

<b>SUBJECT</b> Clinical Practice Guidelines		<b>CHAPTER</b> 05	<b>SECTION</b> 03	<b>SUBJECT</b> 11
<b>CHAPTER</b> Clinical Practice Guidelines		<b>SECTION</b> Care Delivery		
<b>WRITTEN BY</b> Thomas Seilheimer	<b>REVIEWED BY</b> Tom Seilheimer		<b>AUTHORIZED BY</b> PIHP Board	

## I. APPLICATION:

- ☐ PIHP Board
 ☒ CMH Providers
 ☒ SUD Providers  
☒ PIHP Staff
 ☒ CMH Subcontractors

II. POLICY STATEMENT:

Region 10 PIHP shall adopt Clinical Practice Guidelines (CPGs) to guide practitioner and member decision-making regarding appropriate care and service. The purpose of Clinical Practice Guidelines is to provide evidence-based and expert-consensus direction for the assessment and treatment of behavioral health disorders. The PIHP recognizes that services and supports must be provided in an efficient, effective and accountable manner, and that cost-effective care equates with clinically-effective care. In support of these various aspects of quality care, the PIHP and its provider system shall operate within a comprehensive set of CPGs.

III. DEFINITIONS:

Clinical Practice Guidelines: Guidelines adopted by the PIHP to provide evidence-based and expert-consensus direction for the assessment and treatment of behavioral health disorders. CPGs promote sound clinical practice to assist practitioners, individuals and families to make decisions about appropriate treatment and services by presenting systematically developed care strategies, set forth in a standardized format.

IV. STANDARD:

- A. The PIHP is accountable for adopting and disseminating Clinical Practice Guidelines relevant to its members for the provision of behavioral healthcare services.

V. PROCEDURES:A. **ADOPTING CLINICAL PRACTICE GUIDELINES**

1. The PIHP adopts CPGs that are appropriate to its membership.
2. The following criteria are considered when establishing priorities for adopting CPGs relevant to the membership:
  - The incidence or prevalence of the diagnosis or condition.

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- The degree of variability in treatment approaches or outcomes for the diagnosis or condition.
  - The availability of scientific and medical literature related to the effectiveness of various treatment approaches.
  - Input from the PIHP staff and Physician Reviewers.
  - Requests from Practitioners or Members.
3. When adopting CPGs, the PIHP's preference is to adopt, without modification, evidence-based guidelines that have been developed by recognized sources, such as medical specialty societies, using a methodologically sound process involving exhaustive review of the literature supplemented by expert consensus when the body of available research literature is not conclusive.
  4. The Medical Director is responsible for overseeing the processes of
    - Recommending practice guidelines for adoption by the PIHP and
    - Periodically reviewing previously adopted guidelines.
  5. The Quality Improvement Committee (QIC) is responsible for approving CPGs. The PIHP QIC appoints the Improving Practices Leadership Team (IPLT) to assist in the review process.
  6. If the recommendation is to adopt a published CPGs from a recognized source with modification, a written description of the modification, the rationale for the modification, and scientific evidence in support of the modification is prepared.

Modifications are not made solely to accommodate local practice or practitioner preference in the absence of sound scientific evidence; the modification is:

- Superior to the published guideline, *or*
- More appropriate to the treatment resources generally available in the PIHP's service area.

The most common reason for modifying guidelines is that additional research supporting other treatment approaches has been published since the guideline was developed.

7. Prior to adopting CPGs from a recognized source with modification, input is gathered from appropriate practitioners by presenting the CPGs and any proposed modifications to network practitioners at the QIC's IPLT for review and comment.
8. The PIHP QIC reviews the input from the IPLT. This information is integrated into a final recommendation for adoption of the CPGs. If the workgroup or the PIHP QIC determines that the CPGs should be reviewed for possible revision in less than two years, this determination is included in an appropriate work plan at the time the CPGs are adopted. Recommended modifications adhere to the principles outlined above.

