



Contract Providers Transition Team (CPTT) Meeting Agenda

March 20, 2012
10:00 a.m. – noon

- ✓ Welcome
- ✓ Announcements
- ✓ CPTNP Unit Update – Gordon Bunch
- ✓ e-Prescribing – Abel Rosales
- ✓ HIPAA 5010 Update – Zena Jacobi
- ✓ IBHIS Update – Jay Patel
- ✓ Meaningful Use Preparations: Telecare Corporation's Journey – Tim Wafa
- ✓ County Treatment Plan Coalition – Debbie Innes-Gomberg
- ✓ Open Discussion

The Twelfth Annual Behavioral Health Information Management Conference and Exposition

***Addressing the Needs of Mental Health,
Alcohol, and Other Drug Programs***

Preliminary Program

April 4 - 5, 2012

**Hollywood Renaissance Hotel
1755 North Highland Avenue
Hollywood, CA 90028**





Behavioral Health Information Management Conference and Exposition

Wednesday, April 4, 2012

2:00 PM – 3:30 PM **GENERAL SESSION PANEL**

A PANEL OF EXPERTS RESPOND: EMERGING EHR PRIVACY AND SECURITY ISSUES FOR MENTAL HEALTH AND SUBSTANCE USE TREATMENT PROGRAMS

Linda Garrett, JD, Partner, Risk Management Services (RMS), Medical-Legal Consultant and Trainer
David Minch, Chair, HIMSS National HIE Committee, Co-Chair, California OHII Security Committee, HIPAA/HIE Project Manager, John Muir Health

Renée Popovits, JD, Principal Attorney, Popovits & Robinson, Attorneys at Law and Co-Chair of Substance Abuse Legal Committee for the Illinois Office of Health Information Technology (OHIT)

Tom Trabin, PhD, MSM, (Moderator), Conference Chair, Behavioral Health Informatics and Executive Consultant

Each advancing step in widespread implementation of health information technologies introduces new and more complex privacy and security concerns. The panel of county, state and national experts for this perennial session will highlight these concerns, particularly as they pertain to the exchange of mental health and substance use treatment information. They will introduce the latest policy thinking regarding how best to address these concerns. The session will also include time for broad-ranging audience questions for the panel.

3:30 PM – 4:00 PM **BREAK AND EXHIBIT HALL OPEN**

4:00 PM – 5:15 PM **CONCURRENT SESSIONS**

INTRODUCTION TO BEHAVIORAL HEALTH INFORMATION TECHNOLOGY (HIT) AND HEALTH INFORMATION EXCHANGE (HIE): A NON-TECHNICAL PRIMER FOR EXECUTIVES

Lisa Farrell, Senior Analyst, APS Healthcare

Dan Walters, Technology Services Manager, Kern County Mental Health

Delving into the world of behavioral HIT and HIE and finding one's way can seem daunting, and trying to understand all the terms and acronyms can feel overwhelming. Presenters will clarify some of the fundamental concepts and acronyms of HIT, such as EHRs, EMRs, PHRs, HIEs, 42CFR.2, HIPAA, Meaningful Use and the HiTech Act, etc. They will overview the major policy and practice concerns, and explain how to get the most out of the vendor product demonstrations and exhibit booths. They will also provide non-technical explanations of several types of standards intended to facilitate electronic HIE between organizations with disparate information systems, such as CCD, XML and HL7.

SHOW ME THE MONEY – A STEP BY STEP GUIDE TO MEANINGFUL USE INCENTIVES

Gordon Bunch, MA, Project Manager, Chief Information Office Bureau, County of Los Angeles, Department of Mental Health

Dorian Seamster, MPH, Chief of Health Information Services, California Health Information Partnership and Services Organizations (CalHIPSO)

Many organizations are interested in pursuing meaningful use EHR incentive dollars but are unsure how to proceed or aren't clear if they are eligible. The presenters will begin with a brief overview of the intent behind Meaningful Use measures as standards and incentives for EHRs through the HITECH section of the American Recovery and Reinvestment Act. They will then describe some of the specific measures included. The presenters will explain in practical terms the steps to meeting the criteria from the initial application process to meeting the requirements. They will also address the types of situations in which the costs of meeting meaningful use requirements outweigh the benefits.



Behavioral Health Information Management Conference and Exposition

Thursday, April 5, 2012

PROTECTING PRIVACY IN AN INTEROPERABLE WORLD

Paul Litwak, Attorney & Counselor at Law

Dan Walters (Moderator), Technology Services Manager, Kern County Mental Health

Health information exchange (HIE) is expanding throughout our healthcare delivery system, intensifying the challenges of protecting the privacy and security of behavioral health clients. Presenters in this session will describe and explain many of these challenges, including how they apply to the laws and regulations for both mental health and substance use treatment services. They will also provide recommendations for how these challenges can be addressed effectively, and will provide examples of how electronic consent forms for disclosure and re-disclosure might be standardized that help providers comply with 42CFR.2, HIPAA and California state regulations.

HOW TO SELECT THE MOST USEFUL PERFORMANCE AND OUTCOME MEASURES FOR EVALUATION AND QUALITY IMPROVEMENT

Patrick Miles, PhD, Assistant Director, San Mateo County BHRS

Julie Sizelove, Senior Data Analyst, Santa Clara County, Data Analysis & Evaluation, Department of Alcohol and Drug Services

Because usage of BH software is so often concentrated around the actual service providers, executive and quality assurance staff are often unsure how to make use of the treasure trove of data available to them through their EHR. Presenters will provide an overview of some of the data elements most widely used for performance measure dashboards and outcome measures, some of the approaches to analyzing and reporting data that can support decision making and promote quality improvement, and some of the reporting features common to many EHRs that can make data analysis and reporting more efficient.

