

Quality Improvement Work Group

MSSAC Conference Room

December 2, 2010

9 a.m.

MINUTES

Present:

Kim Kwasnick, Cristo Rey
Barb O'Connor, ASAS
Connie Gallagher, AARC
Gail Durham, AARC

Ericanne Spence, HOC
Cara Ludlow, VC Lansing
Sue Wright, FSCA/Born Free
Pat Wheeler, NCA/LRA

Present via Conference Call:

Lori Lehmann, Clearview
Kathy Davis, C&FS
Will Volesky, Kairos
Vicki Hall, FSCA/Lenawee

Carol Waters, ASCC
Deb Thalison, ICSAI/ICHHD
Chris McDaniels, CCCC
Gary McCullough, MVA

Staff Present:

Jeanne Diver, CCC Manager
Patti Tygre, Utilization Coordinator

Lisa Larson, Utilization Coordinator

Medical Marijuana

An e-mail was sent to all QI members asking that medical marijuana and its related issues be added to the agenda. Before the 12/2/10 QI meeting, Jeanne talked to the provider about her concerns and then contacted the State to see if there were any related guidelines or documentation relative to medical marijuana. At the meeting, Jeanne read the State's (Jeffery Wieferrich) response, which was, *"In a nutshell - no we have no guidelines. The enrollment policy for methadone will address it - it is just going to be treated as another prescription drug so no discrimination will take place."* Discussion ensued on how providers were working with clients who have certification for medical marijuana.

Lisa stated the 1970-Federal Controlled Substances Act was enacted and it classified Marijuana as a Schedule 1 drug.

I. Retrospective Review Preparation

Screening is used to determine the need for an assessment for treatment or for referral to a community support system. An assessment is to determine what level of care a person needs and it is the beginning of treatment planning. An assessment update is used to update assessments that have been done within the past 6 months whether they were done at a Mid-South funded provider or an outside source.

There are many screening tools that can be used in combination with a thorough psychosocial history. MAST (Michigan Alcohol Screening Test), DAST (Drug Abuse

Screening Test), CAGE (a screening for alcohol dependence-Cut, Annoyed Guilty, Eye-opener), Hopkins 20, ASSIST (The Alcohol, Smoking and Substance Involvement Screening Test) just to name a few and most are available free on line now.

There shall be an assessment of each client's social and psychological needs. The areas of concern shall include a determination of the following: current emotional state, cultural background, vocational history, family relationships, educational background, socioeconomic status, any legal problems that may affect the treatment plan [R325.14705(1)].

a. Assessment

- i. Lisa referenced paperwork to be completed at a doctor's office and noted the time some take to complete: some briefly skim the questions and answer quickly, some do not complete the form because there are too many cumbersome questions, and some put their all into answering the questions. Once called into the doctor's office, the doctor does not review the form. This is upsetting to some patients because of the time they spent in answering the questions just to have their answers ignored. Some feel this is not a very good beginning of a good relationship with their doctor. Some patients may not like this so much, they may not return for the next appointment.
- ii. The same notion may be applied with assessments and how they are performed. Are there too many questions? Does it take too long to complete? How does the client feel after the assessment – like he/she has been put through the mill and nothing is gained from it? Providers were asked to take a look at their assessment tools and see if they may be scaled down to allow the rest of the questions to be answered during future treatment sessions. Do all of the questions have to be answered on the first day?
- iii. The administrative rules for assessments were provided for both outpatient and residential levels of care. Providers were asked to see what questions were necessary to have in their assessment tools in order to meet accreditation purposes, and if they do not affect their accreditation, to scale the questions down so the focus may be on engaging the client. This way, providers may have time to offer referrals to necessary support services, list the client's problems and together choose which one the client wants to work on first, let the client leave wanting to come back, etc., instead of having the client leave the assessment appointment empty handed and wondering what the assessment did for him/her. Discussion on prioritizing the assessment and what to look for in each category took place.
- iv. **(BIOPSYCHOSOCIAL) Assessment**
 1. Medical History
 - a. Points to consider: excessive habits: coffee, tobacco, energy drinks, eating, alcohol; exaggerated medical problems- unsubstantiated or inconsistent complaints; history of frequent injury or emergency care: trauma, burns, fractures, falls; history of infections: malaria, tetanus, and hepatitis; chronic disease

symptoms yet the client is resistant to medical management such as poorly controlled diabetes, hypertension, etc.