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9. The PIHP QIC, through the IPLT, evaluates adherence to clinical processes recommended in the Clinical Practice Guidelines. The PIHP QIC approves a methodology to measure adherence. Measuring adherence with CPGs is part of the PIHP Quality Improvement work plan.
10. The PIHP QIC is responsible for adopting CPGs and processes for measuring adherence with CPGs recommendations on behalf of the PIHP.

## B. REVIEWING AND UPDATING GUIDELINES

1. The Medical Director is responsible for assuring that all CPGs are reviewed at least every two years.
2. Guidelines are reviewed sooner than two years when any of the following occurs:
  - On the recommendation of the IPLT.
  - By request of the PIHP staff or network Practitioners, if they believe the guideline is not current.
  - If measurement of adherence to the guideline suggests that the guideline may not represent current best practices.
  - Upon revisions made to an adopted guideline by the guideline developer.
  - Whenever national guidelines addressing the same or similar content are revised or published.
3. The PIHP QIC is responsible for the periodic review and approval of guidelines. The PIHP QIC appoints the IPLT to assist in the review process. Members of the IPLT may also include PIHP clinical staff as well as outside experts or network practitioners.
4. The review process includes:
  - A search of the recently published scientific and medical literature.
  - Solicitation of comments from network practitioners regarding the extent to which the guideline represents current best practice.
  - Solicitation of comments from the IPLT and ad hoc members regarding the appropriateness of the guideline.
  - A review of the results of measuring adherence to the guideline.
5. The PIHP QIC, with input from the IPLT, recommends whether the guideline requires modification.

If the guideline requires modification, a written description of the modification, the rationale for the modification and scientific evidence in support of the modification is prepared.

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Modifications are not made solely to accommodate local practice or practitioner preference in the absence of sound scientific evidence; the modification is:

- Superior to the published guideline, *or*
- More appropriate to the treatment resources generally available in the PIHP service area.

The most common reason for modifying guidelines is that additional research supporting other treatment approaches has been published since the guideline was developed.

6. If the PIHP QIC, with input from the IPLT, determines that the practice guideline should be reviewed in less than two years, this determination is recorded in an appropriate work plan at the time the guideline is adopted.
7. The PIHP QIC recommends if any changes to the guideline measurements are required.
8. The PIHP QIC is responsible for making decisions about continuing endorsement of guidelines and adherence measurement strategies for the PIHP.

### C. EVALUATING ADHERENCE TO GUIDELINE RECOMMENDATIONS

1. At a minimum, the PIHP evaluates performance relative to at least three CPGs.
2. Measures may be process or outcome-based.
3. Data collection methodology must be sound enough to produce valid and reliable information on adherence to the PIHP's adopted guidelines.

### D. ACCESSING MEDICAL NECESSITY CRITERIA

The PIHP's approved Medical Necessity Criteria are made available to all practitioners and beneficiaries. Medical Necessity Criteria developed by the PIHP are available on the Region 10 PIHP website

Medical Necessity Criteria developed by other organizations and adopted by the PIHP are available for review at the PIHP's office or by web conferencing technology.

As permitted by license agreements, the PIHP will provide Practitioners and beneficiaries with hard copies of a limited number of criteria sets upon request.

## VI. EXHIBITS:

### A. Region 10 PIHP Provider Service Manual

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VII. REFERENCES:

None.

## REGION 10 PIHP Provider Service Manual

### Clinical Practice Guidelines and Service Utilization Parameters

#### Introduction

**Purpose and Scope:** Region 10 PIHP organizes and oversees public-funded behavioral health services and supports across a four-county provider system for persons with serious mental illness, serious emotional disorders, intellectual and developmental disabilities and substance use disorders. These services and supports are designed to promote key systems values and outcomes such as recovery, community inclusion and self-determination. They also prioritize the need for comprehensive care coordination, incorporating physical health as well as behavioral health goals. Region 10 PIHP recognizes that services and supports must be provided in an efficient, effective and accountable manner, and that cost-effective care equates with clinically-effective care. In support of these various aspects of quality care, Region 10 PIHP and its provider system operate within a comprehensive set of Clinical Practice Guidelines (CPGs). As such, CPGs provide evidence-based and expert-consensus direction for the assessment and treatment of behavioral health disorders. CPGs promote sound clinical practice to assist practitioners, individuals and families to make decisions about appropriate treatment and services by presenting systematically developed care strategies, set forth in a standardized format.