HARNESSING THE POWER OF EHRs FOR TREATMENT PLAN DOCUMENTATION AND DECISION SUPPORT

Edward Cohen, PhD, Lead Clinical Consultant, County Treatment Plan Coalition, Associate Professor and Graduate Program Coordinator, School of Social Work, San Jose State University

Debbie Innes-Gomberg, PhD, Steering Committee Member, County Treatment Plan Coalition, District Chief - MHA Implementation Unit, Los Angeles County - Department of Mental Health

Tom Trabin, PhD, MSM, Chair, County Treatment Plan Coalition, Associate Director of Adult Services, Alameda County Behavioral Health Care Services

EHRs can provide documentation and decision support for treatment planning through lists of extensive sample items that would not be feasible to sift through on paper. A coalition of 27 California counties selected, added to and customized a comprehensive list of over 10,000 items during a two-year period that is now ready for installation. Presenters will describe a historic process of broadly representative and diverse stakeholder groups reaching consensus on a new set of behavioral health content standards for wide usage. They will show excerpts from the content that demonstrate how wording can be consumer friendly in everyday English and still meet Medi-Cal documentation requirements. They will explain how keywords and drop-down boxes that incorporate the organizing headings will serve to make extensive lists of items easily searchable.

12:30 PM – 2:00 PM **LUNCH AND EXHIBIT HALL OPEN**

1:00 PM – 1:45 PM **PRODUCT DEMONSTRATION** 

2:00 PM – 3:15 PM **CONCURRENT SESSIONS**

CASE STUDIES IN BEST PRACTICES FOR IMPLEMENTING AN EHR

Paul Gibson, Manager, Data Management Services & Performance Measurement, Stanislaus County

Tim Wafa, JD, Director of Information Services, Enterprise Solutions, Telecare Corporation

The implementation of a new EHR is a huge and often daunting task that requires substantial time and resources from the implementing organization. Fortunately, much is already known about best practices that can save on expenses and maximize the road to success. Presenters will use their organizations' case examples to provide insight and tools for guiding attendees through an implementation, from the early planning stages through training all staff. It will also include discussion of decisions that impact the roll out of an EHR such as the pros and cons of implementing all functions at once vs. a phased in approach, and deciding to accept the vendor's design of workflow vs. requesting a reconfiguration to fit the varieties of workflow within one's own organization.



Medicare & Medicaid EHR Incentive Programs

Proposed Rule for Stage 2 Meaningful
Use Requirements





Proposed Rule

Everything discussed in this presentation is part of a notice of proposed rulemaking (NPRM).

We encourage anyone interested in Stage 2 of meaningful use to review the NPRM for Stage 2 of meaningful use and the NPRM for the 2014 certification of EHR technology at

CMS Rule: http://www.ofr.gov/OFRUpload/OFRData/2012-04443_PI.pdf

ONC Rule: http://www.ofr.gov/OFRUpload/OFRData/2012-04430_PI.pdf

Comments can be made starting March 7 through May 6 at www.regulations.gov

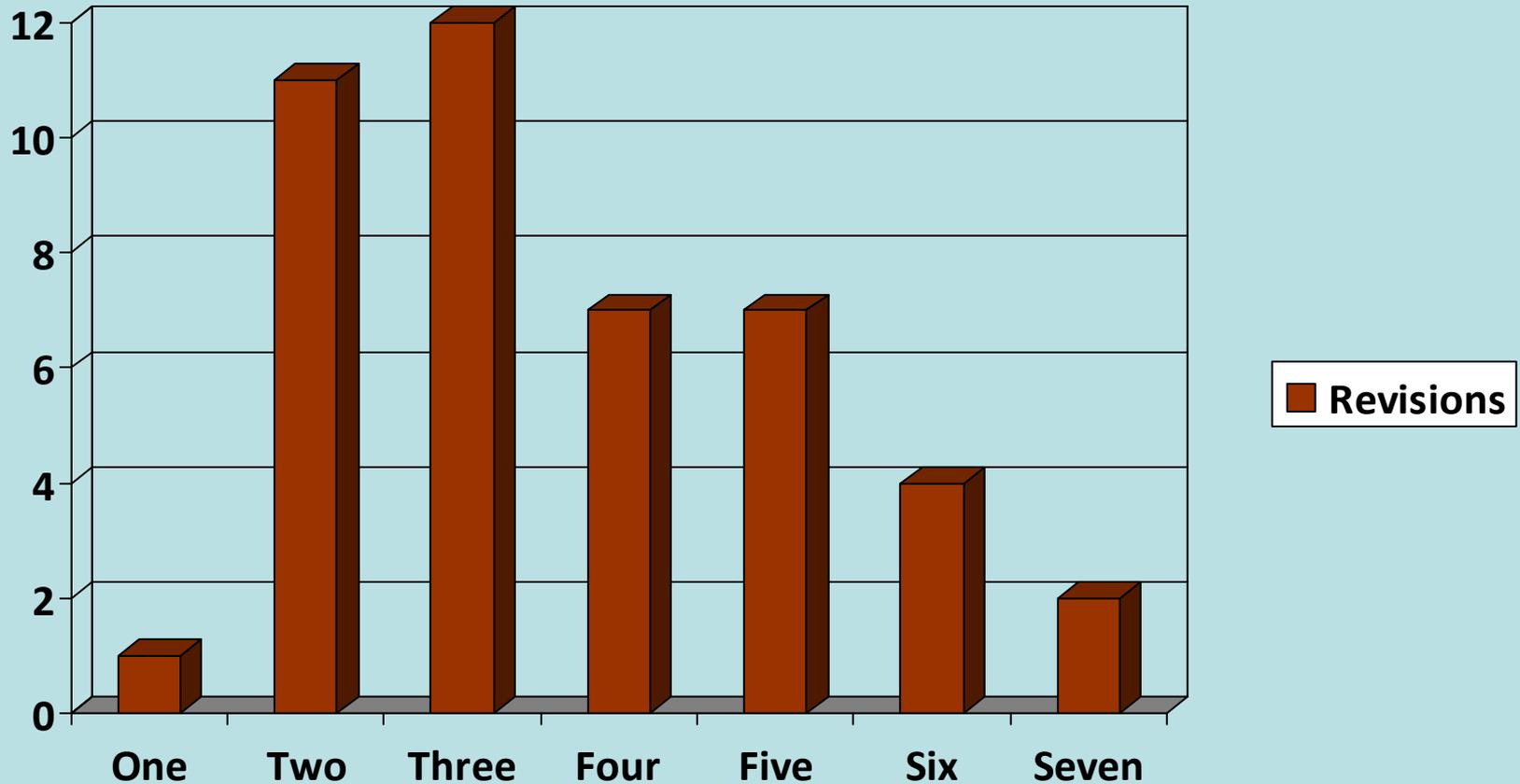
Contract Provider Technological Needs Project Unit: Status Report

