



Clinical Care Committee
Minutes
 6/5/09; 9a-12p; Towner, Rm. #107
 Meeting Room Telephone # 734-544-6810

G. Harris, S. Wiland, S. Keener, P. Moise, D. Healy, S. Reitmeier, J. Sahutoglu, M. Phillips, S. Weary, B. Spalding, J. Terwilliger, L. Newberg, J. Capobianco, M. Scalera, D. Healy, K. Milner, D. Orrin, Vicki Stead, C. Witherow, M. Graban, R. Meyers, S. Risk, Carmela Kudyba (bolded name indicates present at meeting; non-bolded name indicates absent at meeting)

AGENDA ITEM	DISCUSSION POINTS	ACTION/OUTCOME	RESPONSIBILITY
I. Approve Minutes & Agenda	<ul style="list-style-type: none"> • Agenda additions • Minutes changes • Update New committee member: Carmela Kudyba (replacing Donna) 	Agenda and minutes approved	
II. Workgroup updates	<ul style="list-style-type: none"> • PCP/Self-Determination – Britt Paxton No update 		
III. Standing Agenda Items	<p>Performance Improvement (PI) Committee Update – L. Newberg</p> <ul style="list-style-type: none"> • There is a subcommittee of PI being formed to go through the ARR plan to determine which sections should be owned by which committees. It is likely that the CCC will hear in the near future which parts the CCC will champion. Part of the section pertaining to meeting service demands will likely come to the CCC. • Monroe is considering a PI project based on the fact that they have a large number of therapist cancellations. • Lenawee may embark on a PI project because labs being ordered for clients are not being filled. • DD Peer Support: A job description is 		

	<p>currently being developed to correlate with the MI Peer Support job description. A 2-day training is being put together. The project will go to PI in July, then to AEC for approval, and then will be presented to the state. The project is on schedule, expected to be ready by the end of the month.</p> <ul style="list-style-type: none">• DD Outcome Tool: Jessica has been gathering data regarding how many consumers have been given the outcome tool, and there is quite a range of DD consumers who have had the tool, from 5% in Livingston to 31% in Lenawee. <p>Integrated Health Update – J. Capobianco</p> <ul style="list-style-type: none">• There is a block grant for a learning opportunity for the community of learning. The group’s last meeting was last week with a focus on financing. One issue brought up was Integrated Health for people with developmental disabilities. Notes will be posted on the WCHO website.• The SAMHSA grant application was submitted on Tuesday, 6/3. SAMHSA is a 4-year, \$400,000/year integrated health grant. <p>Disease Management – E. Kurtz</p> <ul style="list-style-type: none">• The specific groups being targeted are spend-down’s and dual-eligible’s (both Medicare/Medicaid and Medicaid), because those people are not eligible for managed healthcare.• Approximately 1,000 people will be served.• The group is being headed by Trish Cortes.• The SAMHSA grant will do what the Disease Management group is doing for the uninsured (serving another 400-500 people).• For now, Disease Management will only cover Washtenaw County.		
--	--	--	--

	<ul style="list-style-type: none"> The program will be voluntary, with an automatic admission with the option to opt out. <p>Clinical For Changes – J. Sproat</p> <ul style="list-style-type: none"> No update 		
IV. DBT CPT codes – Jane	Follow-up recommendation that AEC consider local codes for tracking DBT within affiliation.		
V. Evidence Based Practice Inventory – Jane	<p>Discussion of what we monitor and how, # staff trained, # consumers involved, etc. Review existing dashboard report.</p> <ul style="list-style-type: none"> The Directors would like to know what EBPs are being used across the Affiliation. For example, with PMTO, until a trainer is certified, the code cannot be used, so there is no way to know what services are happening because of the data collection issues. Some considerations: Should the Affiliation do every EBP available? Should the Affiliation do only a few EBPs but do them well? The best outcomes have been in Children’s Services (the CAFAS). A Zoomerang survey is a possible tool to gauge who has had exposure to trainings. Staff will need help with defining which cases are PMTO. Once the master list of CPTs has been sent: <ul style="list-style-type: none"> Each clinician should identify each case that is PMTO. Each clinical director should identify the EBPs that are being used, to help narrow the list of 150 codes down. The narrowed down list of codes will be compiled at CCC. 	Links to listings of CPTs to be emailed to the committee.	SW

