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Community Mental Health Association of Michigan

Administrative Efficiencies Final Report

December 2025

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Executive Summary

The Community Mental Health Association of Michigan (CMHA), with funding from the Michigan Health Endowment Fund, engaged Public Sector Consultants (PSC) to identify and address administrative inefficiencies within Michigan's public behavioral health system. Over a two-year period, PSC convened a 28-member advisory committee composed of community mental health service providers (CMHSPs), Prepaid Inpatient Hospital Providers (PIHPs), community providers, consumer advocates, the Michigan Department of Health and Human Services (MDHHS) leadership, and persons served to prioritize issues that delay access to care and negatively affect service delivery.

Through advisory committee meetings, interviews, and discussion groups, stakeholders identified the intake and assessment process as a primary source of inefficiency. The current process is often lengthy, duplicative, and intrusive, requiring individuals to answer the same questions across multiple assessments and appointments, which can delay treatment and negatively impact rapport with providers.

To address these challenges, the advisory committee focused on **minimizing the amount of data collected from people seeking services.** The committee formed three workgroups that developed the following recommendations:

- **Simplify the Behavioral Health Treatment Episode Data Set (BHTEDS):** The workgroup developed a framework to identify which elements of the BHTEDS are necessary for specific populations. CMHSPs should implement this framework to eliminate unnecessary data collection. Additionally, the workgroup should continue working with the State to simplify response options, explore alternative data collection approaches, and ensure future changes are discussed with CMHSPs prior to implementation.
- **Streamline the Biopsychosocial (BPS) Assessment:** The workgroup recommends using a standardized, succinct BPS template that meets all regulatory requirements while reducing assessment length. CMHP testing of their draft template suggested it could reduce assessment length by 40 percent, while maintaining clinical value.
- **Reduce Assessment Duplication:** The workgroup recommends mapping all data elements across state-required tools (such as MichiCANS and the American Society of Addiction Medicine [ASAM] Criteria) to other assessments and the BPS to ensure that essential questions are only asked once.

By focusing on the intake process, the advisory committee has provided a roadmap to achieve a "warm, focused intake" that respects the dignity of the person served while satisfying all regulatory standards. Using the recommended BPS template and the BHTEDS population framework could immediately reduce administrative burden. Continuing to map all required data elements could further reduce duplication. The success of these recommendations relies on the endorsement of these standardized tools by CMHA, CMHSPs, and MDHHS, as well as their adoption by CMHSPs. Implementing these changes will enable clinical teams to focus on expert clinical interviewing and rapport-building, rather than on repetitive compliance.

Introduction

The Community Mental Health Association of Michigan, with funding from the Michigan Health Endowment Fund, engaged PSC to convene an advisory committee tasked with identifying, prioritizing, and addressing administrative inefficiencies in Michigan's public mental health system that can delay or negatively affect the provision of essential services. Inefficiencies can lead to lower quality or even limited access to care, staff burnout, and other issues. The advisory committee included 28 representatives from community mental health service providers (CMHSPs), community providers, persons served by the system, PIHPs, advocacy organizations, and leadership from MDHHS's Bureau of Specialty Behavioral Health Services. The list of advisory committee members is available in Appendix A.

PSC worked closely with CMHA and the advisory committee over the two-year project period to use a human-centered approach[1] to identify and prioritize key areas of inefficiency, develop potential solutions for those areas, and then create three workgroups to develop recommendations to implement those potential solutions. Through this discussion-focused process, the advisory committee ultimately recommended ideas **to minimize the amount of information collected by persons served when first accessing services.**

This report provides more details on the recommendations, as well as the key project activities and processes, the list of identified and prioritized inefficiencies, and the recommended solutions to address those challenges.

Identifying and Prioritizing Inefficiencies

The project's first year focused on identifying and prioritizing inefficiencies, which was eventually narrowed to the intake and assessment process for accessing services. To narrow the focus, PSC:

- Facilitated discussions with the advisory committee
- Met with Civilla—a Detroit nonprofit that helps public-serving institutions use human-centered design principles to make services more accessible and user-friendly
- Conducted interviews with the advisory committee members and other representatives from their organizations
- Conducted discussion groups with frontline staff and persons served

For the purpose of this project, the committee considered an administrative inefficiency as:

> *Any administrative demand that does not directly support the provision of high-quality, accessible behavioral health services and supports or the fiscal and operational integrity of the system.*

[1] Human-centered design is a problem-solving approach that prioritizes the needs of those most affected, such as persons served and providers. By engaging these groups throughout the process, it ensures the solution is functional, useful, and truly resonates with them.

Identification

During the first two advisory committee meetings, the group discussed the major inefficiencies in the behavioral health system. In the first meeting, PSC asked the group about the sources of administrative inefficiencies in Michigan's public behavioral health system, their reasons for these inefficiencies, and their impacts on individuals, colleagues, the organization, and clients. PSC recorded this conversation in a Miro mind map, found in Appendix B, showing the interconnection and complexity of the challenges. The main issues discussed were related to operational and compliance inefficiencies.

- Operational inefficiencies
  - Clinical documentation, including treatment plans, addendums, progress notes and signatures
  - Service entry processes, including assessments, service authorization, and referrals
- Compliance burdens
  - Credentialing and training requirements for frontline staff to provide services
  - Reporting requirements, both those that are routine as well as unique reports to the State, PIHPs, or others
  - Audits and accreditation which are the regular review of treatment plans, policies, and outcomes

Human-Centered Design

The goal of reducing administrative inefficiencies is to ultimately improve access to high-quality services. To support this goal, PSC and CMHA engaged with Civilla to learn more about their approach to human-centered design. Staff from PSC, CMHA, and MDHHS leadership toured Civilla's Project Re:form journey map. In Project Re:form, Civilla (on behalf of MDHHS) successfully shortened and simplified Michigan's benefit application form and process. Civilla CEO Michael Brennan also attended a special advisory committee meeting where he provided an overview of human-centered design and Project Re:form and explained why their process prioritized the "front door"—when and where people first seek services. The committee then discussed focusing on one key area that could have the greatest impact on a person's overall experience.

In the second advisory committee meeting, PSC reviewed the inefficiencies with the committee based on themes from discussions with Civilla and topics from the first meeting, focusing on the most foundational inefficiencies. At the end of the second meeting, the group discussed intake assessments and individual plan of service or treatment planning.

Interviews and Discussion Groups

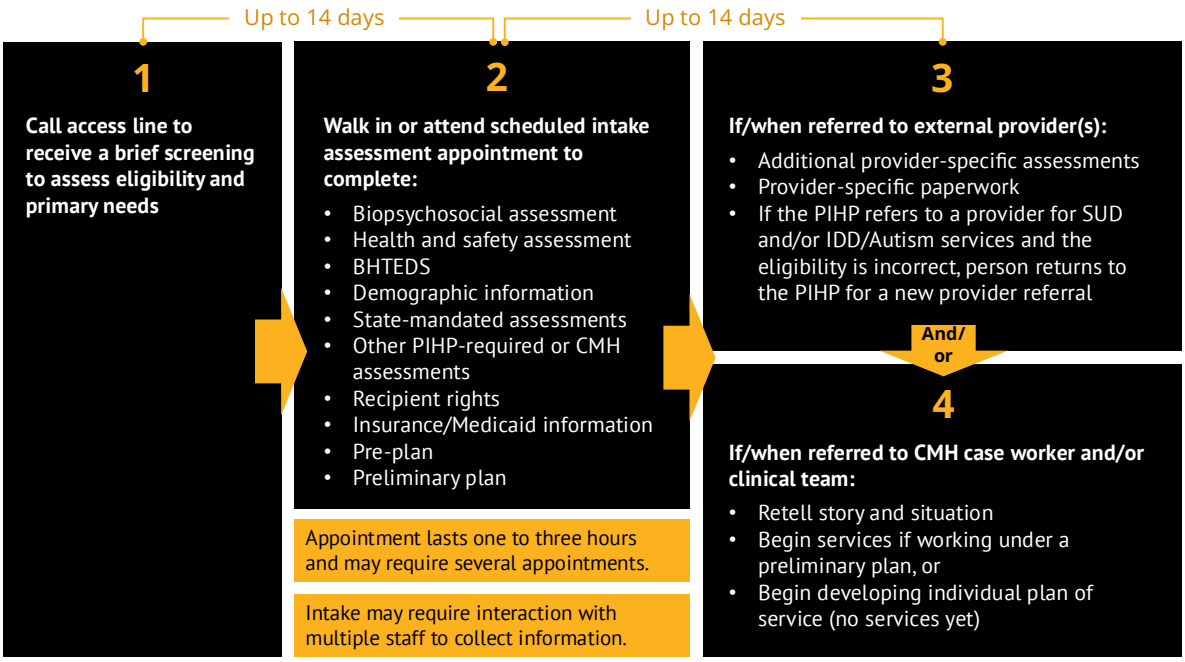
To get more detailed information about these challenges, PSC conducted 18 interviews with PIHPs, CMHSPs, other community providers including substance use disorder services, and consumer advocates. Additionally, the advisory committee supported PSC in facilitating conversations with groups of frontline staff and persons served by the system to gather

information directly by those most impacted. In summer 2024, PSC held two discussion groups with 34 frontline staff from 19 separate organizations and two small group conversations with seven people directly served by the system or their parents or legal guardians. Interview and discussion questions centered on what their intake process looks like, what is and is not working well related to the intake assessment and treatment planning process, and recommendations on how to address those issues. Questions also included how challenges impact service providers and persons served by the system and what potential solutions to address those challenges. An overview of the findings is below. PPT slides of the interview and discussion group findings are available in Appendix C and D, respectively.

Complex and Lengthy Process

Participants described a complex and lengthy process to access services. Although each organization's process differs, a general overview of what interviewees shared is in Exhibit 1.

EXHIBIT 1. Process Individuals Take to Access Services



Source: PSC Interviews with 18 CMHSPs, PIHPs, and other provider organizations.

Participants noted that providing customer service-style options, such as same-day appointments and transportation assistance), along with experienced staff and automated processes, can improve the intake assessment and treatment planning.

