

# **The County Treatment Plan Coalition**

## **Project Plan to Develop**

### **Common Mental Health, Alcohol and Drug Treatment Plan Guides for Inclusion in Electronic Health Record Systems (EHRs)**

All California counties are invited to co-fund and be participating members in a Coalition to develop common treatment plan guides for inclusion in the emerging EHRs of their county operated and contracted provider programs. The coalition is expected to begin its work in November. This paper provides background information for the formation of the coalition, a description of its scope and work plan, a proposed budget, and the processes to be taken to join.

#### **Background**

Over 60 representatives from 33 counties convened on January 27, 2009 at the Alameda County Conference Center to consider forming a statewide coalition of counties to address the mental health and substance use treatment plan challenges they all face. They identified many common challenges shared by all counties, and discussed how the impending adoption of electronic health records (EHRs) might provide an opportunity to address those challenges. County representatives reached consensus that a statewide coalition of counties would be an effective way to turn that opportunity into a reality. They decided on a strategy, nominated a lead consultant, and assigned to a Transition Team the tasks of developing a project plan, budget, and pricing model for county participation.

#### **Common county challenges to formulating and documenting treatment plans**

County representatives agreed that treatment providers are generally not as effective at documenting the services they deliver as they are at delivering those services. Few providers receive training in service documentation as part of their undergraduate or graduate school program. On-the-job training in documentation is very time-consuming, and treatment providers who commonly have large caseloads find it difficult to give the time necessary to get the training and then to document effectively.

Most county representatives concurred that MediCal presents them with their most challenging documentation requirements, particularly as applied to mental health treatment plans. They identified the documentation of clients' treatment plan objectives as among the most difficult documentation tasks. They described common experiences with MediCal audits wherein the focus might change unpredictably from one audit to the next as well as the positions that the auditors might assert regarding specific documentation requirements. Representatives expressed concern that the substantial challenges already inherent in treatment plan documentation are made more daunting by these inconsistencies. They also shared concerns about the common difficulties they experience in obtaining more definitive clarifying information about treatment plan documentation guidelines from DMH MediCal Oversight Branch.

Another documentation challenge identified by county representatives is how to phrase treatment plans so they reflect an orientation of person-centeredness, wellness and recovery, and cultural competence. The interpretation of recovery differs somewhat between mental health and substance abuse fields. Furthermore, within mental health treatment there appears to be a basic

disconnect between deficit-based (MediCal) and strength-based (wellness and recovery (MHSA)) approaches that is challenging to reconcile. Training in these varying perspectives is becoming more widespread, but translating them into specific treatment plan wording is challenging.

### **How widespread county adoption of EHRs can help address treatment plan challenges:**

The group identified many EHR functions that can help address the challenges they face in treatment plan documentation. EHRs can help guide providers in phrasing, either exactly or generically, through drop-down boxes in the treatment plan module with example content for each major category (e.g. strengths, goals, resources, obstacles, objectives, interventions). EHRs can provide core substance abuse and mental health content, just as physical health EHR systems currently provide. County representatives proposed that an EHR set of content libraries for treatment plan categories could be designed to provide core content while allowing for other free text entries.

Participants cited multiple examples of how EHR-embedded treatment plan functions can help resolve the seeming disconnect between MediCal and wellness and recovery paradigms. They suggested the EHR could provide open text fields for entry of key elements in the client's own words, and corresponding drop down boxes of pick lists with suggested wording that corresponds to the client's stated issues in MediCal-compliant terminology. They discussed the potential of automated prompts from one treatment plan category to the next (e.g. selection of specific problem areas prompts suggestions for goals and objectives, and the latter prompts suggestions for interventions). They speculated about the possibility of making some of the MediCal documentation guidelines sufficiently explicit that it would become possible to prompt prevalidation checks regarding whether some aspects of the treatment plan documentation meet MediCal guidelines.

County representatives described other advantages to EHR-embedded treatment plan documentation that can substantially improve the quality of care. They also indicated that, beyond treatment plan content, EHRs can enable workflow connectivity for clinical staff between assessment, treatment plan, progress notes, and billing. This would provide essential components towards realization of an integrated information infrastructure. Consumers are mobile, and their physical, mental health and substance abuse related data must also be mobile for easy tracking. EHRs can provide essential information readily to the entire clinical care team for coordination of care. Furthermore, if counties shared a common treatment plan template and core content across their respective EHRs, they would be able to provide a continuous client record to support care coordination for those clients who receive care in multiple counties. A commonly shared template and core content would enable counties to more easily collect data and provide reports on client progress and outcomes based upon the objectives that clients state are important to them.