As of 3/9/2012

CPTNP Unit: Status Report

- Projects Approved 44
- Funding Agreements Executed 39
- Funding Agreements Pending Execution 3
- Funds committed to Projects \$7,817,653
- Funds expended to date \$2,958,503

Number of Project Revisions To Achieve Project Approval



Revised Proposal Review Process

- First submission reviewed by CPTNP Unit staff instead of review by lead analyst only
- If 1st revision at Level One does not pass to Level Two – Conference call/WebEx with agency

Revised Proposal Review Process

- If 1st revision at Level Two does not move to TNFA – Conference call/WebEx with agency
- If needed, one-on-one meetings will be scheduled



Medi-Cal Registration: Groups and Clinics

CMS allows for patient volumes of Groups or Clinics to be used as a “proxy” for establishing eligibility for EP(s) in the Group/Clinic.

~~The benefit of “proxy” is that the performance of the Group/Clinic with regard to the MU measures is applied to all EP(s) for the purpose of attestation.~~

A provider in the Group/Clinic is eligible for MU incentives if the Group/Clinic Medi-Cal encounters meet threshold even when the individual provider does not meet threshold.

Groups and Clinics: CMS Rules



“All-in” – encounters of all providers in the group/clinic (including those not eligible, i.e. psychologists; LCSW, etc.) must be counted in the group/clinic Medi-Cal percentage. No exclusions allowed.

~~As a Group/Clinic, the “All-in” rule means that the Group/Clinic will implement Meaningful Use throughout the system, for all providers of care regardless of provider field of study and eligibility for incentives.~~

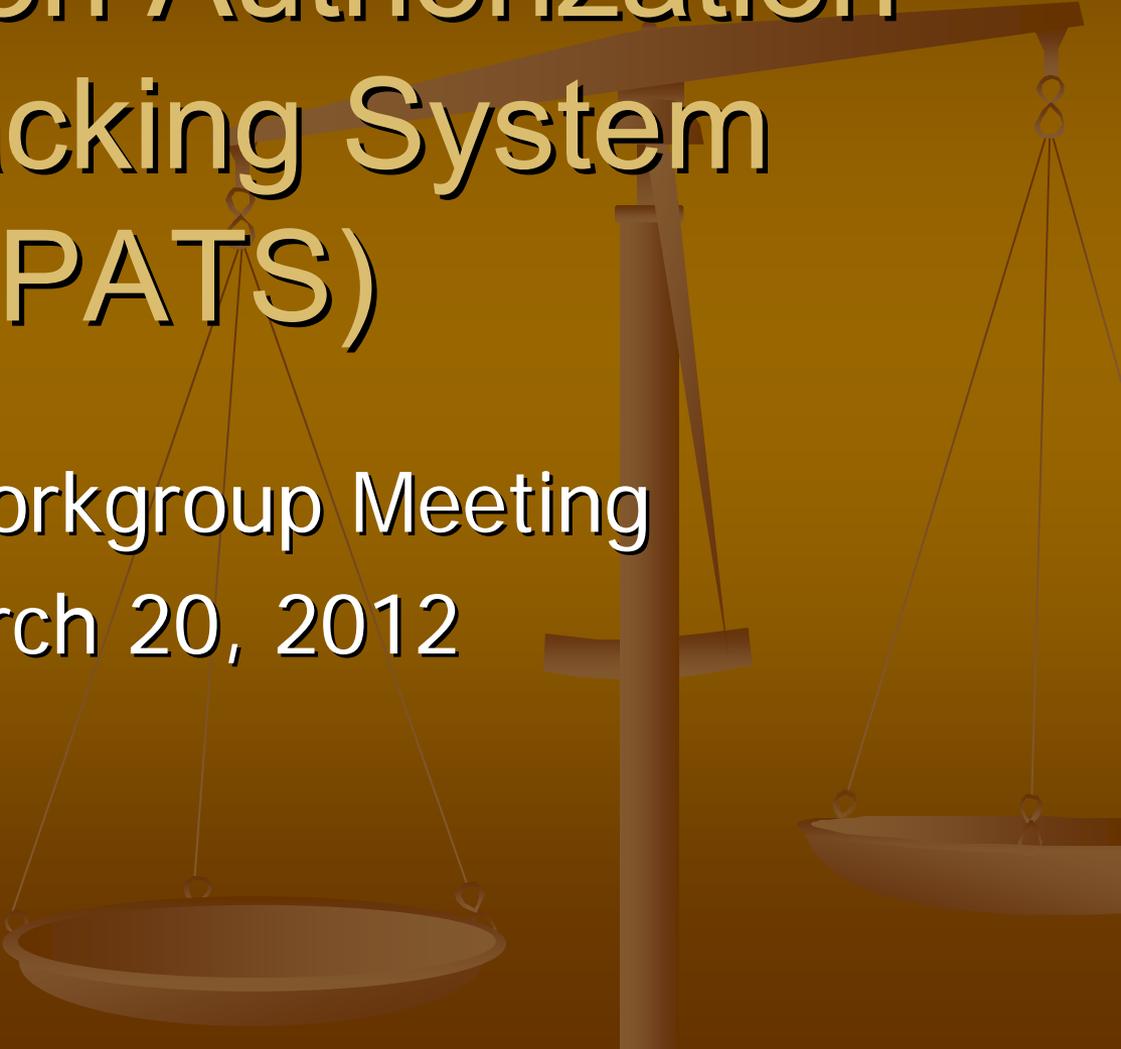
Stages of Meaningful Use by Year

First Payment Year	PAYMENT YEAR				
	2011	2012	2013	2014	2015+
2011	STAGE 1	STAGE 1	STAGE 1	STAGE 2	TBD
2012		STAGE 1	STAGE 1	STAGE 2	TBD
2013			STAGE 1	STAGE 1	TBD
2014				STAGE 1	TBD



Stage 2 has been delayed until 2014

Decommission of the Prescription Authorization and Tracking System (PATS)



CPTT Workgroup Meeting
March 20, 2012

PATS Decommission

- DMH postpones, at least through FY 12/13, the requirement for Contract Providers to acquire an e-Prescribing solution prior to the decommission of PATS.
- DMH strongly encourages Contract Providers to continue to procure and implement a Surescripts® certified e-Prescribing solution.
- Target to decommission PATS is the 1st Quarter of FY 12/13

Issues To Be Addressed by DMH

- Contract Provider's ability to:
 - View the listing of pharmacies in the DMH network
 - View eligibility status of CGF clients
 - View medication history of DMH clients
- Are there any other issues that need to be addressed?

