

Waiting List Workgroup

Follow Up from MACMHB Conference Presentation - October 20, 2009

Context:

The Standards Group (TSG) established a Waiting List Workgroup to develop a proposed set of standards for the CMHSPs regarding waiting list management for individuals funded with state General Fund dollars when the CMHSP cannot provide all necessary services due to funding insufficiency

A copy of the TSG Waiting List workgroup product “*Guidelines for Establishing and Managing General Fund Waiting Lists*” is available at www.macmhb.org/TSG. This guideline will be formally submitted by The Standards Group to MDCH by October 31, 2009 for additional review and public comment prior to promulgation.

On October 20, 2009 the Waiting List Workgroup presented a draft version of the proposed guideline at the MACMHB Fall Conference. Workshop participants were invited to submit questions and comments to the workgroup. This document is the TSG Waiting List Workgroup’s response to questions submitted to the workgroup following this presentation.

Waiting List Questions/Responses:

- 1. If standards for eligibility have not been established, how can standards for a waiting list be promulgated?**

Answer: The workgroup believes that Sec 330.1208 and Sec 330.1100 of the Mental Health Code adequately set the standards for eligibility, including defining the terms Persons with Serious Mental Illness, Developmental Disability and Serious Emotional Disturbance, and priority populations.

- 2. What time frames define the waiting list? Any service not scheduled in 14 days? No service for 30 days? Is the timeframe left to CMSHP discretion?**

Answer: The TSG Waiting List Guideline will be amended to clarify the following: At the time the CMHSP decision has been made to not deny services and to not offer an appointment to an eligible applicant, the individual is effectively on a waiting list.

- 3. If emergent/urgent crisis is resolved and consumer goes to wait list, how would they get ongoing medications? Refer to primary care physician?**

Answer: Once the crisis has been resolved, the individual would be evaluated to determine eligibility based on severity and urgency of need. The need for necessary services (e.g. medications) must be taken into consideration from both an individual and agency risk perspective. If the individual is placed on a waiting list for ongoing services, the CMHSP

shall inform the person of other community resources or services that may be available. This may include information about self-help groups, private-pay options, or other community support services.(WL Guideline A.9).

4. What about “meds only” consumers (single service)? This type of service is not included on waiting list?

Answer: MDCH has indicated a need to have all waiting list services be categorized in four (4) primary program areas. These are noted in Standard E.2 of the proposed guideline. At this time, it is envisioned that all services will roll into one of these four categories. The workgroup will clarify with MDCH what services should be placed into each major category, and offer a technical guideline to the field in this regard as part of the MDCH final advisory. At this time, the simple answer is that “Meds only” services would be included in the “Treatment and Training” category.

A CMHSP could, however, identify additional categories or collect data specific to a more detailed list of services, as long as these service types can be “rolled up” into the four general categories for submission to MDCH.

For an individual receiving meds only service, if there are additional services that the person needs but cannot access due to funding, they would be on a waiting list as under-served for those additional services. If the meds only service is sufficient to meet their identified needs, there is no need to place them on a waiting list if they can receive that service through the CMHSP.

5. The issue of funding disequity should be addressed in your guideline – perhaps under the limited scope section.

Answer: The workgroup reviewed this subject with the TSG Board at the commencement of its workgroup efforts and determined that the scope of this question was not within the assigned purview of the Workgroup. No additional language related to funding across CMHSPs will be added to the draft guideline at this time.

6. Please define Treatment and Training as a service description? Please give examples for what services would fall into the four categories of “type of service”

Answer: Please review the response to Question #4 above. The workgroup will clarify with MDCH what is included in each “type of service” that must be captured on the waiting list.

7. Can the workgroup inspire the MDCH to establish a defined benefit package of GF with specific eligibility criteria to be used statewide without second-guessing from the ORR and site review team?

Answer: The workgroup reviewed this subject with the TSG Board at the commencement of its workgroup efforts and determined that the scope of this question was not within the assigned purview of the Workgroup. As indicated in the Waiting List Guideline under the

Scope Section, the workgroup has determined that this issue rests outside of the scope of this guideline.

- 8. Persons without an SMI, SED or DD who are experiencing a crisis (emergency) are what priority? Many persons present with suicidal ideation who, after stabilization are clearly not SMI, SED or DD.**

Answer: MDCH Administrative Rule 330.2006 defines the minimum emergency intervention services that must be made available to any person suffering from an acute problem of disturbed thought, behavior, mood, or social relationship which requires immediate intervention defined by the person or his/her family or social unit.

During a crisis situation, it may be difficult to determine whether an individual is SMI, SED or DD. Therefore, after resolution of the crisis (which is the first priority), the determination of clinical eligibility should be made by the CMHSP, and appropriate action taken accordingly, including placing the person on a waiting list if necessary.