In discussing these possibilities, participants were not without concerns. One type of concern they voices was whether preformulated content libraries might compromise individualized treatment planning. They spoke about making certain to build into the preformulated lists sufficient variability to accommodate the needs of all age groups and of co-occurring mental health and substance use conditions. They anticipated that some clinical users of the system might be induced by the content libraries to adopt a "cookie cutter approach" that would conflict with a person-centered approach. To mitigate this potentiality, they underscored the importance of proper training and supervision, of offering an "other" category in each of the pick lists, and possibly of offering a free text box to allow for additional entries to the content libraries in the client's own words.

Another type of concern that participants expressed was focused upon the interconnectivity of the treatment plan module with other components of the client's EHR. They acknowledged how crucial this interconnectivity and integration will be, but also expressed concern that trying to address all other aspects of the clinical workflow at the same time as treatment planning may be too much. They concluded that it would be best to begin with a focus only on treatment plans and get to other aspects like assessment later. They also spoke about making certain that whatever is produced can be integrated into the treatment plan module of any major EHR software used in California.

### **How a statewide county coalition can help achieve these gains**

County representatives identified many compelling advantages to forming a coalition for the purposes outlined in this paper:

- County behavioral health departments united together will increase their leverage with standard setters—particularly state MediCal and regional Center for MediCAid and MediCare—to clarify documentation requirements in a consistent manner.
- A coalition can more easily bring expert consultants to the table along with cross-county expertise to help formulate wording that is wellness and recovery oriented and sensitive to cultural diversity.
- The development of core content and standardized templates could enable continuous client records and information exchange across multiple providers within and across counties for effective coordination of care.
- A coalition would make it feasible for each county to achieve these benefits at far less cost than if each county were to embark on this undertaking separately.

Those participating in the formulation of the coalition also acknowledged some daunting challenges. Can county participants figure out efficient and effective ways of working together to develop the treatment plan template and content? Can they reach consensus on the template design and content? Can they actually get MediCal and CMS Medicaid officials to come to their table and work with them?

## **Approach to Developing the Treatment Plan Template Structure and Sample Content**

Counties need a treatment plan template and content that is software neutral so it can be incorporated into each of their respective EHR systems. County representatives decided it would be preferable to select and customize a pre-existing treatment plan toolkit rather than to start from a blank slate and develop one. To facilitate that goal, they decided to first formulate a template/structure for the treatment plan, and then use it to develop an RFP and select a treatment plan toolkit to customize. CIMH will be the intermediary to contract with the treatment plan toolkit developer. Child, TAY, adult and older adult task forces will then work with the developer to customize the toolkit content. Consideration of co-occurring conditions and cultural competence will pervade the content across all the task forces rather than be the focus of a specific task force.

Coalition members will work primarily through webinars, conference calls, and emails. However, there will be a few in-person meetings. Counties should each assemble their own multi-stakeholder advisory groups/task forces to advise their representatives to the coalition on input for each phase of decision-making (template design, toolkit selection, and content customization).

## Proposed Work Plan

### 1. Stage One: Formation

- A. Initial joiners send payment or a letter of commitment signed by their department director to CIMH.
- B. Consultant signs contract with CIMH
- C. Initial joiners form a Steering Committee (or designate others to constitute one) and work with the Consultant to:
  - 1) Draft a Coalition name, mission, goals, and scope of work (building upon what was already developed by the group that met in January and the Transition Team that worked thereafter)
  - 2) Update the list of tasks and resources needed within each Project Stage that were developed by the Transition Team
  - 3) Formulate policies and procedures for the Coalition as needed.
  - 4) Identify and invite MediCal and Drug MediCal officials to work with the Coalition.
  - 5) Identify and invite two clinical consultants to assist the Lead Consultant in facilitation of Coalition task forces, and two content expert consultants (one for wellness and recovery wording and a second for cultural competence wording) to advise the Coalition periodically throughout its work.

### 2. Stage Two: Template Design

- A. Convene a two-day kickoff orientation seminar and working meeting to:
  - 1) Learn treatment plan documentation guidelines from experts in MediCal, Drug MediCal, wellness and recovery, and cultural competence perspectives.
  - 2) Develop decision-making processes and infrastructure for the project, including a steering committee and various task forces.
  - 3) Formulate a draft treatment plan template and structure that includes specification of the major categories (e.g. goals, barriers, strengths, resources, objectives, interventions) and methods to enter content within each category (e.g. free text boxes, content pick lists). Options should be inclusive of all age groups for both mental health and substance use conditions. MediCal and Drug MediCal requirements must be incorporated.
  - 4) Primary representatives to the coalition help arrange their own within-county multi-stakeholder advisory committees to provide input per task for their representatives to convey to the Coalition.
  - 5) In-county multi-stakeholder advisory committees review the draft treatment plan template and structure, and convey their feedback through their county coalition representatives to the Steering Committee for further refinement.

