some opportunity for Medicaid to make other arrangements to get services in areas	

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					where waiting lists are issues. Waiting lists exist for services such as testing and counseling services. Staff are really struggling to provide services to the Medicaid network because it requires so much more of them to do so and often also provides a lower rate. Some providers are using unpaid interns to provide services just to make sure that the child gets services rather than waiting for months. There are some concerns that not all the issues and experiences that parents and families are encountering are represented in the workforce report. The report blends regions and doesn't separate out down to the level of detail that may be necessary.	
9	**11:30 a.m.**	**30 min**	Subcommittee Statement of Purpose	Kim Hokanson	The Statement of Purpose for both subcommittees are ready for final review and vote. These final versions do include feedback and input from Medicaid. The statements may change over time as the groups progress. Ross thanked the subcommittee members for their work on the statements. These documents are to viewed as living, and prior to updates or revisions, changes should be presented to the full IGT for consideration and vote.	The Statement of Purpose for the Clinical Sub-Committee was approved by vote. The Statement of Purpose for the Training Sub-Committee was approved by vote.
10	**12:00 p.m.**	**30 min**	**Working Lunch:** BSU Workforce Capacity Report Update	Candace Falsetti	There is an additional report that is coming from Boise State that will provide more of an analysis. One of the major issues identified in the report is recruitment.	

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					The question was asked if enrollment in these programs has dropped at the universities and it has not. In fact, it has increased, but people are going elsewhere, often for much more money. The report can be found under project information on the YES website (yes.idaho.gov) It is important to remember that this survey only encompasses the Idaho Medicaid network (Optum) and not those outside of the network. Reports are being built with Optum to report on access, providers, utilization, etc.	
11	**12:30 p.m.**	**5 min**	RASCI Chart Feedback	Cindy Day	Feedback was received from the plaintiffs and responses to them were provided. No feedback was received from the IGT. The plaintiffs wanted to change a couple of the areas that directly impacted the IGT. Overall the plaintiffs felt there were some areas were they weren't being fully informed and made some suggestions as to how to improve that aspect of the process. There were places where it was changed from inform to consult the IGT. These included areas on the practice manual and administrative process, among a few others. It is also an acknowledgement of not just where the IGT should be involved, but also all of the areas where work is being done to ensure the IGT is included.	
12	**12:35 p.m.**	**20 min**	Transitions Update	Rhonda House	At the last IGT meeting, the scope of a transition workgroup was discussed. Rhonda created a document to capture what the focus of this subcommittee would be.	Please send any input/feedback to Rhonda House.

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					A transitions subcommittee/workgroup would be reviewing transitions for services in a multitude of situations. Any feedback or insight from IGT would be helpful and appreciated as this is a broad and big project, but these transitions in the system of care need to be identified. Transitions from a crisis hospital stay should be identified as one for review. This is an issue that QMIA is currently reviewing. Some of these transitions are specifically noted in the settlement agreement. This is tied into the overall access model. Feedback has been received from all of the partners. There has been discussion throughout history of access for providers to have some sort of patient portal where common information could be shared. This type of transitional aid would be extremely beneficial. The question was asked what the prevalence of kids transitioning out of being SED. It is not something that has occurred often, and more is a time to review scoring and linkages to the more appropriate services. This is specifically why there has been a push to have an expedited transition back to care. One of the goals of this subcommittee would be to serve as a starting point for handling the "what-ifs" that come up throughout services. Transitions with incarceration situations would also be beneficial to review.	

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					In regards to transition into adult services, it is important to be wary of scope creep and spending efforts outside of the specific focus of the settlement agreement, but it would be beneficial to review the transitions and support leading up to the adult transition.	
13	**12:55 p.m.**	**10 min**	CANS Utilization Update	Seth Schreiber	Seth was unable to attend. As of 9/4/2018, there were 46 community providers who have access to the ICANS system. Of these agencies, 15 of them have completed at least 1 CANS assessment in the system. These 15 providers have completed a total of 176 CANS assessments in the ICANS system between 7/1/2018-9/6/2018. 2,138 Finalized Full CMH CANS with Assessment Dates of 1/1/18 - 9/7/18 for 1,560 unique UCN's (Our best guess is that means 1,560 unique kids, but there might be some overlap). 1,552 are from DBH, 409 from Liberty, and 177 from other providers.	
14	**1:05 p.m.**	**20 min**	Membership Orientation and Recruitment Discussion	Dave Sorensen Jennifer Griffis	There is still an opportunity for youth positions with IGT. Rhonda presented a list of what would be ideal to include into a new member orientation packet; this would result in a nearly 300 page document. It was suggested that there could be a one page document with links to the website to eliminate some of the paper. The question was asked if the IGT could have their own little site on the YES website to put all the links in one spot.	Treena will meet with Brenda and Cindy to discuss how the IGT information and documentation could be consolidated into one location on the YES website. Dave S. will reach out to Maria to see if she will be continuing in her role.