**Oversight, Performance Measurement and Review Intervals:** The Region 10 PIHP Quality Improvement Committee (QIC) authorizes the Improving Practices Leadership Team (IPLT) committee oversight of the CPGs. Oversight includes a) comprehensive monitoring and analyses of service utilization data across the provider program network, and b) performance measurement of select practices, and c) review for practice update. Monitoring and analyses of service utilization data may incorporate one or more of the following activities:

- UM Department / Clinical Manager Utilization Review reports on program contract compliance that pertain to the a) provision of services required within the Michigan Medicaid Provider Manual, and b) implementation of the various MDHHS Contract Attachments service standards
- Service Utilization Outlier Reports (psychiatric inpatient, community-based services) and reports on contingent follow up Utilization Review (per-case and aggregate).
- EBP Service Utilization / Claims Reports.
- Utilization Review on cases sampled from PIHP/CMHSP Performance Indicator (clinical data analytics) Reports to assess adherence to APA Practice Guidelines on select interventions, e.g. medication management.

Performance measurement takes place annually against at least two important aspects of at least three clinical practice guidelines, with at least one of which addresses services for children and adolescents. Analyses of performance are quantitative as well as qualitative and may be population or practice based. Review for practice updates takes place within the IPLT, every two years or more frequently as clinically indicated, so that guidelines reflect clinic best-practice updates and innovations. IPLT also monitors CPG utilization to ensure expedient and meaningful access by practitioners as well as members. The PIHP Chief Clinical Officer (CCO) as IPLT Chair provides operational leadership to committee oversight, and the PIHP Medical Director provides clinical leadership and consultation to the committee.

**Clinical Practice Guidelines (SMI, SED, I/DD and SUD Populations):** The Region 10 PIHP CPGs are comprised of an array of strategically selected clinical documents from across five essential sources: Michigan Medicaid Provider Manual (MMPM), Michigan Mental Health Code (MMHC), Michigan Department of Health and Human Services (MDHHS) Contract Attachments (CA), Evidence-Based Practices (EBP), and selections from the American Psychiatric Association (APA) Practice Guidelines relevant to MMPM specialty services, and in reference to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The first three sources are required as per within the Region 10 PIHP contract with MDHHS (MMPM, MHC, CA). The remaining sources reflect clinical expert opinion as per developed within the IPLT (EBP, APA). Given that the CPGs reflect current quality practice mandates, clinical best-practices, and the aspirations of a progressive health plan provider system, IPLT formatted the CPGs to easily adapt and expand per an evidence-based, continuous-quality improvement approach to clinic

services. The CPGs are utilized in conjunction with the Region 10 PIHP Service Utilization Parameters, which are comprised of criterion-based level-of-care criteria and benefit packages. Level-of-care criteria operationally define appropriate service delivery along the continuum of symptom-intensity / intensity-of-care. Benefit packages delineate groups of services appropriate to the various level-of-care strata. Both inform typical service utilization patterns across the gamut of clinic specialty services. Region 10 PIHP also developed the CPGs to ensure consistent initial and ongoing eligibility determination, taking into account multiple factors that influence service needs and Recovery challenges, such as functional impairment, housing status, legal status, current or past trauma, etc. The CPGs were also informed by historical services utilization data, thus to inform clinical decisions so that individuals receive the right services, at the right time, in the right amount. Listed below are the five essential sources comprising the CPGs. Each source is accessed via hyperlinks.

**Michigan Medicaid Provider Manual (MMPM)** – Behavioral Health Section (Requirements, Services and Supports) (<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>).