In the intake assessment process, they noted that:

- The process can span multiple weeks and take hours to complete
- It includes unnecessary, repetitive, duplicative, and intrusive data collection
- Required data elements and questions can change every year

- Data collection during a time of crisis may be inaccurate
- Lengthy and unnecessary credentialing requirements to conduct and complete the American Society of Addiction Medicine (ASAM) tool

In the treatment planning process, they noted that:

- Preplanning is required but not always needed
- Preliminary treatment plans are used inconsistently
- There can be a lack of clarity around goal development
- Requirements can lead to the plan not being person-centered, which is a hallmark value of Michigan's behavioral health system
- Making even minor changes to the plan can be very burdensome and require addendums and client signatures
- Inability to use service ranges to have flexibility in meeting a clients changing needs and availability
- Lack of transparency around service eligibility and availability

Across assessments and treatment planning, they identified:

- Lack of standardization in CMH contracts, electronic health records (EHRs), assessments, treatment plan expectations, or even treatment
- Inconsistent rule interpretation with MDHSS and across PIHPs
- Data collection and retrieval issues, such as difficulty accessing information in EHRs, Behavioral Health Treatment Episode Data Set (BHTEDS), and the ASAM, and challenges updating information in EHRs

Impact on Persons Served and Providers

These issues are important to address because they can negatively impact persons needing services and the providers delivering those services. Interviewees highlighted that the impact on persons served includes:

- Drawn-out, lengthy process delays treatment
- Repeating traumatic events multiple times
- Responding to questions that can feel intrusive and irrelevant
- No clear sense of the process and of service or treatment options
- Processes can limit their ability to connect and build rapport with clinical staff
- Reduced clinical engagement and stymied motivation to obtain treatment

The impact on providers includes:

- Frustration with lengthy and sometimes duplicative assessments
- Frustration with obtaining data for data's sake
- Concerns regarding low-quality interactions with people seeking services when they want to maintain dignity of persons served
- Perceived lack of clarity around treatment goal development

- Feeling a lack of trust on their clinical expertise and judgment
- Staff turnover and burnout

Prioritization

PSC presented the advisory committee with a set of potential solutions for intake assessments and treatment planning based on these findings and recommendations. Potential solutions for intake assessments (with abbreviated forms in parentheses) include:

Solution	Abbreviation
Reducing duplication across assessment tools	Assessment duplication
Minimizing or removing BHTEDS requirements and/or delay it to after the client can form a relationship with their provider	BHTEDS adjustment
Developing a streamlined BPS assessment that meets state requirements and accommodates local needs and preferences	Streamlined BPS
Ensuring staff are well-trained to complete the intake assessment process efficiently	Staff training
Ensuring persons served have information on how to navigate the system and what to expect, including the intake process	Consumer knowledge

For treatment planning, the potential solutions include:

Solution	Abbreviation
Ensuring staff and persons served have information on all available services and waivers	Available services
Providing clear guidance on treatment plan goal development and the link between goals and service authorization	Tx plan guidance
Supporting the use of preliminary plans and make the preplan optional	Tx plan flexibility
Allowing flexibility in service authorization, including the use of service ranges	Service authorization
Reducing or eliminating requirements for documenting minor changes to treatment plan	Reduced documentation

Prioritization Survey

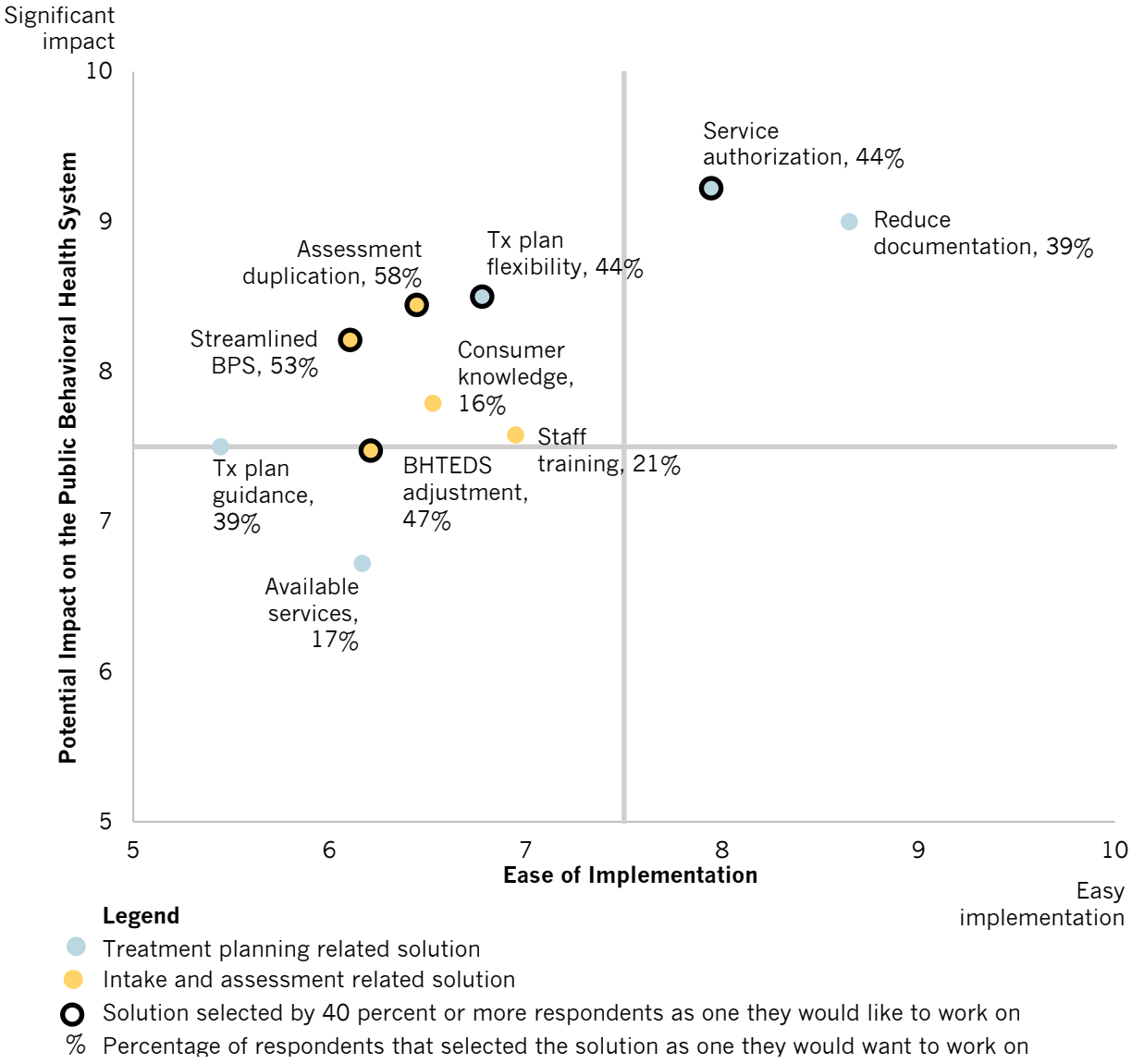
PSC then surveyed the advisory committee to prioritize the potential solutions. The survey asked them to rate solutions based on their ease of implementation and impact on the behavioral health system. They could assign a value ranging from 1 to 10, where a 1 indicated the most challenging to implement and least impactful and a 10 indicated easiest to implement with significant

potential impact. They also identified which solutions they had the greatest interest in addressing. A full survey summary is available in Appendix E. The survey key findings are that:

- Average ease of implementation scores ranged from 5.4 to 8.6; average potential impact scores ranged from 6.7 to 9.2.
- **Reduce or eliminate requirements for documenting minor changes to treatment plans** had the highest average ease of implementation score (8.6).
- **Allow flexibility in service authorization, including the use of service ranges** had the highest average score (9.2) for potential impact on the public behavioral health system.
- The potential solutions with the highest average ease of implementation and potential impact scores were not the same as those respondents said they were most interested in working on.
    - Nearly 60 percent of respondents chose **reduce duplication across assessment tools** as one of the two solutions they would be most interested in working on.
    - More than half chose **develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences.**

PSC created a matrix displaying the implementation and potential impact scores on a graph, alongside the percentage of individuals interested in working on each solution, indicated in parentheses. Solutions that generated the greatest interest are represented by a thick border around their plot points (Exhibit 2).

EXHIBIT 2. Ease of Implementation, Potential Impact of Solutions, and Percentage of Respondents Expressing Interest in Working on That Solution



N = 18–19

After presenting the prioritized solutions, PSC and CMHA worked closely with MDHHS leadership to identify areas the State is supporting and how the State could enhance these efforts. The advisory committee met to review these prioritized solutions, along with information from MDHHS. The group decided to focus on **minimizing the amount of data and information collected from people seeking services,** which involved three separate but related solutions:

- Reducing BHTEDS data collection
- Confirming the information required for a biopsychosocial (BPS) assessment
- Identifying opportunities to eliminate redundant data collection across multiple assessments

Workgroups

In spring 2025, the advisory committee members, if they wanted, joined one of three workgroups, each focused on a solution identified by the advisory committee aimed at reducing the information collected at intake. Each group chose a facilitator and decided whether more people should join the workgroups. A list of participants by workgroup is in Appendix F. The workgroups met over the summer and fall to review and identify steps to support their aims and develop related recommendations. The CMHA administrative efficiencies advisory committee presented, discussed, and approved the recommendations.

Workgroup Recommendations

Each workgroup suggested a recommendation to reduce the data collected from people seeking services. The group discussed the administrative inefficiencies and solutions to improve the intake process, while also envisioning how they want the intake process to look and feel for people seeking services. They identified the following desired future state:

> *The clinical teams in Michigan's public mental health system will conduct, for each person served by the system, a warm, focused intake that ensures individuals and families feel heard, while collecting all required data to satisfy state, federal, and accreditation standards. Using expert clinical interviewing and rapport-building skills. The clinical team will ask each essential question of the person served or their family once—eliminating duplication—and leverage health information technology to auto-populate biopsychosocial and assessment data fields. To support this, we'll define a core data set by population that aligns with all regulatory and accreditation requirements.*

Each of the recommendations described below were accepted and approved by the administrative efficiencies advisory committee.

BHTEDS Workgroup

The Behavioral Health Treatment Episode Data Set (BHTEDS) contains over 70 required questions for individuals receiving mental health or substance use services funded by Medicaid or other Michigan resources. Some CMHSP funding depends on the number of complete BHTEDS submitted to the State. BHTEDS is intended to track the direction and magnitude of change across time in specific areas, including housing, employment, and justice involvement.

BHTEDS was regularly highlighted as a concern for administrative inefficiency during the intake process. Advisory group members, interviewees, and discussion group participants all stated that the BHTEDS significantly increases data collection during intake, with some questions feeling intrusive (e.g., pregnancy status), irrelevant to their service needs (e.g., family military history), and not applicable to the population seeking services (e.g., employment questions for school-aged youth). These stakeholders also noted that BHTEDS changes annually, typically adding new questions and rarely removing any, which requires CMHSPs to frequently update EHR processes

and retrain staff on the questions. They also shared that there are often reporting errors that need to be individually addressed before submitting data to the State.

The BHTEDS workgroup comprised representatives from CMHSPs, CMHA, and MDHHS, including the BHTEDS coordinator. The group reviewed and discussed each state-based BHTEDS element during the meetings. They quickly agreed that 1) they aimed to minimize or eliminate state-based BHTEDS requirements without altering the timeline, and 2) they needed to engage the state's BHTEDS coordinator in the conversation. To support a robust conversation, the CMHSP representatives also gathered input from their agencies on the questions that caused the most confusion for staff, individuals seeking services, or their family members, as well as those with high rates of data validation errors. With support from the BHTEDS coordinator, the group discussed each BHTEDS element to understand its purpose, how the data is being used, and ways to simplify, improve, and/or remove it.

Recommendation

The group suggests the following recommendations and approaches to simplify the BHTEDS:

1. The group built a framework to identify which populations should answer each question and which would not be applicable. CMHSPs should implement this framework; it ensures the state collects all required information while potentially minimizing the number of questions for each client.
2. The workgroup should continue working with the MDHHS BHTEDS coordinator to implement the recommended next steps to simplify, clarify, improve, and/or remove each element. The specific recommendations for each element are in the BHTEDS recommendation report in Appendix G.
3. The workgroup should work with the MDHHS BHTEDS coordinator and relevant staff to identify alternative data collection methods, like an optional survey.

An additional step, not specifically identified by the workgroup, would be to formalize the partnership with MDHHS BHTEDS to ensure that future changes, including any new potential questions, are discussed with CMHSPs before finalization. This will enable MDHHS to leverage the group's experience and expertise to enhance data accuracy and completion.

Biopsychosocial Workgroup

The BPS assessment is a comprehensive evaluation of an individual's biological, psychological, and social needs to determine diagnosis and treatment planning. The workgroup sought to develop a concise BPS assessment that meets state requirements while addressing local needs and preferences. The workgroup was made up of representatives from a PIHP, CMHSP, CMHA, and advocacy organizations. The workgroup created an implementation plan to identify federal and regulatory agency BPS requirements (e.g., MDHHS), determine what essential clinical information, and to develop a core set of questions or minimum elements for a BPS.