2. Social/Family/Vocational/Educational/Socioeconomic/Legal History
 - a. Repeated driving while intoxicated; problems on the job or at school; frequent job changes, tardiness or absence from work, accidents at work; family problems; divorce; child abuse or neglect; changes in friends or relationships; socioeconomic history or changes; spending more time with drug and alcohol users; family history of chemical dependency: children, parents, siblings, aunts and uncle, nieces and nephews, grandparents, half-siblings, first cousins, great grandparents; cultural background with accommodations requested noted.
3. Psychological History/Emotional
 - a. Mood disturbance: depression or anxiety disorder, suicidal thoughts, lack of impulse control, thought disorders, sexual dysfunction, sleep disorders, symptoms yet the client is resistant to medical management to consider their risk factors.
4. Substance Use Symptoms
 - a. Increased tolerance, bingeing, gulping drinks, preoccupation with drinking, sneaks substance, loss of control, excuses for substance use, hiding substances, remorse about drinking and consequences, aggression, changing substance use pattern-to avoid consequence or escaping to another geographic area, blaming others for their substance abuse and consequences. Maintains substance supply by hiding a back-up supply, increased blackouts, attitude changes, apathy, blaming, or anger.
5. Physical Signs
 - a. Demanding to be seen immediately, requesting late Friday afternoons, calling or presenting after regular business hours, frequent ER visits.
 - b. Presenting complaints of low back pain, root canal, migraine headache, ovarian cysts, and uncontrolled cough, vague about medication history, traveling through town or visiting, no primary medical provider, refuses lab tests or changes test or reports ailments that need narcotics, benzodiazepines or codeine.
 - c. Demands a specific narcotic drug right away, makes excuses that alternative non-narcotics are not acceptable because other medications do not work... medication allergy...ulcers...lost or stolen prescription;
6. Physical Findings Suggesting Chemical Dependency:
 - a. Obvious debilitation not related to medical problems; physical findings out of proportion to complaints; alcohol odor to breath, strong odor of mouthwash or after-shave to mask use.
 - b. Eyes: general observation: blank stare; glazing (film over cornea); excessive tear production (marijuana); red eye

(marijuana, inhalant); walleye or bug-eye appearance-drooping eye lids (heroin); swelling of eyelids (phencyclidine or marijuana); retracted upper lid (phencyclidine); pupil size and response-pupil dilation: cocaine, amphetamine; pupil constriction: heroin; slow, delayed, sluggish or absent pupil response: heroin, alcohol, benzodiazepine, cocaine, amphetamine; abnormal movements: fails to hold gaze, involuntary eye movement, phencyclidine (PCP) - vertical movement, alcohol, benzodiazepine, marijuana; unable to hold crossed eyes: alcohol, benzodiazepines; decreased rate of blinking: heroin, cocaine, amphetamine, phencyclidine (PCP). Ask about their condition to assure client wasn't born with it.

- c. Nasal irritation (due to cocaine inhalation).
- d. Cardiovascular changes: Labile Hypertension, Tachycardia
- e. Neurologic changes: unsteady gait, slurred speech, mild tremor, inappropriate lapses in conversation.
- f. Skin changes: "Pop" scars from subcutaneous injections: abscesses, infections, or ulcerations, infective or chemical reactions; dominant thumb is burned in crack abuse (lighter); paint or oil stains (inhalant abuse)-clothing, skin, fingernails; skin tracks or related scars-marks are multiple, hyperpigmented and linear; new lesions may be inflamed; location: neck, axilla, forearm, wrist, hand, foot, ankle, area between knees/toes.

References for the above mentioned information:

Haverkos (1995) Am Fam Physician 52(7):2029,
Mersy (2003) Am Fam Physician 67(7):1529-32 ;
Westreich (1995) Postgrad Med 97(4):111-23

v. It was noted members who attend the Quality Meetings may have 5-10 and even more years of experience with the above information; however their staff may not. As the clinicians working for members may not be familiar with the above, it is recommended members share this information with them.

vi. The following resources are again being shared with members:

1. http://www.who.int/substance_abuse/activities/assist/en/index.html
2. <http://www.fpnotebook.com/index.htm>
3. <http://www.online-testing.com/available.htm>
4. <http://counsellingresource.com/quizzes/>
5. <http://counsellingresource.com/quizzes/alcohol-cage/index.html>
6. <http://counsellingresource.com/quizzes/alcohol-mast/index.html>
7. <http://counsellingresource.com/quizzes/drug-abuse/index.html>

vii. Protocol- The protocol listed in the table below was reviewed. It is subject to change.