**The ASAM Criteria Manual**

**Michigan Mental Health Code (MMHC)** – State of Michigan

([http://www.michigan.gov/documents/mentalhealthcode\\_113313\\_7.pdf](http://www.michigan.gov/documents/mentalhealthcode_113313_7.pdf))

Civil Admissions and Discharge Procedures: Mental Illness

Civil Admissions and Discharge Procedures: Developmental Disabilities

**MDHHS Contract Attachments (CA)** (Service Guidelines, Technical Advisories) ([MDHHS - PIHP Contract Link](#))

P.1.4.1 Technical Requirement for Behavior Treatments Plans

P.4.4.1.1 Person-Centered Planning Practice Guideline

P.4.7.4 Technical Requirement for SED Children

P.4.13.1 Recovery Policy & Practice Advisory

P.7.10.2.1 Inclusion Practice Guideline

P.7.10.2.1 Housing Practice Guideline

P.7.10.2.3 Consumerism Practice Guideline

P.7.10.2.4 Personal Care in Non-Specialized Residential Settings

P.7.10.2.5 Family-Driven and Youth-Guided Policy & Practice Guideline

P.7.10.2.6 Employment Works! Policy

P.7.10.3.1 Jail Diversion Practice Guidelines

P.7.10.4.1 School to Community Transition Planning

P.II.B.A. Substance Use Disorder Policy Manual

**Evidence-Based Practices (EBP)** – Improving Mi Practices (<https://www.improvingmipractices.org/>) and clinical advisory: *Typical Case Status at Admission and Discharge*.

Applied Behavior Analysis

Assertive Community Treatment

Dialectical Behavior Therapy

Family Psychoeducation

Individual Placements and Supports

Infant Mental Health

Integrated Dual-Disorder Treatment

Motivational Interviewing

Trauma Focused CBT

Wrap Around

Medication Assisted Treatment (MAT)

**American Psychiatric Association (APA) Practice Guidelines**

(<https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines>)

Acute Stress Disorder and Post Traumatic Stress Disorder

Bipolar Disorder

Borderline Personality Disorder

Major Depressive Disorder

## EXHIBIT A

Obsessive-Compulsive Disorder  
Panic Disorder  
Schizophrenia  
Substance Use Disorders

### **Service Utilization Parameters** (Utilization Management)

- a. Level-Of-Care Criteria
- b. Benefit Packages

## Region 10 PIHP Clinical Practice Guidelines

### Evidence-Based Practices and Promising Practices Typical Case Status at Admission and Discharge

Practice Area	Typical Case Status at Admission	Typical Case Status at Discharge
Applied Behavior Analysis (EBP)	<ul style="list-style-type: none"> <li>• Scores obtained from valid evaluation tools meet eligibility criteria</li> <li>• Medically able to benefit from BHT</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment goals achieved</li> <li>• Scores obtained from valid evaluation tools no longer meet eligibility criteria</li> <li>• No measurable improvement or progress demonstrated at six-month evaluation</li> <li>• Show-rate is less than 75%</li> </ul>
Assertive Community Treatment (EBP)	<ul style="list-style-type: none"> <li>• Consumer with SMI/COD with difficulty managing medications due to symptoms, behavioral issues and/or complex medical conditions</li> <li>• Socially disruptive behavior placing the person at high risk for arrest and/or re/incarceration</li> <li>• Frequent use of psychiatric inpatient or other crisis services, or homeless shelters</li> <li>• Disruptions or limited ability to attend to basic needs, socialization or other role expectations</li> </ul>	<ul style="list-style-type: none"> <li>• No longer meets severity criteria and is able to function receiving less intensive services/supports</li> <li>• No longer engaged in services despite ongoing, assertive outreach</li> <li>• Consumer and team agree to terminate services</li> <li>• Consumer transitions to similar services in another catchment area</li> </ul>
Dialectical Behavior Therapy (EBP)	<ul style="list-style-type: none"> <li>• Persons with SMI presenting socially maladaptive behaviors due to emotional dysregulation</li> <li>• Para-suicidal behaviors</li> <li>• Patterns of unstable relationships linked to extremes of idealization and devaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Completion of modules along with weekly participation</li> <li>• Strengthened skills to effectively reduce or cease self-harm behaviors</li> <li>• Consumer and team agree to discontinue based on the 4 and Out Rule</li> </ul>



