



Community Mental Health Partnership  
of Southeastern Michigan

Clinical Tech Committee  
**Meeting Minutes**  
12-3-09; 10:30-2:30 Towner II, 2140

In Attendance: Sandy Keener, GERALYN Harris, Kathy Dettling, Steve Wiland, Mike Harding, Sheri Kindle

Guests: Matt Hoffman (Afia), Laura Myers-Meske (Livingston), Tracy Gomez (Monroe), Wendy Cadieux (Lenawee), CJ Witherow (WCHO), Britt Paxon (CSTS), Angela Willoughby (Livingston)

Purpose of Today's meeting: Identify areas in the Assessment – PCP process that are redundant or have little or no value and make recommendations to reduce paperwork and make navigation easier for clinicians while maintaining our core data and documentation requirements.

1) Review of PCP

The PCP Committee had recommended the following changes that were approved by Clinical Care and the Executive Team:

1. Remove the annual PCP review
2. Change the authorization system to be a part of the PCP, and to be more flexible in terms of amending / adding / changing authorizations when tweaks are needed.
3. Removal of the PCP documentation page and move the elements to the assessment, pre-plan and the actual PCP.
4. Create a PCP Summary page that has information from the assessment populating into the summary, so clinicians are not re-typing the information.

The participants reviewed the Saginaw system, where outcomes are populated into the new PCP and clinicians are given a choice to continue with them, or to eliminate them via a check box.

Concerns were voiced about the process –

1. Because you start person centered planning prior to the old plan ending, how would this work for the outcomes?  
Recommendations: The previous outcomes would be terminated at the end of the old plan, or at the implementation date of the new plan.
2. Will the elimination of the annual review put us out of compliance w/ JCAHO? (The original additional of an annual review was to meet JCAHO compliance needs)  
Recommendations: The old plan will be reviewed as part of the annual assessment process. There will be a text box on the outcome renewal section that you can add info about progress being made.
3. One of the biggest mistakes clinicians make is to add info / add interim plans in the wrong PCP.

Recommendations: Once a PCP is “finalized”, an interim plan can not be added to that planning list. The plan will become “read only” at this point. Changes to the plan can only be added during the amend, or periodic reviews.

4. Clinicians have to search all over to find the specialty assessments that have recommendations for the PCP.  
Recommendation: Have a link to “all assessments” at the “Start Planning” section (currently you have access to the intake / annual)
5. With an interim plan – sometimes there is no current auth in place due to the ending of the old plan and a delay in starting the new plan, but services are still being provided, but no authorization is in place.  
Recommendation: Add an authorization link to the interim plan identifying what services are going to be provided during the interim period.
6. With the elimination of the PCP documentation page, will clinicians continue to follow the PCP process w/o using the documentation sheet as a guide? The PCP list also sounds like a duplication of the documentation page too, so why is it necessary? There was significant discussion and strong feelings to leave the documentation as is, especially when the person doing the PCP may not be the same person who did the intake / annual assessment.  
Recommendation: Keep the documentation page as is, and don’t move the questions to the preplan or assessment.
7. When does a current authorization actually “end”? At the time of the new auth? At the time of the PCP effective date?  
Recommendation: The current auth will end once the current PCP is approved.
8. Is there a way for a supervisor to “deny” the auth w/o having the clinician have to re-write everything?  
Recommendation: Add a “deny” feature to the supervisor approval function that has a “message” to it that will not be a part of the chart.
9. Will there be a way to “tweak “ an auth to add one extra unit of service that wasn’t part of the original plan w/o having to do a periodic review or amendment (maybe we added an extra half hour of CLS time due to a special need, all within the scope of the plan) Maybe an extra CSM contact occurred because of paperwork needing to be signed, etc) DCH is only concerned when you give less services than what was offered in the plan, rather than extra.  
Recommendation: Have some sort of “back door” way to add on an extra unit or two of a service that is already authorized and part of the plan.

Also – see the AFIA attachment about phase / scope of the PCP project

## 2) Intake / Annual Assessment

Are there any ways to reduce the amount of documentation in our assessment?

1. Header – for child cases – it’s hard to find the name of parents. Information in demographics is specific to the child, and information regarding the child is sent to the child, rather than in care of the parent.  
Recommendation: Have a section in demographics on the header identifying parent name / guardian name

