Quality Improvement Meeting

MSSAC Conference Room
January 6, 2011
9 a.m.

MINUTES

Present:

Kathy Davis, C&FS
Pat Wheeler, NCA/LRA
Sue Wright, Born Free
Jack Jesse, Eaton Behavioral Health
Connie Gallagher, AARC

Present via Conference Call:

Charlene Stier, Clearview
Will Volesky, Kairos
Vicki Hall, FSCA/Lenawee
Carol Waters, ASCC
Deb Thalison, ICSAI/ICHD
Chris McDaniels, CCCC
Molly Teal, Victory Clinic Lansing
Roger Weigers, Arbor Circle
Barb O'Connor, ASAS
Melissa Cerqueira, ASAS
Judi Cates, CEI/CMH
Ericanne Spense, The Recovery Center
Carol Patterson, Cristo Rey
Kelly Crampton, Born Free
Kelly Turner, Born Free

Staff Present:

Gary VanNorman, Executive Director
Jeanne Diver, CCC Manager
Joel Hoepfner, Program Services Manager
Lisa Larson, Utilization Coordinator
Patti Tygre, Utilization Coordinator
Mary Kronquist, Special Projects Coordinator

Executive Director Update

a. **Contracts**
Gary sent to providers a draft contract and reminded the members they are held responsible for abiding to the Mid-South, PIHP, and State requirements. Attachments specific to each provider will come with the contracts.

b. **Retrospective Reviews**
Mid-South staff met with the Affiliation of Mid-Michigan PIHP and discussed retrospective reviews. The PIHP does not require Mid-South to take money back for minor findings but allows for corrective action plans to bring into compliance. Mid-South will be looking at the quality of the program, expectations, improving services, compliance to the contract, meaningful and purposeful service, and if there are problem areas, will discuss with the provider, request corrective action plans, implement possible probation, and notify the Board.

c. **Ambulatory Detox**
Mid-South did not receive the waiver from the State to provide ambulatory detox, as detoxification is residential in the Administrative Rule. There will be no ambulatory detox until a rule promulgates it. However, other options may be available. The goal is to bring substance use disorder services and primary health closer together where practical.

d. **Other - Medical Marijuana**
Mid-South is not looking to exclude those clients who have medical marijuana. Denying services is not acceptable. Providers are to treat these clients individually on a case-by-case basis as done with other clients. If the use of medical marijuana interferes with treatment, discuss this with the client and follow normal procedures. You may regulate this through your treatment plan. Discuss with the client's primary care physician safer alternatives for the client.

e. **Medicaid Dollars and Where We Are**
Gary explained the major problem of Medicaid overspending. The PIHPs are asking CAs to justify Medicaid spending. They may be asking why we aren't managing costs better. Mid-South looked at data with providers and talked to other Coordinating Agencies (CAs). Some CAs are limiting services for Medicaid clients. Mid-South will look at options including utilization management to control dollars to stay within the Medicaid per member per month (budget) amounts PIHPs have identified and still provide meaningful service. This is a serious problem and Mid-South will be looking at providers for ideas on how to reduce the costs. We will look at data and continue discussion on this major problem.

II. Lisa provided an opportunity for members to raise questions relative to screenings and assessments. A question was raised about addressing adolescents on CareNet and showing evidence for justification of authorization. Lisa recommended comment lines under Access I and II and comment box at bottom of authorization may be used. This covers all age groups. If you receive an assessment from another source, check with the client to see if the assessment is still the same. Update the assessment from what was received; do not start all over with the client.

Problems identified from the assessment lead to the development of goals on the treatment plan.
Problems come from what is identified in the assessment. Be careful of mandated treatment. Need to assure treatment is medically necessary and meets ASAM PPC-2. If a client doesn't want to work on areas identified in the assessment, yet opens up in a group session on a subject, write a progress note that will address this as discussion at the next individual session.

III. Treatment Plans

The treatment plan discusses the action the client will take; not what you will provide. Remember to sign and date the treatment plan. The term "global" will no longer be used and there will be more clarity to assist in improvement.