No.	Protocol	Explanation
1	ASAP, BSAP, or other assessment tool is in the client's file.	Complete assessment tool must be in each client's file. If assessment comes from other than provider, must have complete assessment and release permitting receipt of such.
2	If Provider performed assessment, if urgent case, was client assessed within 24 hours of contact to CCC or Program? If not, why?	Urgent equals pregnant, whether pregnant injecting drug user or not.
3	If urgent case, was client scheduled for treatment within 24 hours of assessment? If not, why not?	Urgent equals pregnant, whether pregnant injecting drug user or not.
4	If Provider performed assessment, if non-urgent case, was client assessed within 7 calendar days (5 working days) of contact to CCC or Program? If not, why not?	All non-pregnant population.
5	If non-urgent case, was client scheduled for treatment within 9 calendar days (7 working days) of assessment? If not, why not?	All non-pregnant population.
6	There shall be an assessment of each client's social and psychological needs. The areas of concern shall include a determination of the following: current emotional state, cultural background, vocational history, family relationships, educational background, socioeconomic status, any legal problems that may affect the treatment plan [R325.14705(1)].	If the client completes assessment questions as a questionnaire, there is a need to review the assessment with the client, document on the assessment that it was reviewed with the client; additionally the treatment plan needs to incorporate problems that were identified by the client in the assessment. (Use of the word <i>problem</i> originates from ASAM PPC2-R).
7	File contains documentation of determination of medical necessity. (Clinical Assessment and Placement Summary, David Mee-Lee, 1998).	The <i>Clinical Assessment and Placement Summary</i> form does not have to be in the client's file if determination of medical necessity is reflected in another way in the record; however, for those who use it, please file the form in the client's file if addressed as a part of the assessment. Please be aware that what the court or PO determines as high risk does not always constitute medical necessity for that level of care.
8	File contains documentation of diagnostic impression using all 5 axes of the DSM-IVTR.	Self explanatory.
9	File contains documentation of level of care determination using ASAM Patient Placement Criteria demonstrating the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity. (Clinical Assessment and Placement Summary, David Mee-Lee, 1998).	<ol style="list-style-type: none"> 1. The <i>Clinical Assessment and Placement Summary</i> form does not have to be in the client's file if determination of medical necessity is reflected in another way in the record; however, for those who use it, please file the form in the client's file. 2. Regarding the Recovery Environment: address what issues will interfere with the client's ability to go back home. 3. In regard to auto authorizations, It is the responsibility of the provider to document the record full justification for what was requested.
10	If the most appropriate level is not utilized, documentation of the most appropriate placement available and the reason for difference between indicated and received level of care is identified as: 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed. (Clinical Assessment and Placement Summary, David Mee Lee, 1998)	The <i>Clinical Assessment and Placement Summary</i> form does not have to be in the client's file if determination of medical necessity is reflected in another way in the record; however, for those who use it, please file the form in the client's file.

11.	File contains documentation of the provision of information on available providers to assist client with informed provider choice.	Inform the client he/she may go to other providers if he/she prefers (unless court ordered in some cases). Some providers have a form listing themselves with other providers in the county the client may go to and the client checks which one he/she chooses to attend.
12.	File contains documentation of the referral to another provider if the client was allowed provider choice.	It is requested to use Mid-South's multi-agency release is used. When using the multi-agency release of confidential information, do not circle specific providers on the form, as that would negate the other providers who are not circled. If the client wishes to cross off other providers listed on form, the client needs to initial each strike off. The release form was created solely to expedite access to appropriate care.

b. **Assessment Summary with ASAM Patient Placement Determination**

- i. This form does not have to be in the client's file if determination of medical necessity in another way is reflected. However, for those who use it, please file the form in the client's file. This answers the protocol, *File contains documentation of determination of medical necessity. (Clinical Assessment and Placement Summary, David Mee-Lee, 1998).*

c. **Ambulatory Detox**

- i. Gary sent the protocol to providers in the past and has not had a response. Providers are to contact Gary if interested in ambulatory detox.

d. **Announcements**

- i. Ericanne announced HOC will be providing "Extended Care" through a DOC contract whereby 12-15 people will be at HOC for 6 months. This may impact bed availability.

II. Next Meeting Date

a. **January 6 @ 9 am at Mid-South**

- i. Will inform in agenda if call-in capability will be available.
- ii. Topic: Treatment Plans.

b. Cases for Discussion

- i. If you wish to provide cases regarding screening or assessments for discussion, please provide the screening, assessment, and release to Lisa no later than **Friday, December 17.**