- 9. Will there be opportunity for care givers (ie: hospital) to have input or impact to person being placed on wait list?**

Answer: This will be left to local CMHSP policy and procedure. In developing local procedures, it is recommended that the CMHSP reference MH Code R. 330.1209a and the requirements of discharge planning from a psychiatric hospitalization for which it purchased services from either a state facility or licensed hospital. The MH Code requires the CMHSP to develop an individualized prelease community placement plan, and an individualized prelease aftercare plan, in concert with the hospital and individual. Therefore, it is assumed that the hospital may have front-end input on the development of any community placement and/or aftercare services plan, as required by the MH Code (§ 209a(1-3)).

- 10. How does an individual appeal your decision to be put on a wait list? Who sits on the review panel?**

Answer: Refer to section A.7 and B.2 of the Waiting List Guideline. The local CMHSP may determine who provides this review (consistent with guidelines). There is no requirement in the guideline that this involve more than one person.

- 11. Is “5 day” working or calendar days?**

Answer: All reference to days in this guideline refer to business days. The guideline will be revised accordingly.

- 12. How does placing someone who was in emergent situation whose crisis has been resolved on a waiting list meet the 7 day aftercare expectation?**

Answer: Section 330.1209a(1-3) of the MH Code address the requirements of each CMHSP to develop, with the assistance of the state facility or licensed community hospital, an

individualized prerelease plan for appropriate community placement, and a prerelease plan for aftercare services appropriate to each individual for which it is purchasing psychiatric hospitalization services.

The MDCH/CMHSP Managed Specialty Supports and Services Contract, Attachment C.6.5.1 contains a performance indicator within the MMBPIS for CMHSPs which indicates “the percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven (7) days, with a 95% performance Standard. “ CMHSPs should be aware of this indicator when planning its pre-release community placement and aftercare services plan for the individual.

Once the individual is stabilized, the services the CMHSP provides to the individual must be based upon the individual’s severity and urgency of need, in light of the CMHSP resources, and current threshold for on-going service delivery. Each CMHSP must determine the needs of all persons with SMI, SED and DD, including those being discharged from a psychiatric hospital, and direct its services to those individuals with the most severe disorders (MH Code: Section 330.1208(1) and (3)).

For those individuals who need follow-up care (i.e. aftercare services), the CMHSP should be aware of the seven (7) day performance indicator. However, the performance indicators are not drivers for providing necessary services. Service delivery should always be delivered in concert with the CMHSP’s access, eligibility and service delivery policy and procedures, as long as these policies adhere to all legal requirements imposed upon the CMH system.

13. Under COFR, if another CMHSP has a different threshold than our CMHSP re: who is placed on waiting list and who gets into services are we required to pay for their services in that county?

Answer: The CMHSP of the County of Financial Responsibility would authorize services according to their resources and prioritization regardless of who the provider is or where the individual is receiving those services. If the requested CMHSP does not have capacity or sufficient availability to serve someone from another county, the CMHSP of County of Financial Responsibility is responsible for locating and arranging the necessary services.

Note: Per the MDCH/CMHSP Contract, Section 1.3, each CMHSP should always respond to an individual’s **emergent** situation regardless of the County of Financial Responsibility (COFR). As it pertains to emergency services, services shall never be delayed or denied as a result of dispute of payment responsibility between two or more CMHSPs

14. The wording in the population cell grid is confusing as it relates to individuals with developmental disabilities.

Answer: The workgroup agrees to modify the language in the cell grid to reflect that this refers to individuals with certain conditions who do not meet the DD definition.

15. Would the group reconsider the requirement for a Maters Level staff to maintain the waiting list?

Answer: No. The individual managing the waiting list needs to have clinical judgment re: decisions of severity and urgency of need. In determining the minimum requirements of the practitioner, the Workgroup strongly considered the scope of functions identified in the Public Health Code licensing rules for practitioners licensed to practice in Michigan. The Workgroup believes the clinical factors determining one's prioritization on a waiting list go beyond the scope of practice of a BA level staff.

16. Should individuals served under special contracts such as MPRI, Courts be considered priority populations?

Answer: These programs should come with adequate funding to serve eligible individuals. However, if that funding is not sufficient and the CMHSP is using General Funds to serve an individual, they must be prioritized using the same methodology as used for any other individual served with general fund dollars. MPRI and court-ordered individuals are not considered a "special priority" when using GF resources.

17. Does a CMHSP have the local discretion to use General Funds for individuals on Medicaid spend-down as a means of providing ongoing services?

Answer: A person who has a spend-down is considered a General Fund consumer until such spend down is met and must be considered and prioritized using the same methodology as used for any other individual served with general fund dollars. It is important to exercise consistency in applying the severity and urgency factors in such determinations. For individuals currently in services, a CMHSP may choose to keep an individual in services due to risks associated with discontinuing such services; however, administrative expediency may not be a factor in determining priority for services.