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	<ul style="list-style-type: none"> <li>• Persistently unstable self-image or sense of self</li> <li>• Impulsivity in at least two life domains leading to risk of self-damaging behavior</li> <li>• Relatively brief bouts of intense anxiety, dysphoria, irritability</li> <li>• Stress-induced displays of paranoid ideation or dissociation</li> </ul>	<ul style="list-style-type: none"> <li>• Service plan goals have been met</li> <li>• Consumer requests and receives an alternative, medically necessary service</li> <li>• No longer engaged in services despite ongoing, assertive outreach taking place for over 35 calendar days</li> </ul>
Family Psycho-Education (EBP)	<ul style="list-style-type: none"> <li>• Consumer with SMI and family complete joining session and educational workshop</li> </ul>	<ul style="list-style-type: none"> <li>• Significant progress or achievement with the consumer's Recovery plan</li> </ul>
Infant Mental Health (promising practice)	<ul style="list-style-type: none"> <li>• Parent or child identified as having attachment concerns</li> <li>• Multiple complaints or substantiated child abuse/neglect currently or historically</li> <li>• DECA scores indicate concerns</li> <li>• Parent diagnosed with current Postpartum Depression</li> </ul>	<ul style="list-style-type: none"> <li>• Minimal to no concerns with parent child attachment</li> <li>• Child is placed in foster care or minimal to no complaints substantiated at time of case closure</li> <li>• Improved DECA scores</li> <li>• Postpartum Depression is being treated and/or in a phase of remission</li> </ul>
Individual Placement and Support / Supported Employment (EBP)	<ul style="list-style-type: none"> <li>• Consumer with SMI/COD chooses to pursue a goal of attaining meaningful employment in the community</li> </ul>	<ul style="list-style-type: none"> <li>• Time unlimited for as long as the consumer wants and needs the support</li> </ul>
Integrated Dual-Disorder Treatment (EBP)	<ul style="list-style-type: none"> <li>• Co-Occurring SMI and SUD (often engaged via active outreach)</li> </ul>	<ul style="list-style-type: none"> <li>• Person-served chooses not to continue services (time-unlimited service)</li> </ul>
Motivational Interviewing (EBP)	<ul style="list-style-type: none"> <li>• This practice is applicable across clinical populations and levels of care</li> </ul>	<ul style="list-style-type: none"> <li>• This practice is applicable across clinical populations and levels of care</li> </ul>
Trauma-Focused Cognitive Behavioral Therapy (EBP)	<ul style="list-style-type: none"> <li>• Trauma screens and trauma assessments identify clinically significant trauma issues</li> </ul>	<ul style="list-style-type: none"> <li>• Significant decrease in short-term and longer-term negative effects of trauma</li> </ul>
Wraparound (promising practice)	<ul style="list-style-type: none"> <li>• Child with SED or I/DD presenting with at least one other issue, below</li> <li>• Involved in multiple systems of care/service</li> <li>• Current or potential risk for out of home placement</li> </ul>	<ul style="list-style-type: none"> <li>• Child is experiencing reduced symptoms and improved behaviors across multiple settings</li> <li>• The family/community support system is effectively providing essential care, and there is</li> </ul>

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	<ul style="list-style-type: none"><li>• Risk factors exceed and/or compromise the capacity for community based services to be effective</li></ul>	<p>no longer risk of out of home placement</p> <ul style="list-style-type: none"><li>• The family is unwilling to make changes necessary to ensure safety in the home for staff</li><li>• The family chooses to withdraw from services</li></ul>
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