2. When doing a new assessment, information entered during the “add initial assessment” populates into the demographics. Information added during “change initial assessment” does not. This leads to missing information on DCH data.  
Recommendation: Once an assessment is signed / finalized, demographic information will populate into demographics. If a document is amended due to missing or incorrect demographic information, that data will populate into demographics.
3. We continue to struggle with missing information leading to incomplete demographic information.  
Recommendation: Require all demographic information to be completed before completing the page and / or finalizing the form.
4. We have errors where clinicians are putting a “yes” or “no” for the DHS information on adult consumers. Because these are radio buttons, we can’t change the answer to blank as required.  
Recommendation: If possible, have the DHS information only appear if the consumer is under 18, or add an N/A (Adult) option to the choices.
5. There is no easy way to find parental & guardian information without reading the narratives on the Guardian / Parent section.
  - A. Recommendation: On the 1<sup>st</sup> page, have an entry for parent names, contact info & identify their status as one of the following:
    - a) Custodial parent
    - b) Joint custody
    - c) Physical custody
    - d) No contact allowed
  - B. Recommendation: On the 1<sup>st</sup> page, have an entry for guardian name, contact info & identify their status as one of the following:
    - a) Full guardian
    - b) Plenary guardian
    - c) Temporary guardian
    - d) Durable power of attorney
    - e) List of other choices
6. The Brain Injury Tool (page 2) is from a project from years back and no one has ever run a report about it, or used it as it was intended.  
Recommendation: Eliminate the Brain Injury Tool
7. The finance section (page 3) does not contain accurate information and cannot be changed because it is linked to other functions.  
Recommendation: Eliminate the Financial Information form the assessment all together.
8. Guardian / Parent page (Page 4)  
This information is not well laid out, and the ages of family members are never accurate / cannot use for an infant under the age of 1.  
Recommendation: Have a narrative to describe who is in the home. Move the “Contacts” function from the initial page to this page.

9. The education section (page 5) is pretty messy. Sometimes the required DCH data is not checked.  
Recommendation: Make the DCH data elements required to be checked prior to leaving the page. Re-arrange the education section to indicate the following:

- a) School Information: indicate the grade via a drop down that indicates grades 1-12 and “Graduated”
- b) Special Education radio buttons Yes / NO, with a drop down for yes with all the choices.

10. Legal (page 6) - Some of the information was directly related to old substance abuse required data  
Recommendation: Remove “Describe current involvement”. Add directions to the narrative box indicating what type of information should be added.

11. Presenting Problem (page 7) – Staff think the 2 boxes are redundant and they often contain the same info.  
Recommendation: Combine the two boxes to “Presenting Problem”:

12. Bio-psycho-social (page 8) - The box is too small to be able to review everything you are writing without having to use the arrow keys to go up & down.  
Recommendation: Make the narrative box visibly bigger on the page.

13. Risk (Page 9) – The group was concerned that self abusive behavior could be lumped in w/ danger to self.  
Recommendation: Have a add on box with:

Self abusive behavior	Yes	NO	Describe
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14. Needs assessment (page 10) Sometimes, a person has needs that are met with both natural and paid supports  
Recommendation Instead of radio buttons for “needs”, use check boxes

15. DD section (page 12) - This section, once done, cannot be changed. Clinicians have either skipped it, or have done it for non-DD people, which makes inaccurate data for DCH.  
Recommendation If this is still required, have a pop up that warns clinician that this should be done for persons w/ DD, and then, have the ability to change it in demographics so its not locked in for a year.

16. Strengths (page 13) - needs more direction  
Recommendation: add the following directions from the PCP documentation page. Populate the responses to the documentation page.

**What makes you unique? What are your gifts? What are your strengths?**  
i.e. What is important to you - work, home, heritage, background, etc; what talents, skills and hobbies do you have?

17. Barriers (page 14) – needs more direction

Recommendation: Add the following directions from the PCP documentation page. Populate the responses to the documentation page.

**What might be some challenges?**

**Identify all health and safety issues that might prevent you from achieving your vision**

x

**What are some other things that might make it hard to reach your goals? What kind of support or assistance is needed to overcome this challenge?**

Ex: Transportation, finances, community inclusion, lack of natural supp

18. Mental Status (page 15) –some symptoms are too vague  
Recommendation: Add narratives to sleep, appetite & insight (if not normal, explain)
19. Psychiatric & SA History (page 16) - the history boxes are too cumbersome  
Recommendation: Make Family history all of a narrative box. Make abuse all of a narrative box
20. SA box (page 17) - way too cumbersome  
Recommendation: Use the ELMER SA check boxes module
21. Diagnosis and treatment readiness (page 18) – lots of the items are not applicable and sometimes not completed.  
Recommendation: Remove the “requires psychological” and “requires psychiatric” from form. Take the ASAM and move it to SA page 17. Have the diagnostic summary have a spell check feature to it.
22. Eligibility Criteria (pages 20-21-22) – update to reflect the 2010 UR manual changes
23. Dispositions (page 23) –Livingston has a different set of questions that lead to the initial PCP required within 14 days.  
Recommendation: All 4 boards use the Livingston set up. Add “assign to waiting list” as a disposition option, and have a link to the wait list module, with the disposition info populating into the narrative of the wait list.
24. Other recommendations: Have a print set up for MI, DD and MI / SA are options, where pages 1-6 are eliminated, and parts not applicable to the population are eliminated also. This will reduce the size of the eval we send on to other parties.
25. Other recommendations: Have the SA page be a free standing document also, so programs can assess substance use on a regular basis.
26. All above changes populate into the annual assessment excluding pages currently not on the annual..