Questions?



HIPAA 5010 Update

HIPAA 5010 Schedule

- ▶ The IS was brought down on Friday, March 16
- ▶ The IS will be brought back up on Monday, April 2
- ▶ **After the IS comes up in HIPAA 5010 mode, the IS will only accept HIPAA 5010 claims**
- ▶ April Cutoff Dates for May Payment:
 - EDI cutoff extended to April 10
 - DDE cutoff extended to April 11
 - Anticipated warrant date – remains May 1

HIPAA 5010 EDI Testing

- ▶ Current EDI provider testing continues through the IS shutdown
 - ALL providers are encouraged to perform EDI 5010 testing prior to sending production claims
 - Test EDI claim processing will be up between 10 AM – 3 PM each day
 - 277CA & 997s for test 5010 claims submitted after 3 PM will be available the next business day
- ▶ DMH will begin EDI 5010 testing for new EDI vendors & providers in April, 2012

HIPAA 5010 – What's New

- ▶ Rendering Provider NPIs must be unique within a Service Location
- ▶ HIPAA 5010 claims will be denied if the same NPI is associated to a Service Location multiple times (for the same time period)
- ▶ Rendering Provider forms will be rejected if they result in duplicate NPI issues

HIPAA 5010 Update

- ▶ DMH will provide more information as it is available via IS Alerts and RMD Bulletins
- ▶ All providers should subscribe to IS Alerts RMD Bulletins to ensure efficient communication

Questions

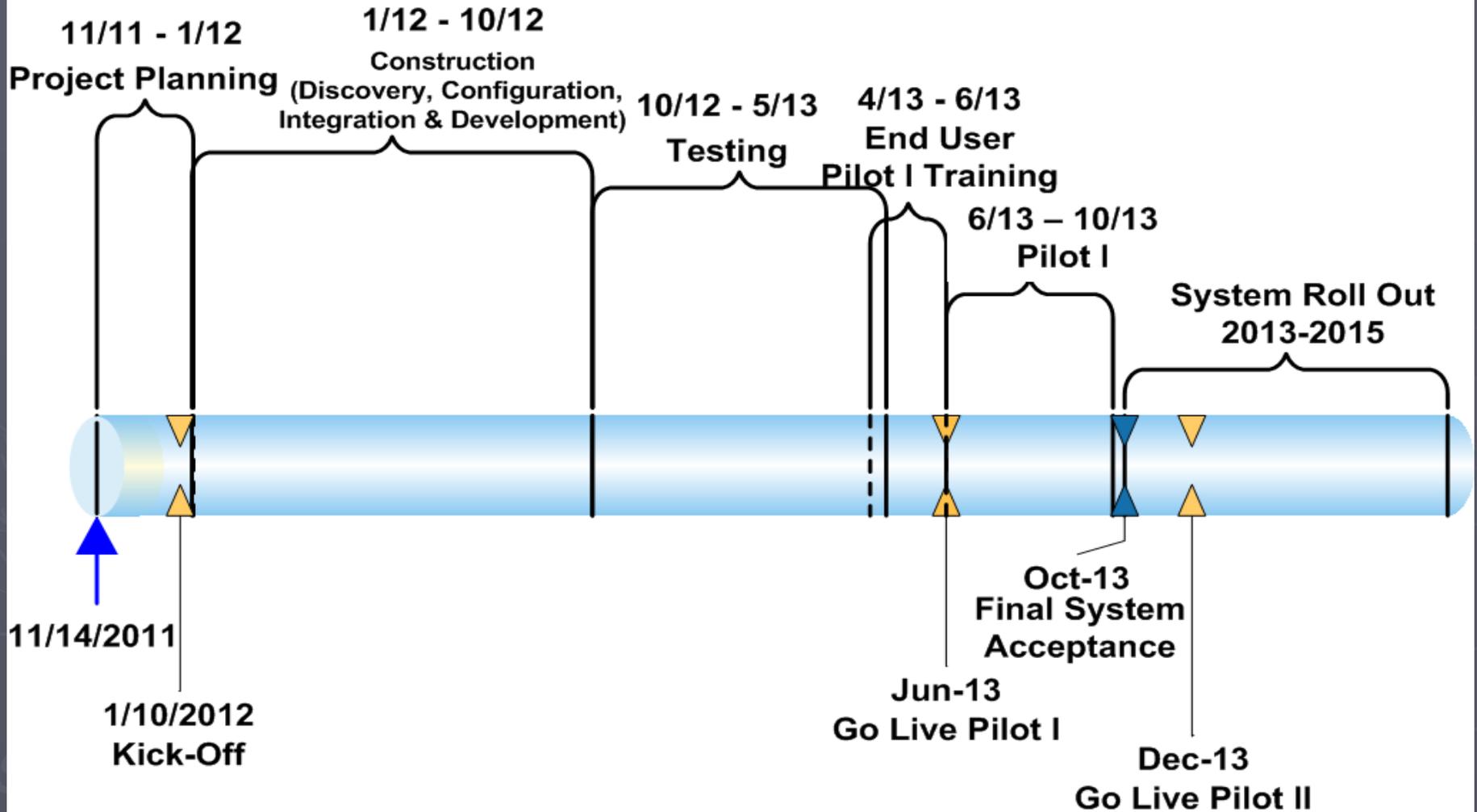




IBHIS Update

- ▶ Netsmart Avatar configuration
- ▶ Integration development
 - Client Data Integration
 - Clinical Information Exchange
- ▶ Pilot I Go-Live
- ▶ Pilot II...