The BPS workgroup reviewed payer, accreditor, and regulatory requirements for BPS content, including six different Community Mental Health Services Program (CMHSP) BPS formats. The

group used a modified policy Delphi method—a structured communication technique used to gather expert opinion from independent specialists through a series of questions to reach a group consensus, often in iterative stages. The goal was to structure and streamline debate and reveal the range of expert opinions on minimum BPS elements, leading to the BPS comprehensive review document.

Next, the group used Google Gemini to query the minimum elements required for a biopsychosocial assessment in the Michigan public CMH system and compared Gemini's results to their comprehensive BPS review. The workgroup found the templates were well aligned with the required content and structure. The Gemini-suggested template provided the succinct structure and clinical focus requested, while the BPS document provided the mandatory checklist of fields. From this process, the workgroup created a succinct BPS template for Michigan CMHSPs that uses a structured, heading-based format to ensure all mandated domains are addressed clearly and concisely, focusing on narrative efficiency. Additionally, a handful of CMHSPs tested their BPS against the suggested template and found that they could reduce their assessment length by about 40 percent. The template is available in Appendix I. The template highlights key values of the BPS process to:

- **Be person-centered:** Ensure the consumer's voice, goals, and strengths are clear, as required by CMH and the person-centered planning (PCP) guidance.
- **Be concise:** Use bullet points and focus on clinically relevant data. Avoid "wall of text" narratives.
- **Clearly state negative domains** (e.g., "Denies history of hospitalization," "No current legal issues").
- **Establish medical necessity:** The information gathered must support the need for the service.

Recommendation

The workgroup recommended ways to reduce the information collected at intake and promote the use of the BPS template.

1. Enlist a data scientist or data architect to ensure all assessment and BPS elements are mapped.
2. Separate history and train staff appropriately. Separate clinical history and train staff on what to document to avoid cluttering the presenting problem. The idea that "history relates to an ongoing service discussion, not an initial determination" should keep the initial BPS concise and focused on current needs.
3. Use external standardized tools like LOCUS, MichiCANS, WHODAS 2.0, and PMLA to allow the clinician to state results and the corresponding service recommendation (e.g., LOCUS Level 3), instead of writing a lengthy justification for the level of care.
4. Integrate BHTEDS where possible. Many BPS fields are connected to BHTEDS (e.g., veteran, education, employment, housing). Since these data are often pulled from an initial intake form, the BPS only needs to verify and synthesize the information, not collect it.
5. Use checklists, data points, and structured summaries to address all required BPS elements while keeping the assessment succinct.

6. Use the BPS template to improve efficiency while maintaining accreditor, regulatory, and payer requirements.
7. Complete an analysis of the organizations existing BPS compared to recommended BPS using AI tools to discern areas of reduction via AI.
8. Vet and support AI findings for accuracy.
9. Recommend one BPS format that can be affirmed and endorsed as a promising practice by MDHHS.
10. Engage EMR vendors to create the uniform BPS template.
11. Recommend that a group of users work with their data system vendor to account for systemic upgrades for a new BPS for all CMH systems.
12. Ensure that CMH agreement is secured to proceed.
13. Account for accreditor and other variations as appropriate (i.e., courts, grants, etc.).

Assessments Workgroup

The State mandates a specific assessment for each group served by the public behavioral health system. PIHPs, CMHSPs, and other providers may need to conduct more assessments with those seeking services, along with the biopsychosocial assessment. Members of the advisory committee, interviewees, and discussion group participants expressed concerns about duplication in the number of questions on required assessments that cover the same areas, as well as overlaps with the biopsychosocial assessment. They noted that the ASAM and MichiCANS assessments are similar to the BPS and provide a complete overview of the whole person. Depending on the provider and the person conducting the intake, these questions may be repeated, requiring those seeking services to answer similar questions multiple times during the intake process. This makes the intake process feel burdensome to individuals and families instead of welcoming and helpful. The assessment workgroup identified and recommended ways to improve the process.

The workgroup reviewed all state-required assessments and assessments commonly used across CMHSPs (e.g., Columbia Suicide Severity Rating Scale), then created a crosswalk identifying similarities among these tools. Many tools overlap in assessing common domains (e.g., risk, mood, functioning), leading to redundant data collection and a lengthier, less welcoming experience for those served. As suspected, tools like MichiCANS and ASAM cover broader biopsychosocial areas, reducing the need for several specific tools.

Recommendation

It may be possible to use the more comprehensive tools to replace the traditional BPS instead of adding to it. Revising the tool selection process according to the required domains could alleviate staff workload and facilitate faster access to services. Due to slight variations in how questions are phrased and their response options across different elements**, the group recommends a comprehensive data mapping of all data elements within the MDHHS-required tools and regulatory standards** to the relevant sections and items in the biopsychosocial assessment:

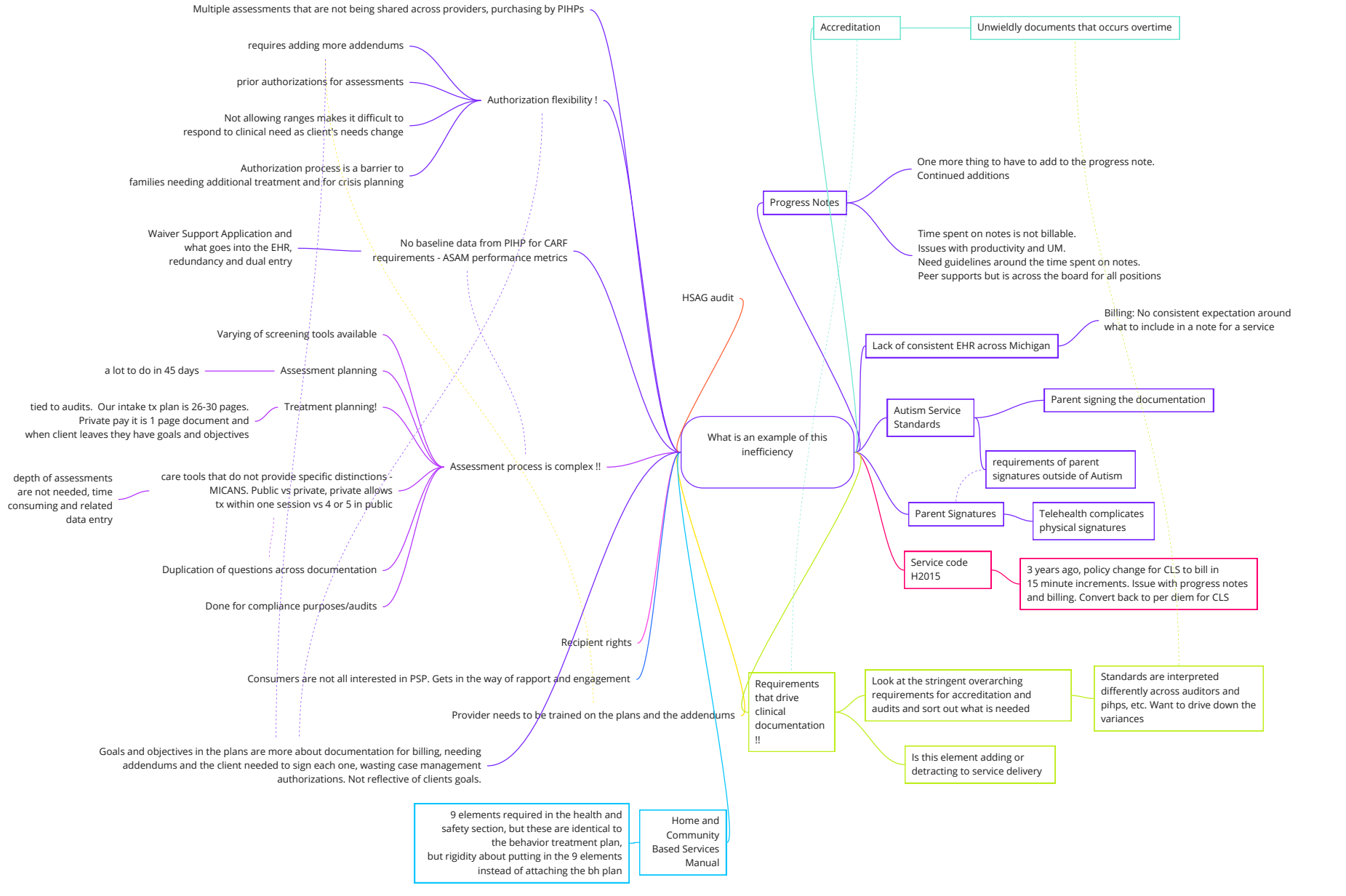
- CAFAS (Child and Adolescent Functional Assessment Scale)
- PECFAS (Preschool and Early Childhood Functional Assessment Scale)

- LOCUS (Level of Care Utilization System)
- WHODAS 2.0 (World Health Organization Disability Assessment Schedule)
- MichiCANS (Michigan Child and Adolescent Needs and Strengths)
- ASAM Criteria (American Society of Addiction Medicine)
- CCBHC Assessment Requirements
- CARF Accreditation Standards
- Joint Commission Accreditation Standards
- BHTEDS

Appendix A: Advisory Committee Participants

- Destiny Al Jallad, Turning Leaf Behavioral Health Services
- Sherri Boyd, ARC Michigan
- Jeffrey Brown, Centria Healthcare
- Cameron Bullock, Pivotal
- Sally Culey, Montcalm Care Network
- Todd Culver, incompass Michigan
- Stacey Dettloff, Training and Treatment Innovations
- Annette Downey, Community Living Services
- Crystal Ann Dussia, Hegira Health
- Kevin Fischer, National Alliance on Mental Illness, Michigan
- Sue German, Pines Behavioral Health
- Tess Greenough, Gogebic Community Health Authority
- Belinda Hawks, Michigan Department of Health and Human Services
- Laura Higle, Washtenaw County Community Mental Health
- Kimberly Hinton, The Guidance Center
- Marianne Huff, Mental Health Association of Michigan
- Kristen Jordan, Michigan Department of Health and Human Services
- Sydney Larsen, AuSable Valley Community Mental Health Authority
- Todd Lewicki, MidState Health Network
- Melissa McKinstry, CMHA Board of Directors and Right Door for Hope, Recovery and Wellness
- Johanna Nicolia-Adkins, CMHA Persons Served Advisory Group
- Carla Pretto, Association for Children's Mental Health
- Robert Sheehan, Community Mental Health Association of Michigan
- Susan Sheppard, Arbor Circle
- Jackie Sproat, Michigan Department of Health and Human Services
- Robert Stein, Michigan Assisted Living Association
- Ronnie Tyson, Flint Odyssey House
- Michele VanderSchel, Community Mental Health of Ottawa County
- Denise Verschure, Sacred Heart
- Jacquline Wilson, Training and Treatment Innovations (retired 2024)