### 3. Stage Three: Select a Treatment Plan Toolkit to Customize

- A. Decide during the two-day kickoff meeting whether to review and select a specific treatment plan toolkit, or to conduct an outreach effort to generate a broad list of treatment plan toolkit developers to whom to send the RFP. If the latter:
- B. Outline a selection process and design its components to include a preliminary RFI (if there are a large number of likely candidates), an RFP with a weighting formula, a demo and interview, and a method for selecting a final vendor and product.
- C. Implement the selection process

- D. Develop and sign the contract. The agreement should address any development costs, licensing fees, and eventual licensing discounts for all coalition members.

4. **Stage Four: Customize the Toolkit**

- A. Each member county assembles its own in-county multi-stakeholder advisory group including representation of contracted providers, consumers, and family members. Each group reviews the selected toolkit, considers modifications to it, and conveys their input to the statewide Coalition workgroups composed of Coalition county member representatives.
- B. Coalition participants designate statewide workgroups composed of county Coalition members to use the feedback from in-county multi-stakeholder workgroups to guide their content modifications of the Toolkit. The workgroup tasks are to address both mental health and substance use conditions for each major age group (children, TAY, adults and older adults).
- C. The Coalition also obtains reviews and feedback from consultant experts on possible content modifications from MediCal audit, person-centered, recovery, wellness, co-occurring and cultural competence perspectives.
- D. Workgroup representatives consider input they obtained from their own county advisory groups (4A), the coalition consultant experts and MediCal/Medicaid officials (4C). They then modify the content in the Toolkit to incorporate California county needs. Their work should preferably begin with an in-person meeting, and subsequently meet by webinar.
- E. Coalition participants consider the recommendations from each of the workgroups and finalize recommendations for appropriate content modifications to the Toolkit.
- F. Toolkit developer works with Coalition participants to incorporate all the content modifications into a Toolkit version designed especially for California counties.
- G. Coalition participants review and approve the final version of the Toolkit, ready for licensing to California counties.
- H. Toolkit is licensed to interested California counties according to the Coalition contract terms, which involve a discount for Coalition participants.

5. **Stage Five: Revisit to make updates**

- A. After a set period (two years?), revisit the customized Toolkit to consider desired updates
- B. Toolkit developer incorporates updates and disseminates new version to licensees.

## Projected Project Budget (Summary Overview)

The Project Transition Team worked with the Project Lead Consultant to develop a detailed budget, the summary overview budget listed below, and a formula-driven pricing model based upon county size.

<u>Items</u>	<u>Cost Estimate</u>
All consultant services (lead consultant, clinical task force consultants, and content expert consultants (e.g. recovery & wellness, cultural competence, etc.)	\$132,900
Combined travel and lodging expenses for all consultants	7,200
Medicaid officials travel and lodging expenses	2,000
CiMH web services	2,400
Meeting related expenses including CiMH staff fees	11,000
<b>SubTotal</b>	<b>\$155,500</b>
CiMH Overhead charge	15,550
Contingency (25%)	30,546
Developer fee (may be waived)	25,000
<b>Total Project Cost</b>	<b>\$226,596</b>

### Cost per county and MHPA coverage

A formula based on size of county population was used to determine the exact rate, similar to what was done with the CBS Coalition several years ago. The actual cost to join the coalition is \$2000 for a county with a population under 100,000, \$4000 for small counties, \$8000 for medium-sized counties, and \$12,000 for large counties. Three large, founding counties—Alameda, Los Angeles and Orange—each contributes substantially more to jump start the project and enable the cost to be more manageable for the other counties.

Other county costs will include county staff time to participate in clinical work groups and expenses for limited in-person meetings. Several counties are already planning how to use MHPA funds to fund these costs. Some are planning to use the MHPA Capital and Facilities and Technological Needs (CF/TN) funding application process, some are planning to use other MHPA funds they received for their EHR development, and some others are considering use of the Workforce Education and Training (WET) funding application process. For those planning to use the CF/TN application process, an Exhibit 3 boiler plate with basic Coalition information was prepared by Kern County in cooperation with the Coalition Transition Team and is available through the Coalition Lead Consultant, Mike Gorodezky. His email address is: [mgorodezky@cox.net](mailto:mgorodezky@cox.net) and phone is 805-450-8948.