IBHIS Project Schedule Overview



Note: These are currently projected dates

Next...

- ▶ Gap Analysis
- ▶ Discovery and Build
- ▶ Hands-On-Training

Questions



Meaningful Use Preparation: Telecare's Journey

LA County CPTT Meeting
March 20th, 2012

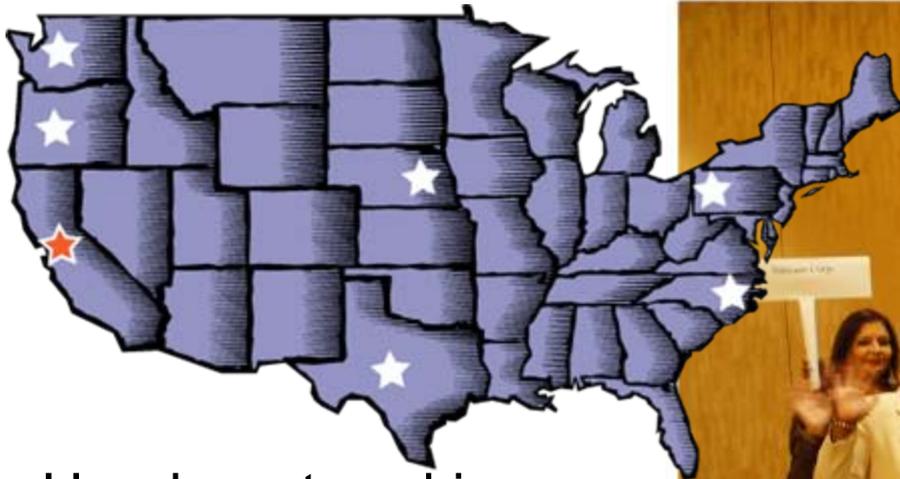
Tim Wafa, IS Director (Enterprise Solutions)

Agenda

<u>Topic</u>	<u>Time</u>
■ Overview of Telecare Corp.	10 Min.
■ EHRIS Implementation	10 Min.
■ MU Preparations	15 Min.
■ MU as Change Driver	5 Min.
Q & A	

Overview of Telecare

2010
**Best Places
to Work** IN THE
BAY AREA



Headquartered in
Alameda, CA

80+ programs,

2,300 + employees
in 8 states

Employee and
family owned



Specialize in services
for people with SMI
and co-occurring
disorders



Our Locations (In LA)

- Los Angeles County
- Example Programs
 - La Casa MHRC (Long Beach)
 - La Paz Gero Psychiatric (Paramount)
 - Area 7 ACT (Bellflower)
 - Long Beach MHUCC (Long Beach)
 - LAOA7/8 ACT (Norwalk)
 - Las Casa PHF (Long Beach)
 - LA 4 ACT (Downtown Los Angeles)

Our Locations (CA Counties)

- California Counties

(where we have programs):

- Alameda
- Placer
- San Mateo
- Sacramento
- Stanislaus
- Ventura
- Yolo
- Los Angeles
- Orange
- San Bernardino
- San Diego
- Santa Barbara
- Santa Cruz*
- Also contract with 10 other counties

Our Locations (Outside of CA)

- Oregon
- Nebraska
- Washington
- North Carolina
- Texas
- New Mexico
- Pennsylvania

Target Populations

- Persons with complex mental health needs
 - Adults
 - Older adults
 - Dual diagnosis / co-occurring disorders
 - Developmental / intellectual disabilities
 - Substance abuse
 - More limited basis
 - Neurobehavioral disorders*
 - Seriously emotionally disturbed adolescents*
 - Early intervention services
- *inpatient services only

Telecare Service Offerings

- Acute Psychiatric Inpatient
- Crisis Stabilization
- Subacute & Secure Residential Services
- Early Intervention
- Assertive Community Treatment (ACT)
- Full Service Partnerships (FSP)
- Intensive case management
- Transitional / target case management
- Residential Services / Supportive Housing
- Wellness
- Employment

Telecare

Service Offerings (Cont.)

Inpatient Acute	Inpatient Non-Acute	Crisis	ACT	Case Management	Residential	Outpatient	Administrative Services
Within Medical Hospital	Recovery Centered 16-Bed	23-Hour Facility-Based Crisis	PACT	Intensive	Residential Treatment	Outpatient Clinic	Service Access
Free Standing Psychiatric	Subacute	Mobile Services	Enhanced CARF ACT	Transitional	Transitional Community Living		Payment Authorization
	Extended	Crisis Residential	CARF ACT				Appeals
		Telephone Support					