Appendix B: Inefficiencies Miro Map


What is an example of this inefficiency
Accreditation
Unwieldly documents that occurs overtime
Progress Notes
One more thing to have to add to the progress note.
Continued additions
Time spent on notes is not billable.
Issues with productivity and UM.
Need guidelines around the time spent on notes.
Peer supports but is across the board for all positions
HSAG audit
Lack of consistent EHR across Michigan
Billing: No consistent expectation around what to include in a note for a service
Autism Service Standards
Parent signing the documentation
requirements of parent signatures outside of Autism
Parent Signatures
Telehealth complicates physical signatures
Service code H2015
3 years ago, policy change for CLS to bill in 15 minute increments. Issue with progress notes and billing. Convert back to per diem for CLS
Requirements that drive clinical documentation !!
Look at the stringent overarching requirements for accreditation and audits and sort out what is needed
Standards are interpreted differently across auditors and pihps, etc. Want to drive down the variances
Is this element adding or detracting to service delivery
Home and Community Based Services Manual
9 elements required in the health and safety section, but these are identical to the behavior treatment plan, but rigidity about putting in the 9 elements instead of attaching the bh plan
Provider needs to be trained on the plans and the addendums
Goals and objectives in the plans are more about documentation for billing, needing addendums and the client needed to sign each one, wasting case management authorizations. Not reflective of clients goals.
Consumers are not all interested in PSP. Gets in the way of rapport and engagement
Recipient rights
Assessment process is complex !!
depth of assessments are not needed, time consuming and related data entry
care tools that do not provide specific distinctions - MICANS. Public vs private, private allows tx within one session vs 4 or 5 in public
Duplication of questions across documentation
Done for compliance purposes/audits
Varying of screening tools available
Assessment planning
a lot to do in 45 days
Treatment planning!
tied to audits. Our intake tx plan is 26-30 pages. Private pay it is 1 page document and when client leaves they have goals and objectives
No baseline data from PIHP for CARF requirements - ASAM performance metrics
Waiver Support Application and what goes into the EHR, redundancy and dual entry
Authorization flexibility !
requires adding more addendums
prior authorizations for assessments
Not allowing ranges makes it difficult to respond to clinical need as client's needs change
Authorization process is a barrier to families needing additional treatment and for crisis planning
Multiple assessments that are not being shared across providers, purchasing by PIHPs

Appendix C: Interview Findings PowerPoint

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Administrative Inefficiencies Interview Findings

August 1, 2024

1

Interviewees

2

Interviewees

- Provider representatives: PIHPs, CMHSPs, other community providers
- Consumer advocates

3

What's Working

4

Customer Service Approaches and Processes

- Offering same-day appointments
- Offering transportation to appointments
- Going to the client's home to complete the initial paperwork
- Setting the client up in one room in the service provider setting and having staff members rotate in and out of the room rather than making the client move from room to room
- Having a person with lived experience collect some of the intake information and initial paperwork to help make the client more comfortable
- Scheduling the next appointment before the client leaves the office

5

Experienced Staff

- Having staff with a lot of experience conduct intake assessments
- Ensuring newer staff have good clinical supervision

"Experienced staff tend to know the assessment well, which allows them to make the process feel more natural and conversational."

6

Automated Processes

- Building automated steps into EHR for intake process
- Asking questions that are most relevant to the person's situation
- Establishing connections with relevant service providers

"When a person seeking services indicates an area of need, like a living arrangement, the assessment asks if there is an IDD need. If yes is selected, then it automatically prefills into the IPOS, which helps with the golden thread to prevent things falling through the cracks."

7

Inefficiencies in Intake Assessments

8

Inefficiencies in Intake Assessments

- Unnecessary and intrusive data collection
  - Information collected for the Behavioral Health Treatment Episode Data Set (BHTEDS) and biopsychosocial assessment (BPS) feels irrelevant and, often, intrusive
- Frequent updates
  - New questions are frequently added to the BPS due to rule changes and updates–making it longer and longer
- Process can span several weeks and take hours to complete

9

Inefficiencies in Intake Assessments

- Repetitive and duplicative data collection efforts
  - People seeking services are often required to repeat their (sometimes traumatic) stories to multiple people throughout the process (e.g., phone call to obtain intake appointment, multiple people during intake assessment, treatment planning team)
- Unnecessary credentialing requirement to conduct and complete the American Society of Addiction Medicine (ASAM) assessment tool

10

Inefficiencies in Treatment Planning

11

Inefficiencies in Treatment Planning

- Preplanning process is required, but not always needed
  - Opinions vary: Never needed, helpful for some people and populations, should be optional for all populations
  - Often leads to redundant meetings with people who are not planning to involve family/caregivers in plan development
- Time frames for preliminary plans vary from 30 to 90 days or more

12

Inefficiencies in Treatment Planning

- Differences in plan development across providers
  - Lack of clarity around goal development
  - Inconsistent feedback on goals from state auditors
- Making changes to plans is burdensome
  - Plans must be reviewed (and possibly updated) regularly
  - Much of the information remains the same but making minor changes/updates requires a lot of work.

"My biggest frustration is that it doesn't matter how we write them, auditors are always going to say, 'This isn't a good goal.' We end up adding goals that the client didn't come up with."

13

Inefficiencies in Treatment Planning

- Unable to use service ranges
- All plan and service changes require full addendums and client signatures

"They don't allow ranges in case management. You can't say two to four times a week. You have to choose two or four. If it says four and a day is missed, you have to do an addendum, which requires a client signature. People may need more help one week than another. "

14

Overarching Inefficiencies

15

Lack of Standardization and Inconsistent Rule Interpretation

- Lack of standardization in CMH contracts, provider pay rates from county to county, EHRs, assessments, treatment plan expectations, or even treatment
- Inconsistent interpretation of rules within MDHHS and across PIHPs and CMHSPs
- Limited MDHHS guidance for rule interpretation

16

Data Collection and Retrieval Issues

- Difficult to access or update information in EHRs
- Difficult to access BHTEDS and other assessment data
- Unable to access ASAM data

17

Why It Matters

18

Impact on Persons Served

- Drawn-out lengthy process delays treatment and stymies motivation to obtain treatment
- Repeating traumatic events multiple times
- Responding to questions that can feel intrusive and irrelevant
- Lacking a clear sense of the process, steps, and treatment options, which can hinder engagement in treatment
- Processes can limit their ability to connect and build rapport with clinical staff

"We have to skip the care concern and engagement and ram through the questions. We tell the client right off, 'we have to get this done—it is awful and then we will get on to what you need.' We have a 50% drop off rate after that first session."

19

Impact on Providers

- Frustration with obtaining data for data's sake
- Lack of clarity around treatment goal development
- Low-quality interactions with people seeking services—not being able to maintain dignity of people seeking services
- Frustration with lengthy assessments due to frequent additions to questions and information that needs to be collected
- Feeling lack of trust on their clinical expertise and judgement
- Staff turnover and burnout

20

Interviewee Proposed Solutions

Develop a streamlined and standardized BPS assessment tool

Provide clear guidance on treatment plan goal development and the link between goals and service authorization

Allow flexibility in service authorization, including the use of service ranges

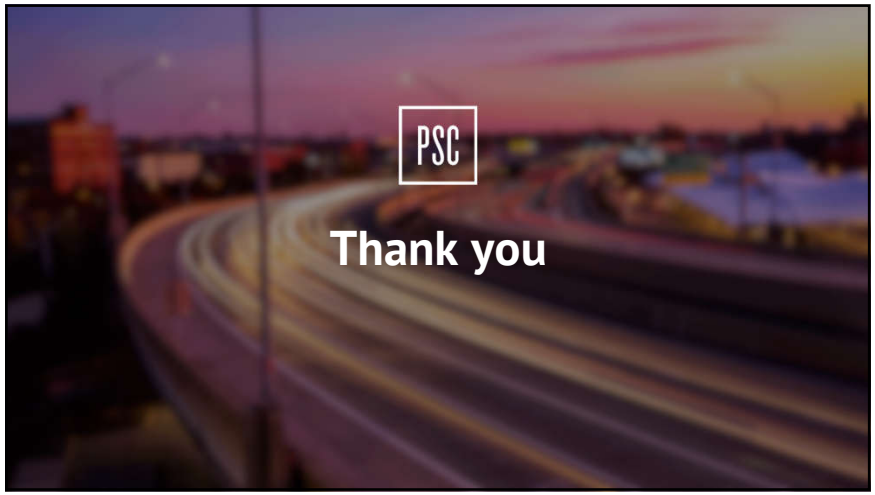
21

Potential Solutions

Minimize or remove BHTEDS requirement and/or delay it to after the client can form a relationship with their provider

Reduce requirements for documenting minor changes to treatment plans

22



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Appendix D: Frontline Staff and Persons Served Discussion Group Findings PPT

PUBLIC SECTOR CONSULTANTS

Administrative Inefficiencies Advisory Committee Meeting

November 15, 2024

1

Discussion Groups

2

Discussion Group Participants

- Two discussion groups with frontline staff
  - 34 participants across 19 provider organizations
- Two discussion groups with persons served
  - Two participants in the SMI/SUD group
  - Five participants in the I/DD group
    - 4 parents and/or legal guardian participants

3

Discussion Topics

Bright spots and inefficiencies in the intake assessment and planning processes

Impacts of inefficiencies on persons served and frontline staff

Recommendations for improvement

4

Bright Spots in Intake Assessment and IPOS Development

5

Dedicated intake teams or specialists

Preliminary plans that allow for more time for client engagement and IPOS development

Linking persons served with a dedicated clinician right away

Frontline Staff

6

Dedicated intake teams or specialists

"We used to have multiple people doing assessments and now we have an intake specialist, so the client does not need to explain their story over and over again."

"Smaller groups of intake coordinators who can focus on, for instance, just children's services is ideal."

7

Preliminary plans that allow more time for client engagement and IPOS development

"Our intake specialists do an interim plan that is good for up to 45 days with initial authorizations. The primary clinician than does a pre-PCP and PCP within 45 days."

"The assessment specialists complete a preliminary plan giving the case worker time to build rapport and build a really good IPOS."

8

Linking persons served with a dedicated clinician right away

"IPOS input works best when it's done with the therapist who is going to hold the case because the family knows when they share information it's stable and gives the clinician the opportunity to know the family better"

9

Initial intake (triage) and meetings with providers

Having experience with the system

Persons Served

10

Initial intake and meetings with providers

"The triage process was useful – 'How are you feeling and what are you experiencing?' And the first meeting with the provider works well. These were set up in a way that made sense and flowed. The meeting in between those seemed less relevant to getting treatment going."

11

Having experience with the system

"The process runs more smoothly for people who already know and understand the system—it is harder for people who are engaging with the system for the first time because 'you don't know what you don't know.'"

12

Intake Assessment Inefficiencies

13

Too much time spent on administrative tasks

Redundant, duplicative, and/or irrelevant information collected

Some required questions are not relevant to all populations

Frontline Staff

14

Too much time spent on administrative tasks

"Probably the most inefficient part of our system is the number of administrative tasks that come along with assessment and planning. From the moment that someone comes in, we're looking at them through a lens of documentation—there's the consent for treatment, recipient rights information, financial determination, types of services available.... It becomes a checklist more than an assessment of clinical need."

15

Redundant and duplicative information collected

"My biggest takeaway from MichiCANS training was that we already have an assessment tool that looks at all of this—that is our biopsychosocial. I really don't see how the added time it takes to score the biopsychosocial is going to make any sort of impact on eligibility."

16

Some required questions are not relevant to all populations

"The assessment covers every department in the county – every area you could be requesting services for. There are a lot of things that aren't relevant for everyone, but I have to go over it when I could be helping families."

17

Information collected is often irrelevant to behavioral health needs

Information collected in a time of crisis is often incorrect

Same questions asked at different points in the process by different staff members

Persons Served

18

Information Collected is Often Irrelevant

"Many of the questions did not have anything to do with what was going on at the time."

19

Information collected in a time of crisis may be inaccurate

"They wanted to know about family, family health history, how did my grandfather die – I don't know – questions that need a lot of thought and I wasn't in a place to think about them at the time. Information is in my record and is probably not correct because I just gave answers to get through the assessment."

20

Same questions asked at different points in the process by different staff members

"The same questions are asked by several different people."

21

Inefficiencies in IPOS Development

22

Frontline Staff

- Requirements lead to the plan not being person-centered
- Making changes to the plan is burdensome
- Requirement to use pre-planning
- Lack of clarity around IPOS development

23

Requirements lead to the plan not being person-centered

"Because of the requirements – you are not writing a PCP. It doesn't end up being what the person identified and it's not user friendly to the individual."