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					Having all of the information on the website would also be beneficial in helping aid transitions between people serving from any given organization. There may be potential to have outgoing members transition and mentor incoming folks. October will be renewal month; if anyone is choosing to step down, please let Mindy know. A new vice-chair is needed, and cannot be anyone from DBH, Medicaid, or IDJC.	Rhonda will create an electronic version of a welcome letter including links to the appropriate sites and information.
15	**1:25 p.m.**	**5 min**	Cost Sharing/300% Update	George Gutierrez	At the last Implementation Workgroup meeting, a draft was shared showing the calculations for determining someone's share of payment. It applies some deductions to the family income before the 5% cost sharing premium is assessed. This document can be shared here at the next IGT meeting. Included in this document is the process for how a family an request their premium be reduced or waived if they feel they cannot pay. A written policy on the cost sharing calculation and implementation is being drafted, including appeal requests and timelines. A process for identifying families when they come over from SR is being created, and tracking is being put into place so reporting to the legislature can be done. A flier explaining the process is being created, providing examples of why there is a premium and how to handle it. Language for the eligibility notification is being created.	George will share this document with the IGT at the next meeting.

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					The initial notification for families currently enrolled in Medicaid who will be subject to the new premium is also being drafted. An explanation of terms is also being put together. A tentative timeline is set for October. The parent network conference is set for October 11th and 12th, and would be a good opportunity for sharing some of this information with parents. Medicaid is slated to attend.	
16	**1:30 p.m.**	**10 min**	Family Engagement Subcommittee Update	Jennifer Griffis	A parent's rights and responsibilities document was discussed, reviewed and updated. The responses were sent to the DAG for review. The document was revised to be more in line with the current system. Information from the various agencies demonstrating opportunities for parent engagement was discussed. Youth advisory boards were discussed. Holly Riker completed extensive research on youth advisory boards across the nation and shared it with Sabrina for review.	
17	**1:40 p.m.**	**10 min**	Training and Clinical Subcommittee Update	Kim Hokanson	The principles of care and how it applies to the different systems was reviewed. It was refreshing to hear the work that IDJC has done to incorporate this into their system and provided suggestions on how to reach out to the counties. Optum presented their training information (past, present, and future). It provided a lot of information on how many people have been trained throughout the state and what training really looks like.	

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					Amy Korb has decided to step up for chair for the subcommittee, and a new vice-chair will be needed.	
18	**1:50 p.m.**	**5 min**	Other Items	Dave Sorensen	Candace will share the QMIA update via email. The QMIA is currently working on a review of several transitions. They are also working on establishing a quality review.	Candace will provide the QMIA review for attachment with the minutes. QMIA update will be an ongoing agenda item.
19	**1:55 p.m.**	**5 min**	Review Future Agenda Topics and Action Items	Treena Clark	The next IGT meeting will occur on November 2nd. The October meeting will not be held. The ICAT meeting will be cancelled as well.	Mindy will send out an updated recurring meeting invite.
20	**2:00 p.m.**	**--**	Dismissal	Dave Sorensen		

The IGT will track action items and their status from the meetings here:

Follow Up Items	Date Opened	Owner	Due Date	Complete/Comments	Status
IGT Members will have feedback for Cindy on the RWSCI Chart Review	7/13/18	Cindy	8/3/18		**New**
Report on Medicaid's communication plan regarding the new Medicaid eligibility and potential premium costs	2/2/18	George	3/2/18	5/4/18—No update 7/13/18—Still in discussion now, sufficient notice will be sent to the families once an agreement is reached	**Ongoing**
Candace will discuss the Provider Subcommittee moving to the IGT with the QMIA Council.	1/5/18	Candace	Next QMIA Council Mtg	Discussion has occurred and the QMIA would like to see the subcommittee's charter prior to making a decision. 7/13/18 – QMIA did not meet last month Discussion has occurred and the QMIA would like to see the subcommittee's charter prior to making a decision.	**Ongoing**