EHR Implementation

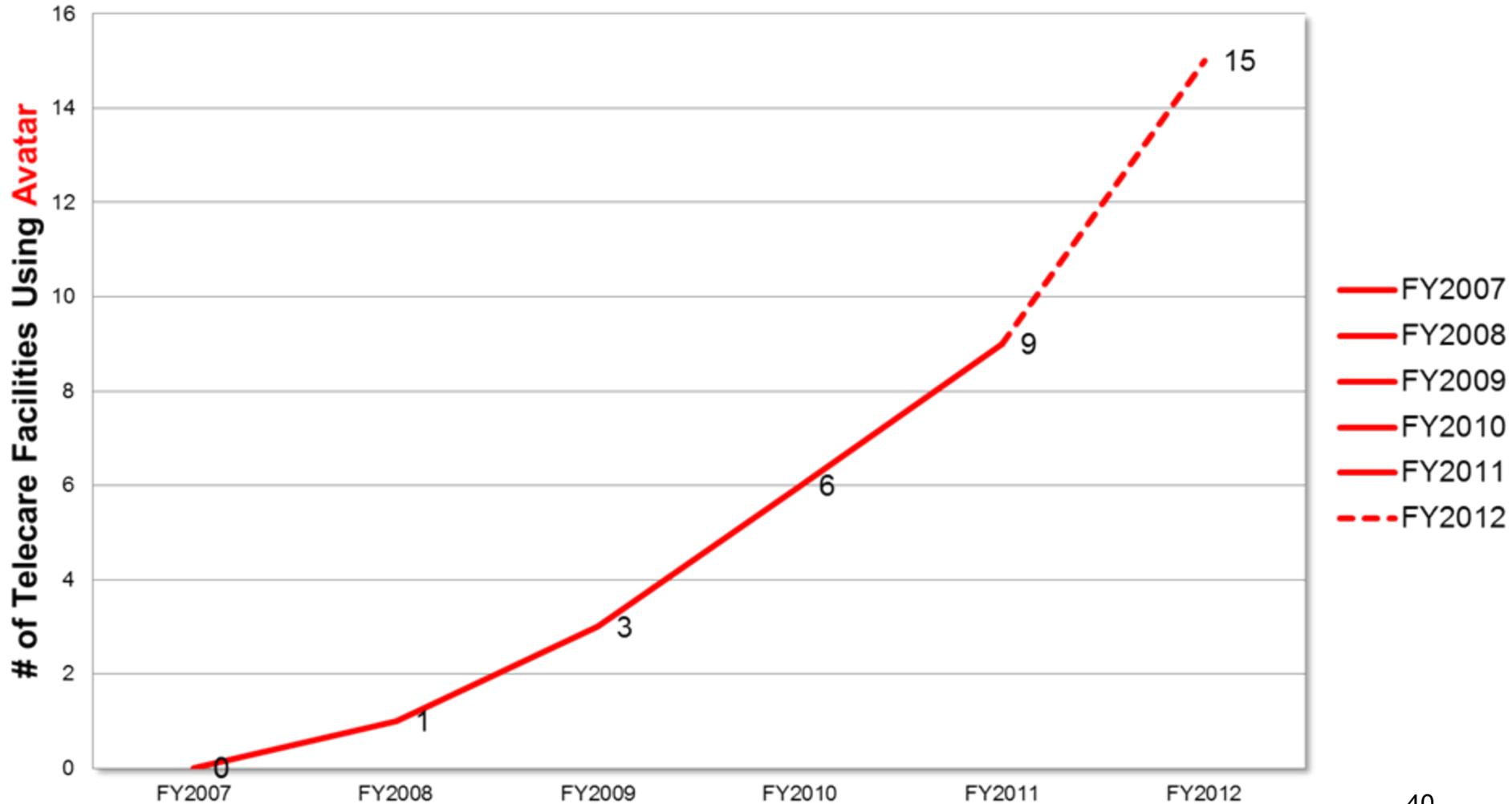
- Telecare EHR Goals: Improve Health of Population, Improve Care to Individuals, Lower Costs.
- Telecare Currently Relying on Netsmart Avatar and BHS Caminar as Health Information Systems.
 - Both Netsmart and BHS are important partners to Telecare.
- A EHR roll-out has many potential scenarios. Business considerations to help set direction...
 - Customer Requirements
 - Financial/Revenue Benefits
 - Operational/Clinical Benefits
 - Meaningful Use Incentive \$\$\$'s*
 - Scalability of Roll-Outs
 - Estimated Duration of Roll-Outs
 - Driving Outcomes

* Note: MU is one of many drivers in our roll-out calculus.

Roll-Outs Considered (Overview)

Roll-Out Options	Meets Impending Customer Requirement	Finance/ Revenue Benefits	Operational / Clinical Benefits	Meaningful Use Incentives	Scalability of Roll-Out	Est. Duration
Option 1	★★★★	★★★★	★	?	★★★★	★★★★
Option 2	★★★★	★	★★★★	?	★★★★	★★★★
Option 3	★★★★	★	★★	?	★★	★

Rolling out Avatar @ Telecare



Meaningful Use Preparations

- Implementing MU Certified EHR –
 - **Understanding the Incentive Programs**
 - Visit CMS EHR Incentive Website
 - Attend County & State Presentations
 - Behavioral Health EHR Vendor FAQ's
 - **Putting Together a Plan**
 - Stakeholder Involvement
 - Ties to Health Information System Strategy
 - **Execution**
 - Blocking and tackling to get the job done.

Meaningful Use Preparations

Chronology

- High Level Due-Diligence (Fall 2010)
- Initiative Kick-Off (Spring 2011).
- EP Reach Out (Summer 2011).
- EP Assignment (Fall 2011)
- Certified EHR (Intent to Upgrade) – Dec 2011
- Medi-Cal Registration – In Progress

Meaningful Use Preparations

Path to Payment

- Step 1: Determine which Incentive program is most beneficial (Medicare or Medicaid)? Determine which EP's qualify?
- Step 2: Have applicable EP's "assign" their incentive payments. (via contract)
- Step 3: Register through the applicable State Medicaid EHR website (if Medicaid)
- Step 4: Adopt/Implement/Upgrade to a Certified EHR.
- Step 5: Deploy EHR in accordance with proscribed MU milestones. Eligible to receive additional payments in subsequent years, if key meaningful use milestones are met .
- Step 6: "Attest" through the State Medicaid web-site that requirement criteria have been met (that we have adopted, implemented, upgraded or meaningfully used certified EHR technology)

Meaningful Use Preparations

Resources / Stakeholders

- Stakeholder involvement spanned all strata of the organization.
 - Chief Information Officer
 - Executive Vice President
 - Chief Medical Officer
 - Counsel
 - Health Information System Strategy Team
 - Focal Point for Heavy Lifting

Meaningful Use Preparations

Services

- Proportion of Medicaid Eligible Services: ~60%
- Proportion of Medicare Eligible Services: ~25%
- Service Mix
 - Inpatient/Residential: 40%
 - Outpatient: 60%

Meaningful Use Preparation

Process for Determining Which Eligible Providers would Qualify for MU Incentives.

Starting # of Service Providers: 367

Filter	# of EP's (Remaining)
Filter 1 – EP - MD/NP?	167
Filter 2 – EP Working in Relevant Facility? (e.g. non-IMD)	70
Filter 3 – EP Working > 8 hours/wk for Tcare?	40
Filter 4 – EP Not Serving Predominantly Dually Eligible	20

After Vetting - Total # of Eligible Practitioners Who Would Qualify = 20

** Note: Based on Telecare's Conservative Interpretation of Guidelines*

Meaningful Use Preparations

Eligible Practitioner (EP) Engagement:

-Engagement led by Medical Leadership

- Medical Leadership described need/approach with each facility Administrator. Provided Administrators with all materials in advance.