"There's a lot of legal-ese in the IPOS – a tremendous amount of language that does not feel person centered."

24

Making changes to plans is burdensome

"All plan and service changes require full addendums and client signatures."

25

Requirement to use pre-planning

"Cut down on pre-planning. We end up doing the same thing over and over. We can complete some of the steps at the same time."

"Would love to see a way for families or individuals to waive the pre-plan process."

"We need to honor the fact that initial assessments *are* preplanning. Maybe the family is ready to step right into the treatment plan."

26

Lack of clarity around IPOS development

"The State can be vague in their expectations and interpretations may not align, based on the auditor."

27

Preplanning is unnecessary for many and should be optional

There is a lack of transparency statewide around eligibility

It is unclear to people receiving services and staff what services are available

Persons Served

28

Preplanning is unnecessary for many and should be optional

"Some people need preplanning and some don't. Make it optional for those who don't need it. For people with a guardian or a big family, it can make a difference. But I am by myself – I don't need that."

29

Lack of transparency statewide around eligibility

"I'm on the recipient rights advisory committee and I haven't heard of some of the waivers being mentioned today"

"You have to know exactly what you want, and you may still get a staff person who doesn't know what you are talking about – even case managers. I had to find services that work with private insurance and Medicaid. There's a real lack of information."

30

Unclear to people receiving services and staff what services are available

"There are navigators, but you have to ask for them, and if you don't know to ask, you don't get them."

"Parents don't know and aren't aware how to look for services."

"There is no where to go to find what services are available"

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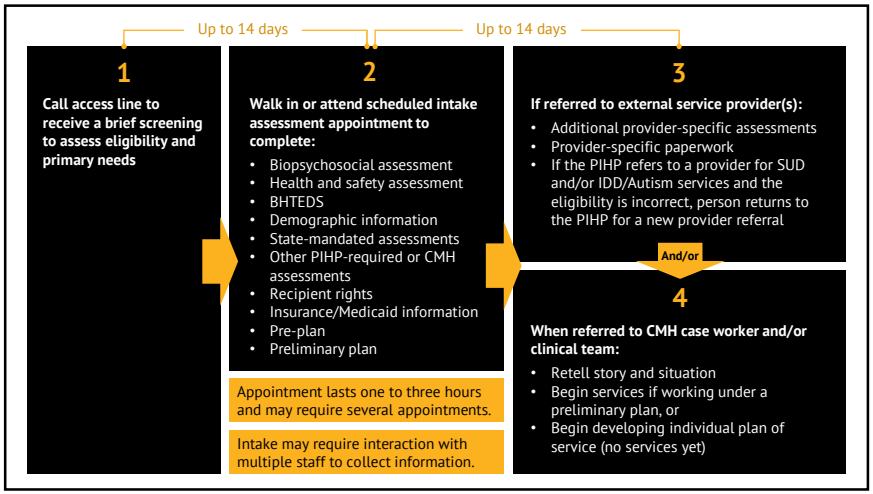

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Impact on Persons Served

- Drawn-out, lengthy process delays treatment
- Repeating traumatic events multiple times
- Responding to questions that can feel intrusive and irrelevant
- No clear sense of the process and of service or treatment options
- Processes can limit their ability to connect and build rapport with clinical staff
- Reduced clinical engagement and stymied motivation to obtain treatment

33

Impact on Providers

- Frustration with lengthy and sometimes duplicative assessments
- Frustration with obtaining data for data's sake
- Low-quality interactions with people seeking services—difficult to maintain dignity of persons served
- Lack of clarity around treatment goal development
- Feeling lack of trust on their clinical expertise and judgement
- Staff turnover and burnout

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Potential Solutions: Intake Assessments

- Reduce duplication across assessment tools
- Minimize or remove BHTEDS requirements and/or delay it to after the client can form a relationship with their provider
- Develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences
- Ensure staff are well-trained to complete the intake assessment process efficiently
- Ensure persons served have information on how to navigate the system and what to expect, including the intake process

35

Potential Solutions: Treatment Planning

- Ensure staff and persons served have information on all available services and waivers
- Provide clear guidance on treatment plan goal development and the link between goals and service authorization
- Support the use of preliminary plans and make the preplan optional
- Allow flexibility in service authorization, including the use of service ranges
- Reduce or eliminate requirements for documenting minor changes to treatment plans

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Appendix E: Advisory Group Prioritization Survey Summary

Community Mental Health Association of Michigan—Identifying Solutions for Administrative Inefficiencies in the Public Behavioral Health System

Solution Prioritization Survey Summary

January 2025

Introduction

The Administrative Inefficiencies Advisory Committee has met four times since February 2024 to discuss, identify, and prioritize administrative inefficiencies in Michigan's public behavioral health system. These discussions have been informed by committee member's own experience captured both during the meetings and through conducting nearly 20 in-depth interviews. Additionally, small group discussions were held with frontline behavioral health staff and persons served. Through this process, the committee identified two areas of the system where they believe inefficiencies are especially prevalent: (1) intake and assessment and (2) treatment planning. They also identified ten potential solutions (five for each focus area) to address those inefficiencies.

Potential Administrative Inefficiency Solutions

Intake and Assessment

The five potential solutions identified to address intake and assessment administrative inefficiencies in the public behavioral health system are:

Potential Solution	Report Descriptor
Reduce duplication across assessment tools (e.g., ASAM, MichiCANS)	Assessment duplication
Minimize or remove BHTEDS requirements and/or delay collecting this information until after the person receiving service can form a relationship with their provider	BHTEDS adjustment
Develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences	Streamlined BPS
Ensure staff are well trained to complete the intake assessment process efficiently	Staff training
Ensure persons served have information on how to navigate the system and what to expect, including during the intake process	Consumer knowledge

Treatment Planning

The five potential solutions identified to address treatment planning administrative inefficiencies in the public behavioral health system are:

Potential Solution	Report Descriptor
Ensure staff and persons served have information on all available services and waivers	Available services
Provide clear guidance on treatment plan goal development and the link between goals and service authorization	Tx plan guidance
Ensure treatment planning responds to the urgency of a person's symptoms and/or needs (e.g., offer a shorter, narrowly focused process for those not requiring the full current process; make the preplan optional; support the use of preliminary plans for all people seeking services)	Tx plan flexibility
Allow flexibility in service authorization, including the use of service ranges	Service authorization
Reduce or eliminate requirements for documenting minor changes to treatment plans	Reduced documentation

Next, the committee needs to identify one solution on which to focus its efforts. To begin solution selection, committee members were asked to complete a survey in which they rated each solution according to its ease of implementation and potential impact on the behavioral health system. They also identified the two solutions in each focus area they were most interested in working on, indicated the first step(s) to implementing these solutions, and suggested who should be involved in implementing them. Nineteen committee members responded to the survey.

Key Findings

- Average ease of implementation scores ranged from 5.4 to 8.6; average potential impact scores ranged from 6.7 to 9.2.
- **Reduce or eliminate requirements for documenting minor changes to treatment plans** had the highest average ease of implementation score (8.6).
- **Allow flexibility in service authorization, including the use of service ranges** had the highest average score (9.2) for potential impact on the public behavioral health system.
- The potential solutions with the highest average ease of implementation and potential impact scores were not the same as those respondents said they were most interested in working on. For example,
    - Nearly 60 percent of respondents chose **reduce duplication across assessment tools** as one of the two solutions they would be most interested in working on.
    - More than half chose **develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences.**

Survey Results

This report highlights average scores for the ease of implementation and potential impact for each potential solution, along with which solutions members are interested in working on. Additionally, a summary of who should be involved in solution development and implementation and possible first steps

is shown for the five potential solutions that more that 40 percent of respondents chose as one of their top two out of five in each focus area.

Ease of Implementation and Potential Impact on the Public Behavioral Health System

Committee members rated the ten potential solutions on a scale of one to ten for ease of implementation and the level of potential impact the solution would have on the intake and assessment or treatment planning process. A score of 1 meant the solution would be very challenging to implement and would potentially have minimal impact. A score of 10 meant the solution would be easy to implement and potentially have a significant impact on the public behavioral health system.

The average score for ease of implementation ranged from 5.4 to 8.6, with the solution **to reduce or eliminate requirements for documenting minor changes to treatment plans** being selected as the easiest to implement (Exhibit 1). The average score for potential impact on the public behavioral health system ranged from 6.7 to 9.2, with the solution to **allow flexibility in service authorization, including the use of service ranges** receiving the highest average score (Exhibit 2).

EXHIBIT 1. Average Scores for Ease of Implementation

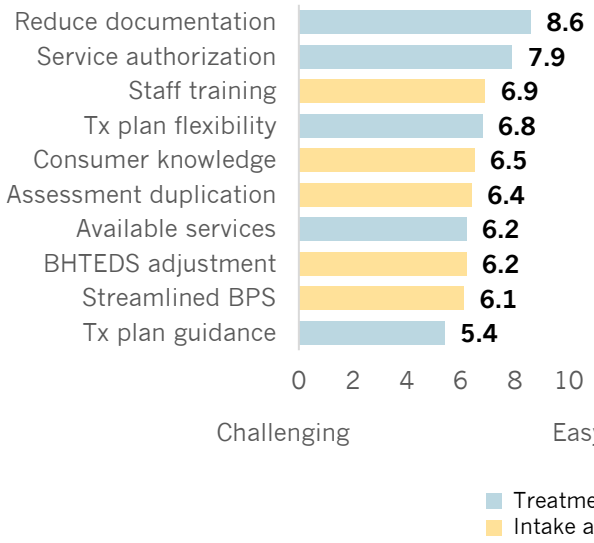
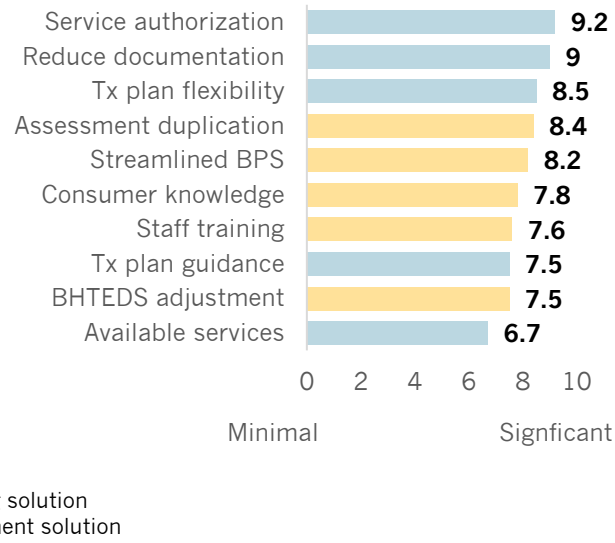
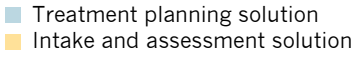


EXHIBIT 2. Average Scores for Potential Impact on the Public Behavioral Health System





N = 18–19

Solution Prioritization

Five of the potential solutions were selected by 40 percent or more of the respondents as one they were most interested in working on. Three of these solutions were in the intake and assessment area and two were potential treatment planning solutions (Exhibit 3).