A. The <u>initial step</u> in developing an individualized treatment plan involves the completion of a biopsychosocial assessment (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06, p. 1 of 4). An initial treatment plan is developed as soon after the client's admission as feasible, but before the client is engaged in extensive therapeutic activities [R325.14705 (2)].

B. From the assessment, the needs and strengths of the client are identified (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06). The treatment plan is individualized based upon the assessment of the client's needs and, if applicable, the medical evaluation [R325.14705 (2)(a)].

C. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06, p. 1 of 4).

D. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06 and ODCP Treatment Policy #12, Women's Treatment Services, 9/30/10).

E. The treatment plan identifies the clinical problem(s), relevant to substance use/abuse, (Dr. Mee-Lee 9/14/06 Training).

F. Once the goals and objectives are jointly decided on, they are recorded in the treatment plan document utilized by the provider (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06).

G. "A recipient shall participate in the development of his or her treatment plan." (Recipient Rights Rules, Section 305(1)]. Treatment plans are signed and dated by the client (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06) and (ODCP Policy #08, Substance Abuse Case Management Program Requirements, 1/1/08)

H. The treatment plan contains **specific, individualized objectives** that relate to the goals [R325.14705 (2) (d)].

I. Goals must be stated in the client's words (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06), are time limited and measurable (Dr. Mee-Lee correspondence, dated 9/28/09).

J. Each goal that is written down should be directly tied to a need that was identified in the assessment (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06). The treatment plan goals relate to the identified clinical problem relative to substance use/abuse (Dr. Mee-Lee 9/14/06).

K. Throughout the treatment process, as the client's needs change, the treatment plan must be revised to meet the new needs of the client (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06).

L. The treatment plan identifies what action the client will take to achieve the objective of the goal (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06).

M. The treatment plan identifies what action the counselor will take to assist the client in achieving the goal (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06).

N. Once the treatment plan is completed, the client, counselor, and other involved individuals (family, significant other, etc.) must sign and date the form indicating understanding of the plan and the expectations (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06, p. 2 of 4).

O. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the treatment plan (ODCP Treatment Policy #06, Individualized Treatment Planning, 9/22/06, p. 3 of 4).

P. There are no standard or routine goals that are used by all clients (Treatment Policy #06-Individualized Treatment Planning, 10/1/06, p 3 of 4).

Q. The treatment plan includes **referrals for services** that have been deemed timely and necessary, but are not directly provided by the treatment program [R325.14705 (2)(c)].

R. The treatment plan and the treatment plan reviews not only serve as tools to provide treatment to the client, they help in the administrative function of service authorization. All decisions concerning, but not limited to, authorizations, length of stay, transfer, discharge, continuing care, and authorizations by CAs must be based on individualized determinations of need and on progress toward treatment goals and objectives. Such decisions must not be based on arbitrary criteria such as pre-determined time or payment limits (ODCP Treatment Policy #06-Individualized Treatment Planning, p. 3 of 4).

S. The treatment plan **objectives** identify the steps needed to be taken to achieve the goal (Treatment Policy #06-Individualized Treatment Planning).

T. The treatment plan **objectives** must be developed with the client but do not have to be recorded in the client's exact words (Treatment Policy #06-Individualized Treatment Planning).

U. The individualized objectives need to be written in a manner in which they can be measured for progress toward completion (Treatment Policy #06-Individualized Treatment Planning, 10/1/06, p 2 of 4).

V. The **objective** completion dates must be realistic to the client (Treatment Policy #06-Individualized Treatment Planning, 10/1/06, p 2 of 4).

W. The treatment plan dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan (Treatment Policy #06-Individualized Treatment Planning, 10/1/06, p 4 of 4).

X. The treatment plan is not limited to just the client and the counselor. The client can request any family members, friends, or significant others be involved in the treatment process (Treatment Policy #06-Individualized Treatment Planning, 10/1/06, p 2 of 4).

Y. The client has the right to know who he/she will be working with. The treatment plan identifies the **staff members assigned** to work with the client.

Z. The treatment plan will define the services and identify the **intervention strategies** - specific types of strategies used in treatment (group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.) {Treatment Policy #06-Individualized Treatment Planning [R325.14705 (e)]}.

IV. Next Meeting Date

a. Thursday, February 3 @ 9 a.m. at Mid-South.