Each EP:

- (1) Received a personal letter,
- (2) Received a follow-up phone call from CMO office, and
- (3) Received a simple 1 page “what you need to do” letter.

Meaningful Use Preparations

Eligible Practitioner Engagement:

- Obstacles:
 - Engagement requires careful coordination across organization.
- Key Concerns:
 - Concerns about tax implications. Addressed in letter.
 - Concerns about legalese in assignment contract. Addressed through analogy of a Medicaid assignment.
 - Concerns about time to register on websites. Addressed via streamlined process, with a Corporate based support team.
- Contracted EP's vs. Employed EP's
 - Contract EP's require additional step of engagement with contracting agency.

Result: Nearly 100% Reassignment Success Rate.

Meaningful Use Preparations

Miscellaneous:

- (1) Medi-Cal SLR website – remains buggy. Won't accept Certified Product EHR #.
- (2) Telecare will not form a group. Based on our specific circumstances, a group would put us under 30% Medi-caid Incentive Program threshold.
- (3) Contact Medi-Cal for guidance on key issues – e.g. EHR-vendor/agency/EP relationship and attestations.

Meaningful Use to Drive Change

- “Meaningful use” means providers need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity.
 - Use in a meaningful manner (e.g. e-prescribing)
 - Electronic Exchange of Health Information
 - Submit clinical quality & other measures.
- Intent of MU funding is to incentivize entities to employ electronic health records, not a “refund” or a “reward”.

Meaningful Use to Drive Change

Transformative Change

- Plan should align with Stages of meaningful use.
 - Opportunity for workflow redesign. Pay close attention that you remove barriers to new workflows, roles, and processes.
 - Tailor and respond to stakeholder needs.
 - Make a deep, visible, and personal commitment to the change process for your organization.
 - Learn from each-other.

SUPPLEMENTAL MATERIALS

Key Questions Answered

Does agency have to “fully” implement a certified EHR to be eligible for incentive funds?

No. In the first year of Medicaid participation, eligible providers can adopt (acquire, install), implement (commence utilization), or upgrade to a certified EHR capable of meeting meaningful use requirements. Eligible providers are not required to demonstrate meaningful use in the first year and no EHR reporting is required. This is significant because it means that to qualify for MU incentive payments in their first year of participation, a provider can simply adopt (purchase) a Complete ARRA-Certified EHR.

Key Questions Answered

Who is considered an “eligible provider” (EP)?

To qualify as an eligible professional, a physician or nurse practitioner, must (1) be non-hospital based, (2) have > 30% Medicaid *encounters* over a representative 90-day period and (3) assign their incentives to the organization using an EHR in a meaningful way. It is important to note that an EP cannot assign their incentive payment to more than one employer,

Encounter = Services rendered on any one day to an individual where Medicaid paid for part or all of the service or part of their premiums, copayments or cost-sharing

Key Questions Answered

Some of our EPs work in multiple agencies. Can they assign their incentives to our organization?

To be eligible for incentive payments, in addition to 30% Medicaid encounters, an EP must have 50% or more of their patient encounters during the EHR reporting period at a practice or combination of practices equipped with certified EHR technology. An EP who does not conduct 50% of their patient encounters in any one practice can meet the 50% threshold through a combination of practices equipped with certified EHR technology.

•Note: An EP cannot reassign the incentive payment to more than one employer.



The County Treatment Plan Coalition:
Treatment Plan Library
Providing Documentation Support to
Counties, Providers and Clients

Debbie Innes-Gomberg, Ph.D.

Addressing Common Challenges of Paper-Based Treatment Plan Documentation

- Inconsistent Medicaid/Medi-Cal audit focus
- Differences between Medicaid documentation requirements and consumer-friendly, strength-based and recovery-oriented wording
- Inefficient documentation training for clinicians
- Lack of standard forms and nomenclature to support continuous client records across multiple providers and counties

First Steps to Realizing EHR Benefits for Treatment Planning

- Establish a set of common treatment plan categories that fit for the organization's documentation requirements
- Supply a comprehensive set of pick lists/libraries of sample content for each category from which clinicians and their clients can select
 - Wording must match the organization's documentation requirements
- Offer clinicians and clients flexibility to modify or replace wording when appropriate

What Would It Take to Develop Core Content for Treatment Plans?

- Who can best create extensive content lists for EHR treatment plan modules: multiple stakeholders, treatment plan toolkit developers, or EHR software vendors?
- Can multiple stakeholders within the substance use and mental health treatment field work together to reach consensus on a common framework and core content?

From Ideas to a Plan: The County Treatment Plan Coalition

- January 2009: 33 counties met in January 2009 to share common dilemmas with treatment plan documentation and consider forming a coalition
- Spring 2009: A task force developed a project plan and budget
- Fall 2009: 26 counties joined and paid member dues to fund the plan

County Coalition Members

Alameda
Berkeley
Butte
Fresno
Humboldt
Imperial
Inyo
Lassen
Los Angeles

Mendocino
Monterey
Napa
Orange
Placer
Sacramento
San Francisco
San Joaquin
San Luis Obispo

San Mateo
Santa Clara
Sierra
Solano
Sonoma
Stanislaus
Tuolumne
Yolo

Our Mission

- Improve the quality and consistency of treatment plan documentation throughout the California public substance use and mental health care system
 - Build core content for substance use and mental health treatment that reflects:
 - Medi-Cal and Drug Medi-Cal requirements
 - wellness and recovery language
 - cultural competence considerations
 - attention to differences in age group needs
 - Build content that can be embedded in any of the emerging EHRs

Making the Coalition Operational

- Fall 2009: Consultants were hired to assist with project management and periodic content review
- Fall 2009: DMH Medi-Cal and ADP Drug Medi-Cal agreed to advise the Coalition on content