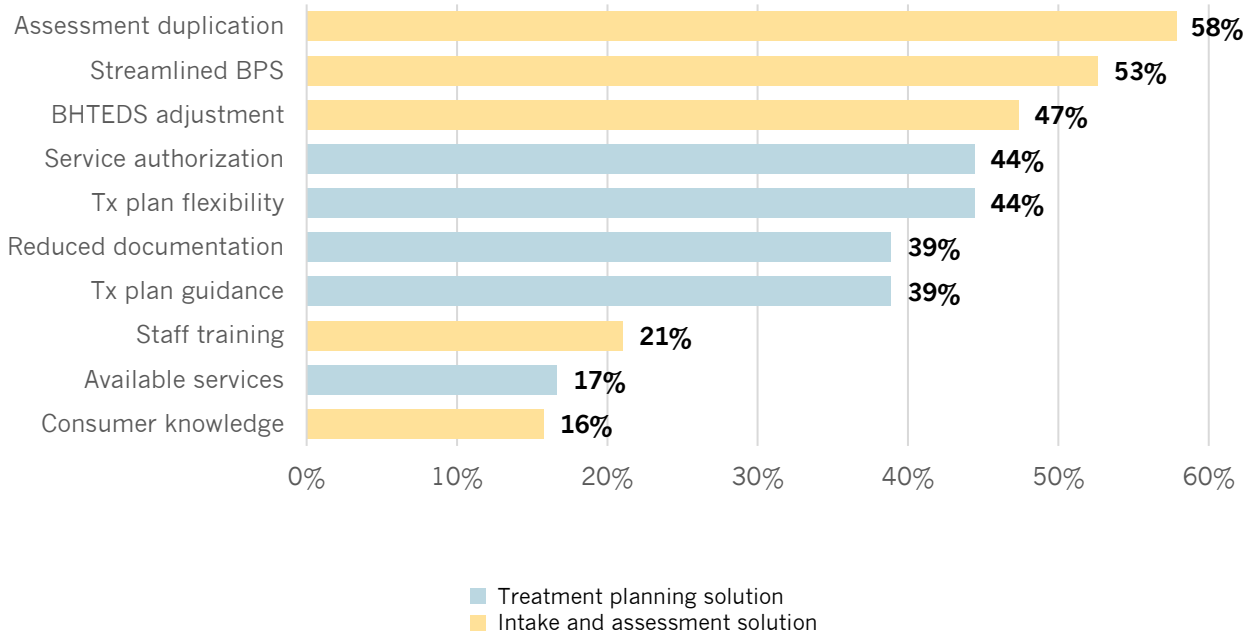
The intake and assessment solutions that the most people were interested in working on were:

- Reduce duplication across assessment tools (58 percent)
- Develop a streamlined BPS assessment that meets state requirements and accommodated local needs/preferences (53 percent)
- Minimize or remove BHTEDS requirements and/or delay collecting this information until after the person receiving services can form a relationship with their provider (47 percent)

The treatment planning solutions with the largest percentage interest were:

- Allow flexibility in service authorization, including the use of service ranges (44 percent)
- Ensure treatment planning responds to the urgency of a person's symptoms and/or needs (44 percent)

EXHIBIT 3. Percentage Who Chose Solution as One of Their Top Preferences

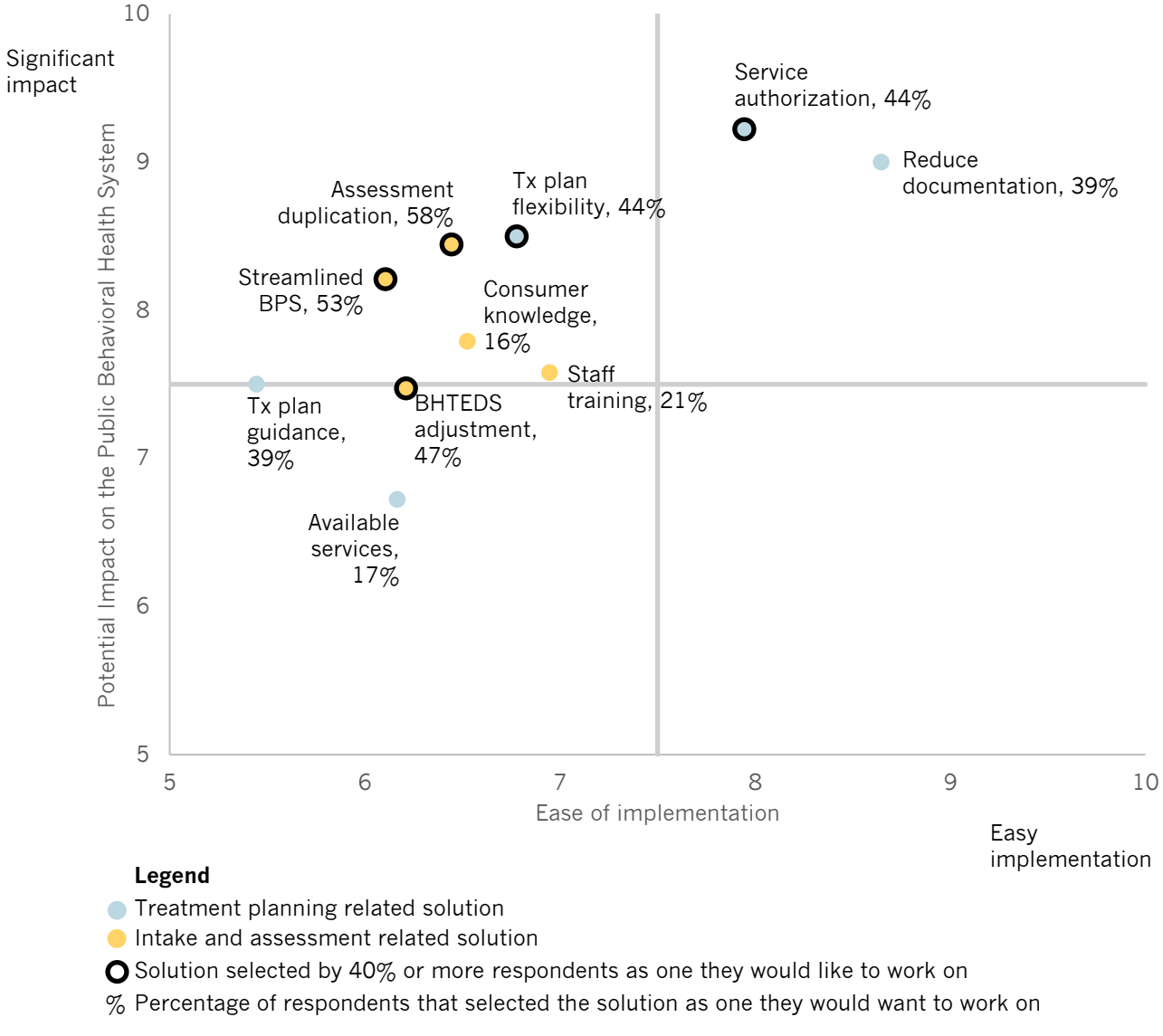


N = 18–19
Note: This question was asked separately for the five intake and assessment solutions and the five treatment planning solutions, so no inferences can be made regarding the percentages of the intake and assessment solutions compared to the percentages of the treatment planning solutions.

The potential solutions receiving the highest average ease of implementation and potential impact scores were not the same as those receiving the highest percentage of interest. For example, **reduce or eliminate requirements for documenting minor changes to treatment plans** rated high for both ease of implementation and significance of potential impact, but less than 40 percent of

respondents said they were interested in working on that solution. Whereas, **reduce duplication across assessment tools** had a high percentage of people express interest in working on it even though it fell lower on the ease of implementation and impact rating scale, as did **develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences** and **minimize or remove BHTEDS requirements and/or delay collecting this information until after the person receiving service can form a relationship with their provider** (Exhibit 4).

EXHIBIT 4. Ease of Implementation, Potential Impact of Solutions, and Percentage of Respondents Expressing Interest in Working on That Solution



N = 18–19

Implementation and Developers

Respondents shared who they believed should be involved in implementing the potential solutions and what would need to be the first step to implementing each of their chosen top two potential solutions. Exhibit 5 shows a summary of these responses for the top five selected solutions.

EXHIBIT 5. Organization/Individual Involvement and First Steps to Implementing Top Five Selected Solutions

Potential Solution	Organization/Individuals	First Step to implementation

Reduce duplication across assessment tools	• Advocacy
	• CMHSPs
	• Community partners
	• MDHHS
	• Persons served
	• PIHPs
	• Providers
	  ○ Direct service providers
	  ○ Direct care staff
	  ○ Clinical directors
	  ○ Physical health (different perspective)
	  ○ Supervisors
	  ○ Quality and compliance roles
		• Identify the key stakeholders to work on this solution—MDHHS should take the lead on this
		• Identify all the current assessment tools being used across the State and which each one is specifically assessing and the specific purpose of each tool
		• Define current requirements/who is requiring it
		• Determine the need for information, identify other areas where information is collected, understand what the information translates to, understand how it impacts and benefits the CLIENT
		• Identify and emulate what is required for private insurance
		• Determine what is duplicative
		• Get agreement from MDHHS and PIHPs
		• Produce a journey mapping and end-user, both staff and clients of the domains that define the presenting problem and potential solutions

Develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences	• Advocacy
	• CMHSPs
	• EMR vendors
	• MDHHS
	• Persons served
	• PIHPs
	• Persons familiar with current requirements and strong clinical leadership
	• Statewide contracted entity to review and evaluate assessment forms used to identify elements not required by federal or state law, regulation, waiver or contract
		• Determine what is legally required
		  ○ Identify the federal requirements around BPS and the leeway that is allowed in building a focused BPS process
		  ○ Provide PIHP and CMH direction and indicate that it is standardized and they cannot deviate
		  ○ Review what regulatory agencies (MDHHS, CMS, etc.) are requiring we gather versus what is important clinically
		• Get agreement from MDHHS
		• Determine MDHHS's willingness and partnership with the CMHs and their EMR vendors
		• Identify where information is collected, the reason for collecting the data, and where the information is provided so that it is not duplicated
		• State final intention (outcome) then determine who is requiring and for whom

Minimize or remove BHTEDS requirements and/or delay collecting this information until after the person receiving	• Advocacy • CMHSPs • CMS • MDHHS	• Change frequency of data collection—begin at 6 months • Determine a range of days in which to complete this assessment • Identify a set of alternatives to take to MDHHS

services can form a relationship with their provider	• Persons served
	• PIHPs
	• Providers
	  ○ Case managers
	  ○ Direct care staff
	  ○ Supervisors
	  ○ Quality and compliance roles
		• Identify which BHTEDS questions are related to addressing the services and supports needs of each person presenting for services and retain only those questions.
		• Determine if it is even feasible since I believe it is a federal requirement; some of this information would likely already be collected as part of the intake/assessment process
		• Determine what data is actually needed/required and for what purpose
		• Get agreement of the benefit of moving the collection of data from intake until established relationship/rapport is built
		• Get MDHHS buy-in

Allow flexibility in service authorization, including the use of service ranges	• CMHSPs
	• Health Services Advisory Group (HSAG)
	• MDHHS
	• Persons served
	• PIHPs
	• Providers
	  ○ Case managers
	  ○ Direct care staff
	  ○ Physical health (different perspective)
	  ○ Supervisors
	  ○ Quality and compliance roles
		• Allow a range
		  ○ Develop guidance around types and amounts of ranges
		  ○ Recognize that planning for supports/services is not an exact science and that individual needs vary depending on what is happening in their lives
		• Understand the current requirement and where they come from
		• Change HSAG requirements, or interpretations of requirements identifying that people are human and not widgets
		• Discuss how this does not align with the CCBHC model as well impedes service delivery
		• Set uniform standards (PIHPs)