	<p>– Consideration: Adding a checkbox to the PCP to indicate the presence of CPT codes.</p> <p>To-Do: By the next CCC meeting (7/10), identify EBP promising practices from SAMHSA, the 137, and local practices from each CMH, to be compiled by the CCC.</p>	<p>Compiled list of EBP codes</p>	<p>GH, SK, LN, SW</p>
<p>VI. MI Outcome Measure</p>	<p>Denver Mental Health Center tool vs. adapted DD Outcome tool. Last month, some in the CCC asked for more information about the Denver tool, so Matt Hoffman arranged for a webinar for frontline staff at each affiliate to preview the tool.</p> <p>Livingston feedback: Given the choice between the Denver tool, no tool, or an internal tool, some staff said they would rather have no tool because it is going to add time to their workload. But, at the same time, people recognized that the Denver tool is a better tool than the internal one, but people were concerned about add-ons to staff responsibilities.</p> <p>CSTS Feedback: Outcome data is needed. S. Wiland does not believe it is an exact comparison between the 2 choices, and wonders if the true costs (dollars, development time, etc...) have been explained fully. Frontline staff do not want added responsibility.</p> <p>Lenawee Feedback: Staff thought the new tool would take a lot of time, but with not a lot of additional value.</p> <p>Question: Why not use the GAFF? S. Wiland advised that it is too subjective. There is also the concern that the state might eventually require the use of an outcome tool, adding another tool to staff workload. Lenawee staff was not in favor of a new tool, but would be willing to work with an internal</p>	<p>Gradient of agreement on the Denver tool:</p> <p>L. Newberg: 4 J. Capobianco: 5 D. Healy: 4 P. Moise: 2 V. Stead: 4 B. Spalding: 4 M. Scalera: 4 S. Wiland: 5 J. Sahutoglu: 3 C. Witherow: 4 J. Terwilliger: abstained C. Kutyla: abstained S. Keener: 3</p> <p>Recommendation of the Denver tool will go to the AEC on 6/8/09.</p>	<p>S.K.</p>

tool.

Monroe Feedback: Staff was solidly in support of the Denver model. The staff would be even more receptive to the Denver tool if only 2 of the 4 modules were used.

Committee discussion:

J. Terwilliger advised that the affiliation probably should not base its decisions on what the state may or may not do in the future.

J. Sahutoglu pointed out that if the affiliation is an early adopter of an outcome tool, the affiliation might provide influence across the rest of the state.

The Denver tool is quarterly. The cost would be \$10/person/year.

If the Denver tool were pared down to 2 modules, those modules would be the Consumer Recovery Measures and the Recovery Marker Measures.

The goal is to have data that the affiliation can benchmark.

The affiliation does not control the CAFAS data, and getting the data on a consistent basis has been an issue. The Denver organization has said the affiliation can batch up data and forward it to them.

The Denver tool can be used in Encompass.

P. Moise stated that if staff is dedicated full-time to developing an internal tool then it will be possible to develop something that would be better than going with the Denver tool.

P. Moise advised that he would not block the Denver tool's approval if the rest of the

	<p>committee recommends it.</p> <p>L. Newberg agreed that staff would be able to create a more precise tool, but that the tool would not be as effective in reaching conclusions about how the affiliation is doing in regard to other providers because the internal tool would not allow for benchmarking.</p> <p>The committee believes it is important to get input from the local advisory boards, RCAC, and consumers.</p>		
VII. MDCH response to CAP review – CJ	<ul style="list-style-type: none"> • A corrective action plan is due in 2 weeks, and the AEC needs to see the plan on Monday, 6/8. CJ needs the committee's input to write the plan. • CJ will send a draft copy to the CCC. 		
VIII. Affiliation Policies	Move to the next CCC meeting.		
IX. Next Meeting	The next committee meeting will be moved from 7/3/09 to 7/10/09.	Agenda Items	Parking lot <ul style="list-style-type: none"> • CSTS supervisor communication concept • Recovery Workshops-D. Orrin • Behavior Treatment Technical Requirement Review