First Official Meeting

- December, 2009 – Sacramento two-day kick-off
 - 24 of the 27 member counties participated in the meeting
 - DMH and ADP support
 - Decision to search for, select and customize existing treatment plan library product
 - Established overarching values for treatment plan content
 - Medi-Cal and Drug Medi-Cal compliant
 - Recovery oriented and consumer friendly
 - Culturally competent
 - Age group relevant
 - Comprehensively behavioral health – substance use and mental health disorders

Infrastructure for Decision-Making

- Elected Steering Committee
 - Tom Trabin – Alameda (Chair)
 - David Horner – Orange (Treasurer)
 - Marty Marcus – Sonoma (Liaison to CMHDA Medi-Cal Policy Committee)
 - Jim Featherstone/Doug Hawker – Napa
 - Debbie Innes-Gomberg – Los Angeles
 - Madelyn Schlaepfer – Stanislaus
 - Uma Zykofsky – Sacramento
 - Mike Gorodezky – Lead Consultant (ex officio)
- In-County Multi-Stakeholder Workgroups
- Content Advisory Group
 - Ed Cohen (Lead Clinical Consultant)
 - Debbie Innes-Gomberg
 - Marty Marcus
 - Uma Zykofsky

Content Reviewers

- CA Department of Alcohol and Drug Programs Drug Medi-Cal – Marjorie McKisson
- CA Department of Mental Health MediCal – John Lessley, Barbara Mason, Craig Harris, Carole Sakai
- Treatment Plan Library Developer – Stan Taubman
- Content Review Consultants
 - Cultural competence – Peter Manoleas
 - Mental health recovery perspective – Betty Dahlquist
 - Substance use recovery perspective - ADPI (Victor Kogler, Bill Manov, Valerie Gruber)
 - Consumer perspective – Catherine Bond

Role and Importance of In-County Multi-Stakeholder Groups

- Develop common categories and their sample lists with broad stakeholder input to obtain and incorporate their insights and comprehensive perspectives
- Actively encourage and obtain stakeholder involvement at the local level, and channel it through the statewide Coalition workgroups

Primary Stakeholders Included in Content Formulation

- County and contracted treatment providers (clinicians, clinical supervisors and other direct service staff)
- Clients/consumers
- Family members
- County administrators
- State administrators of Medi-Cal and Drug Medi-Cal documentation requirements for mental health and substance use treatment settings

Steps Taken to Elicit Broad Stakeholder Input

- Set up Coalition website
- Web-posted ongoing work materials and list of primary contact persons for each participating county and their contact information
- Informed and invited stakeholders through their statewide associations to contact their web-listed in-county contact person
- Held webinars to encourage member counties to invite and assemble key stakeholder representatives with perspectives encompassing all age groups, cultural diversity, and recovery issues for both substance use and mental health conditions
- Asked stakeholder groups in winter of 2010 to formulate core content categories for Treatment Plan Library RFP

Core Treatment Plan Categories Formulated by Member Counties

- Personal life and treatment goals
- Personal strengths and resources related to each goal
- Barriers and problems related to each goal
- Objectives involved in achieving each goal
- Interventions
 - What the provider will do to help
 - What the consumer will do
 - What family members, close friends, and/or significant others will do

Selecting a Treatment Plan Documentation Guide

- April – August, 2010: Conducted nationwide RFP search process
 - Drafted RFP
 - Broadcast emailed, web posted, and advertised in national publications
 - Reviewed responses and interviewed finalists
- August – September 2010: Selected Treatment Plan Library and negotiated contract terms with Stan Taubman, Ph.D. from Berkeley Training Associates
- November, 2010: Signed contract with Dr. Taubman and CiMH on behalf of coalition members with plan for:
 - Copyrighted material to be reviewed by Coalition and consultants
 - Dr. Taubman to incorporate changes as requested by Coalition
 - Final product to be licensed at steep discount to Coalition members

First Steps in Customizing the Treatment Plan Library

- Winter 2011 – Spring 2011:
 - In-county multi-stakeholder groups and consultants provided feedback leading to some initial modifications and sending of a second draft
 - Each county's multi-stakeholder workgroup reviewed the second draft, generated over a thousand comments and edits, and sent them to the Coalition project consultants
 - Project consultants consolidated all edits and comments for review and disposition by statewide coalition workgroups

Statewide Coalition Workgroups Meet to Decide on Suggested Modifications

- July - August, 2011
 - Statewide Coalition Workgroups complete edit decisions, consultants incorporate them, and Content Advisory Group resolves parking lot issues
 - Coalition consultants distribute first draft for review and feedback to DMH Medi-Cal and ADP Drug Medi-Cal officials,
and to content consultants

Reviews and Edits

- September – November 2011
 - Comments/edits received and collated by consultants
 - Content Advisory Group, including lead clinical consultant and product developer, decided upon disposition of edits and incorporated most of them.
 - Reviewers were contacted to discuss disposition of their suggestions and agreed to them.
 - Steering Committee made final decisions and determined there were no parking lot items of controversy requiring reconvening of the entire Coalition.

Product Completion

- January 2012 – Final product available for licensing and use to Coalition counties at \$1 for first year and steep discounts for ensuing years

Preview of the Product

- The completed Treatment Plan Library has a comprehensive set of over 5,000 items spanning 7 treatment plan categories
- The items within each category are be associated/nested within many types of optional headings designed for use in EHRs as search functions in drop down boxes to yield short, targeted item lists
- The items are also intended to be searchable through keywords for easy access

How Providers and Consumers Might Use the Product

- Providers are encouraged to:
 - work collaboratively with their clients in selecting treatment and recovery planning content options
 - use headings and/or keywords as search functions to narrow the list of options
 - select items from the Library as is or with modifications, or use free text and refer to the items for guidance regarding phrasing

Implications for Behavioral Healthcare Nationwide

We have shown from this project that we can:

- organize ourselves along with multiple stakeholders to develop behavioral health content standards that are much-needed to more fully use the potential of EHRs
- reconcile Medicaid documentation requirements with wording that is consumer-friendly, strength-based, recovery-oriented and culturally sensitive
- envision how computer supports can be used with training to enrich a collaborative treatment planning process between the consumer/client and the provider

Questions & Further Information

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