Ensure treatment planning responds to the urgency of a person's symptoms and/or needs	• Advocacy
	• CMHSPs
	• CMS
	• Community partners
	• MDHHS
	• Persons served
	• PIHPs
	• Providers
	  ○ Direct care staff
	  ○ Physical health (different perspective)
	  ○ Supervisors
	  ○ Quality and compliance roles
	• Whoever can formulate new procedures to take to MDHHS should be involved in the development
		• Determine the PCP requirements in Michigan statute, federal waivers, and MDHHS contracts with PIHP and CMHSPs, and determine which would have to change to allow for person- and condition-specific PCP/IPOS development process and content
		  ○ Identify what is required to begin services and what current guideline/law/language would have to change in order to make needed changes
		  ○ Understand the purpose of the current requirement and where it came from
		• Identify definitions and allowances for treatment planning to respond to the individual's symptoms and/or needs
		  ○ Determine where and with whom the flexibilities can be used
		• Identify a clear plan to determine level of urgency to ensure a similar process can be used throughout the state

Appendix: Summary Table

Potential Solution	Average Ease of Implementation Score	Average Potential Impact on the Public Behavioral Health System Score	Percentage Interested In Working on Solution
Reduce duplication across assessment tools	6.4	8.4	58%
Minimize or remove BHTEDS requirements and/or delay collecting this information until after the person receiving service can form a relationship with their provider	6.2	7.5	47%
Develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences	6.1	8.2	53%
Ensure staff are well trained to complete the intake assessment process efficiently	6.9	7.6	21%
Ensure persons served have information on how to navigate the system and what to expect, including during the intake process	6.5	7.8	16%
Ensure staff and persons served have information on all available services and waivers	6.2	6.7	17%
Provide clear guidance on treatment plan goal development and the link between goals and service authorization	5.4	7.5	39%
Ensure treatment planning responds to the urgency of a person's symptoms and/or needs	6.8	8.5	44%
Allow flexibility in service authorization, including the use of service ranges	7.9	9.2	44%
Reduce or eliminate requirements for documenting minor changes to treatment plans	8.6	9.0	39%

Appendix F: Workgroup Participants

Workgroup leads and co-leads are noted in italics

BHTEDS

- Emily Alpers, Centra Wellness Network
- Carol Hyso, MDHHS
- Caryn Melotti, Shiawassee Health and Wellness
- Robert Sheehan, CMHA
- *Lia Sibilski, Community Mental Health—Clinton, Eaton, Ingham*
- Jackie Sproat, MDHHS

BPS

- Gwen Alwood, Montcalm Care Network
- Jeff Brown, Centria
- April Ceno, Training and Treatment Innovations
- Taylor Hirschman, Gratiot Integrated Health Network (CMH for Gratiot County)
- *Todd Lewicki, MidState Health Network*
- David Lowe, LifeWays
- Jenelle Lynch, Community Mental Health for Central Michigan
- Erin Nostrandt, Saginaw County Community Mental Health Authority
- Robert Sheehan, CMHA

Assessments

- Destiny Al Jallad, Turning Leaf Behavioral Health Services
- *Sarah Bowman, Gratiot Integrated Health Network (CMH for Gratiot County)*
- Amanda Eveleth, The Right Door for Hope, Recovery, and Wellness
- Belinda Hawks, MDHHS
- *Kimberly Hinton, The Guidance Center*
- Lindsey Hull, Turning Leaf
- Sydney Larsen, AuSable Valley Community Mental Health Authority
- Melissa McKinstry, CMHA Board of Directors and Right Door
- Keith Morley, Community Mental Health of Ottawa County
- Kristen Morningstar, MDHHS
- Johanna Nicolia-Adkins, CMHA Persons Served Advisory Group
- Liz Parker, Community Mental Health—Clinton, Eaton, Ingham
- Carla Pretto, Association for Children's Mental Health
- Susan Sheppard, Arbor Circle

Appendix G: BHTEDS Workgroup Recommendation Documents

CMHA Administrative Efficiencies BHTEDS Workgroup Recommendations

October 31, 2025

Background

The CMHA administrative efficiencies advisory committee created three workgroups to achieve its overarching goal to minimize the amount of information collected during the intake process in Michigan's public behavioral health system. The BHTEDS workgroup aim is to minimize or remove BHTEDS requirements and/or adjust the frequency of the data collection.

The Behavioral Health Treatment Episode Data Set (BHTEDS) is a set of federal and state-required questions of anyone with mental health or substance use services paid in whole or part by Medicaid or other State of Michigan administered funds. The goal of BHTEDS is to look at the direction and magnitude of change across time in specific areas, including housing, employment, and justice involvement.

The BHTEDS workgroup is made up of representatives from community mental health service providers (CMHSP), Community Mental Health Association of Michigan and the Michigan Department of Health and Human Services (MDHHS), including the BHTEDS coordinator. The group was supported by Public Sector Consultants staff. The group met five times between August and October 2025.

During the workgroup meetings, the group obtained, reviewed, and discussed each of the state-based BHTEDS elements. The workgroup quickly agreed that 1) they were only looking to minimize or remove state-based BHTEDS requirements and 2) that they needed to engage the state's BHTEDS coordinator, Carol Hyso in the conversation. To support a robust conversation, the CMHSP representatives also gathered input from their respective agencies on which questions caused the most issues either through confusion from staff or from individuals seeking services or their family members or due to high rates of data validation error. With support from Carol Hyso, the group discussed each BHTEDS element, looking to understand why it is being asked, how the data is being used, and how it could be simplified, improved, and/or removed.

The workgroup would like to extend a large thank you to Carol Hyso, without whom, the workgroup's recommendations would not be possible.

State-based BHTEDS Recommendations

The group identified two areas of recommendation. The first was to build a framework to articulate which population(s) need to complete each question and identify which populations would not be applicable for each question. This framework can be implemented by CMHSPs while still ensuring the state is collecting all the information it is requiring while potentially minimizing the number of questions being asked of each client. A table showing the 2026 state-based BHTEDS elements and clarification of which population(s) each question is relevant for and the EHR programming rules that can be implemented to ensure each question is only answered by the relevant population is shown below in Exhibit 1.

EXHIBIT 1: 2026 State-based BHTEDS Elements

Field Info					Population Response Requirements			
T1	**T2**	**Field Name**	**F (Federal) or S (State) Requirement**	**FY Implemented**	**Youth or Adult**	**Consumer Population** SUD, SMI, I/DD, SED	**Other qualifier**	**N/A Rules (e.g., 96)** for EHR programming
A006	DU006	Social Security Number	S	FY16	Both	All		
A007	DU007	Medicaid ID	S	FY16	Both	All		
A012	DU012	Service Start Date Time of Day	S	FY16	Both	All		
A015		Detailed Criminal Justice Referral	F & S	FY24	Both	All		
	DU016	Service Update/End Time of Day	S	FY16	Both	All		
A018	DU018	ID/DD Designation	S	FY16	Both	All		
A019	DU019	MI/SED Designation	F & S	FY16	Both	All		
A025		County of Residence	S		Both	All		
A034	DU025	Detailed 'Not in Competitive, Integrated Labor Force'	F & S	FY16	Both	All	16 years or older	If under 16 years of age
A035	DU026	Minimum Wage	S	FY16	Both	All	16 years or older	If under 16 years of age
A051	DU048	Co-occurring/Integrated Substance Use and Mental Health Treatment (at Update/Discharge)	F & S	FY20	Both	MI or SUD	13 years or older	If under 13 years of age
A053	DU036	Detailed Residential Care Living Arrangement	S	FY16	Both	I/DD or SED	Living arrangement: adult group home or youth in state care	If not I/DD or SED
A055	DU038	Legal Related Status	F & S	FY16	Both	All		

Field Info					Population Response Requirements			
T1	**T2**	**Field Name**	**F (Federal) or S (State) Requirement**	**FY Implemented**	**Youth or Adult**	**Consumer Population** SUD, SMI, I/DD, SED	**Other qualifier**	**N/A Rules (e.g., 96)** for EHR programming
A063	DU044	LOCUS Composite Score	S	FY17	Adult	MI		If youth
A064	DU045	LOCUS Assessment Date	S	FY17	Adult	MI		If youth
A065	DU046	Work/Task Hours	S	FY17	Both	All	16 years or older	If under 16 years of age
A066	DU047	Earnings per Hour	S	FY17	Both	All	16 years or older	If under 16 years of age or not in labor market
A067		Most Recent Military Service Era	S	FY17	Adult	MI or SUD		If youth
A068		Branch Served In	S	FY17	Adult	MI or SUD		If youth or if T1 A067 = 96
A069		Client/Family Military Service	S	FY17	Adult	MI or SUD		If youth or if T1 A067 = 96
A070		Client/Family Enrolled in/Connected to VA/Veteran Resources/Other Support & Service Organizations	S	FY17	Adult	MI or SUD		If youth or if T1 A067 = 96
A071	DU049	MH BH-TEDS Full Record Exception	S	FY17	Both	All		
A073	DU052	Youth Prior Law Enforcement History	S	FY24	Youth	SED		If adult
A074	DU053	Youth Juvenile Justice History	S	FY24	Youth	SED		If adult
	DU054	Juvenile Justice Involvement at Update/Discharge	S	FY24	Youth	SED		If adult
A075	DU055	Other Activity for those Working Part-time in the Competitive, Integrated Labor Force	S	FY25	Both	All	16 years or older	If under 16 years of age
A076	DU056	Legal Guardianship	S	FY25	Both	All		
A077	DU057	Type of Guardianship	S	FY25	Both	All		
A078	DU058	Guardian's Relationship to Individual Being Served	S	FY25	Both	All		
A079	DU059	Foster Care Status	S	FY25	Youth	SED		If adult
A080	DU060	Foster Care Placement	S	FY25	Youth	SED		If adult

Secondly, the group recommended the next steps needed to simplify, clarify, improve, and/or remove each element. These recommendations fell into the following categories, which are color coded in Exhibit 2.

1. The elements highlighted in Exhibit 2 in blue are those the workgroup wants to work with the BHTEDS coordinator and the MDHHS section leader responsible or interested in that data collection element to discuss potentially simplifying or removing responses or consider collecting the questions through an alternative approach, such as a sample survey. This includes the following fields:

    - Detailed Criminal Justice Referral
    - Detailed 'Not in Competitive, Integrated Labor Force'
    - Legal Related Status
    - Work/Task Hours
    - Earnings per Hour
    - Most Recent Military Service Era
    - Branch Served In
    - Client/Family Military Service
    - Client/Family Enrolled in/Connected to VA/Veteran Resources/Other Support & Service Organizations
    - Youth Prior Law Enforcement History
    - Youth Juvenile Justice History
    - Juvenile Justice Involvement at Update/Discharge
    - Other Activity for those Working Part-time in the Competitive, Integrated Labor Force
    - Legal Guardianship
    - Type of Guardianship
    - Guardian's Relationship to Individual Being Served

2. The elements highlighted in Exhibit 2 in yellow are those that may no longer need to be collected through BHTEDS; the workgroup recommends that the BHTEDS coordinator confirm if the information is captured elsewhere and/or no longer needed by those initially requesting it. This includes the following fields:

    - Minimum Wage
    - Co-occurring/Integrated Substance Use and Mental Health Treatment (at Update/Discharge)
    - Detailed Residential Care Living Arrangement
    - MH BH-TEDS Full Record Exception
    - Foster Care Status
    - Foster Care Placement

3. The elements highlighted in Exhibit 2 in salmon are already slated to be removed in 2026. This includes the following fields:

    - MIChild ID
    - Medicare ID
    - SDA/SSI/SSDI Enrollment
    - Mainstream Special Education Status
    - Total Annual Income
    - Number of Dependents
    - Gender Identity

4. One element, Detailed Criminal Justice Referral, highlighted in blue, was identified as benefiting from additional review during the annual BHTEDS training.

To support the potential of collecting some elements through a survey sampling approach, Carol Hyso, the CMHA, and other workgroup members plan to meet in November 2025 to discuss what this could look like.

EXHIBIT 2: All 2025 State-based BHTEDS Elements with Population-based Response Requirements and Workgroup Group Recommendations

Field Info					Population Response Requirements				
T1	**T2**	**Field Name**	**F (Federal) or S (State) Requirement**	**FY Implemented**	**Youth or Adult**	**Consumer Population** SUD, SMI, I/DD, SED	**Other qualifier**	**Auto N/A Rules (e.g., 96)** for EHR programming	**Workgroup Recommendations**
A006	DU006	Social Security Number	S	FY16	Both	All			No Change
A007	DU007	Medicaid ID	S	FY16	Both	All			No Change
A008	DU008	MIChild ID	S	FY16	Both	All			Will be eliminated FY26
A009	DU009	Medicare ID	S	FY16	Both	All			Will be eliminated FY26
A010	DU010	SDA/SSI/SSDI Enrollment	S	FY16	Both	All			Will be eliminated FY26
A012	DU012	Service Start Date Time of Day	S	FY16	Both	All			No Change
A015		Detailed Criminal Justice Referral	F & S	FY24	Both	All			1) Work with Carol Hyso/BHTEDS Coordinator and the Family and Community Partnerships section to simplify children's response options 2) Carol Hyso/BHTEDS coordinator will include this question in annual BHTEDS training.
	DU016	Service Update/End Time of Day	S	FY16	Both	All			No Change
A018	DU018	ID/DD Designation	S	FY16	Both	All			No Change
A019	DU019	MI/SED Designation	F & S	FY16	Both	All			No Change
A025		County of Residence	S		Both	All			No Change
A028	DU021	Mainstream Special Education Status	S	FY16					Will be eliminated FY26

Field Info					Population Response Requirements				Workgroup Recommendations
T1	**T2**	**Field Name**	**F (Federal) or S (State) Requirement**	**FY Implemented**	**Youth or Adult**	**Consumer Population** SUD, SMI, I/DD, SED	**Other qualifier**	**Auto N/A Rules (e.g., 96)** for EHR programming	
A034	DU025	Detailed 'Not in Competitive, Integrated Labor Force'	F & S	FY16	Both	All	16 years or older	If under 16 years of age	Work with Carol Hyso/BHTEDS Coordinator and Joe Longcor/Adult and Community-Based Services to simplify and clarify response options
A035	DU026	Minimum Wage	S	FY16	Both	All	16 years or older	If under 16 years of age	Carol Hyso/BHTEDS coordinator to confirm no longer needed by HSAG; if no longer needed, remove in 2027
A036	DU027	Total Annual Income	S	FY16					Will be eliminated FY26
A037	DU028	Number of Dependents	S	FY16					Will be eliminated FY26
A051	DU048	Co-occurring/Integrated Substance Use and Mental Health Treatment (at Update/Discharge)	F & S	FY20	Both	MI or SUD	13 years or older	If under 13 years of age	Carol Hyso/BHTEDs coordinator to revise question to ask only about cooccurring starting in FY27. Integrated plan can be noted if any encounters have the HH modifier
A053	DU036	Detailed Residential Care Living Arrangement	S	FY16	Both	I/DD or SED	Living arrangement: adult group home or youth in state care	If not I/DD or SED	Carol Hyso/BHTEDS Coordinator to identify if this is captured elsewhere. If captured elsewhere, remove in 2027.
A055	DU038	Legal Related Status	F & S	FY16	Both	All			Work with Carol Hyso/BHTEDS coordinator and the Family and Community Partnerships section to simplify and clarify response options
A063	DU044	LOCUS Composite Score	S	FY17	Adult	MI		If a youth	No Change
A064	DU045	LOCUS Assessment Date	S	FY17	Adult	MI		If a youth	No Change
A065	DU046	Work/Task Hours	S	FY17	Both	All	16 years or older	If under 16 years of age	Work with Carol Hyso/BHTEDS Coordinator and Joe Longcor/Adult and Community-Based Services to simplify responses and consider a sampling approach to data collection

Field Info					Population Response Requirements				Workgroup Recommendations
T1	**T2**	**Field Name**	**F (Federal) or S (State) Requirement**	**FY Implemented**	**Youth or Adult**	**Consumer Population** SUD, SMI, I/DD, SED	**Other qualifier**	**Auto N/A Rules (e.g., 96)** for EHR programming	
A066	DU047	Earnings per Hour	S	FY17	Both	All	16 years or older	If under 16 years of age or not in labor market	Work with Carol Hyso/BHTEDS Coordinator and Joe Longcor/ Community-Based Practices and Innovation to simplify responses and consider a sampling approach to data collection
A067		Most Recent Military Service Era	S	FY17	Adult	MI or SUD		If a youth	Work with Carol Hyso/BHTEDS Coordinator and Brian Webb/ Community-Based Practices and Innovation to simplify responses, consider a sampling approach, and/or remove question
A068		Branch Served In	S	FY17	Adult	MI or SUD		If a youth or if A067 = 96	Work with Carol Hyso/BHTEDS Coordinator and Brian Webb/Community-Based Practices and Innovation Section to simplify responses, consider a sampling approach, and/or remove question
A069		Client/Family Military Service	S	FY17	Adult	MI or SUD		If a youth or if A067 = 96	Work with Carol Hyso/BHTEDS Coordinator and Brian Webb/Community-Based Practices and Innovation Section to simplify responses, consider a sampling approach, and/or remove question
A070		Client/Family Enrolled in/Connected to VA/Veteran Resources/Other Support & Service Organizations	S	FY17	Adult	MI or SUD		If a youth or if A067 = 96	Work with Carol Hyso/BHTEDS Coordinator and Brian Webb/Community-Based Practices and Innovation Section to simplify responses, consider a sampling approach, and/or remove question

Field Info					Population Response Requirements				Workgroup Recommendations
T1	**T2**	**Field Name**	**F (Federal) or S (State) Requirement**	**FY Implemented**	**Youth or Adult**	**Consumer Population** SUD, SMI, I/DD, SED	**Other qualifier**	**Auto N/A Rules (e.g., 96)** for EHR programming	
A071	DU049	MH BH-TEDS Full Record Exception	S	FY17					Carol Hyso/BHTEDS Coordinator to check with Milliman and PIHPs on if this question is still needed; remove in 2027 if no longer needed
A072	DU050	Gender Identity	S	FY22					Will be removed in 2026
A073	DU052	Youth Prior Law Enforcement History	S	FY24	Youth	SED		If an adult	Work with Carol Hyso/BHTEDS coordinator and the Family and Community Partnerships section to simplify responses and/or consider a sampling approach to data collection
A074	DU053	Youth Juvenile Justice History	S	FY24	Youth	SED		If an adult	Work with Carol Hyso/BHTEDS coordinator and the Family and Community Partnerships section to simplify responses and/or consider a sampling approach to data collection
	DU054	Juvenile Justice Involvement at Update/Discharge	S	FY24	Youth	SED		If an adult	Work with Carol Hyso/BHTEDS coordinator and Family and Community Partnerships section to simplify responses and/or consider a sampling approach to data collection
A075	DU055	Other Activity for those Working Part-time in the Competitive, Integrated Labor Force	S	FY25	Both	All	16 years or older	If under 16 years of age	Work with Carol Hyso/BHTEDS Coordinator and Joe Longcor/Adult and Community-Based Services to simplify responses and/or consider a sampling approach to data collection
A076	DU056	Legal Guardianship	S	FY25	Both	All			Work with Carol Hyso/BHTEDS Coordinator and the Family and Community Partnerships section to simplify and clarify response options

Field Info					Population Response Requirements				Workgroup Recommendations
T1	**T2**	**Field Name**	**F (Federal) or S (State) Requirement**	**FY Implemented**	**Youth or Adult**	**Consumer Population** SUD, SMI, I/DD, SED	**Other qualifier**	**Auto N/A Rules (e.g., 96)** for EHR programming	
A077	DU057	Type of Guardianship	S	FY25	Both	All			Work with Carol Hyso/BHTEDS Coordinator the Family and Community Partnerships section to simplify and clarify response options
A078	DU058	Guardian's Relationship to Individual Being Served	S	FY25	Both	All			Work with Carol Hyso/BHTEDS Coordinator and the Family and Community Partnerships section to simplify and clarify response options
A079	DU059	Foster Care Status	S	FY25	Youth	SED		If an adult	Carol Hyso/BHTEDS Coordinator to confirm if this is captured elsewhere, if captured elsewhere remove for 2027
A080	DU060	Foster Care Placement	S	FY25	Youth	SED		If an adult	Carol Hyso/BHTEDS Coordinator to confirm if this is captured elsewhere, if captured elsewhere remove for 2027

Appendix H: Biopsychosocial Workgroup Recommendation Documents

Biopsychosocial Subgroup Activity Report 2 and Recommendation
Succinct BPS Template for Michigan CMH-Recommended for Consideration

The below "succinct" biopsychosocial (BPS) format was generated from Google Gemini based on the query for the minimum elements required for a BPS assessment in the Michigan public Community Mental Health (CMH) system. This template uses a structured, heading-based format to ensure all mandated domains are addressed clearly and concisely, focusing on narrative efficiency. This content was compared to the BPS Subgroup comprehensive review results and was found to be a high-quality match. Refer to the document "Comparative Analysis of BPS Subgroup Content Recommendations to AI "Succinct Concept."

Key Values for the Biopsychosocial Assessment Process and Outcome

- **Be Person-Centered:** Ensure the consumer's voice, goals, and strengths are clear, as required by CMH and the Person-Centered Planning (PCP) guidance.
- **Be Concise:** Use bullet points and focus on clinically relevant data. Avoid "wall of text" narratives. If a domain is negative, state it clearly (e.g., "Denies history of hospitalization," "No current legal issues").
- **Establish Medical Necessity:** The information gathered must support the need for the services being recommended.

1. Identifying Information & Presenting Problem

Field	Required Information (Be Brief & Factual)
Client Name/DOB/CMH ID	Pull from initial intake.
Date of Assessment	
Referral Source	
Presenting Problem (Chief Complaint)	*Client's own words.* Onset, duration, and precipitating events (e.g., job loss, crisis).
Client Goals	*Client's desired outcomes, aligning with PCP.* (e.g., "I want to get a job and move into my own apartment.")

2. Biological Domain

Component	Required Data (Checklist/Brief Narrative)
Current Medical Status	List all current medical diagnoses (Axis III conditions). Date of last physical exam. **Note any acute or chronic pain.**
Current Medications	List name, dose, frequency, and prescribing provider. **Note any side effects or compliance issues.**
General Health/Functioning	Brief status of sleep (quality/duration), diet, and physical activity. **Activities of Daily Living (ADLs)/Instrumental ADLs (IADLs)**: Note any deficits in self-care, money management, or transportation.
Substance Use History	Current/Lifetime use of Alcohol, Tobacco, Illicit Drugs, and Rx Misuse. **Date of last use for each.** Document any history of treatment.
Family Health History	Brief mention of family history of medical illness, mental illness, or substance use.

3. Psychological Domain

Component	Required Data (Concise Narrative & Observations)
Psychiatric History	List all previous mental health diagnoses. Document any prior inpatient (dates/locations) or outpatient treatment (type/efficacy).
Current Symptoms	**Briefly** summarize current symptoms (e.g., depressive, anxious, psychotic, cognitive) and the impact on functioning/impairment. Note intensity and frequency.
Trauma History	**Screening:** Document any history of physical, sexual, or emotional abuse/neglect/trauma. Note current emotional or behavioral impact.
Coping Strategies	Describe current coping mechanisms (positive and negative). What has helped in the past?
Mental Status Exam (MSE) Summary	**Focus on key abnormal findings or risk factors.** (e.g., *Appearance:* Disheveled. *Mood/Affect:* Depressed/Constricted. *Thought Process:* Linear. *Insight/Judgment:* Fair. *Cognition:* Mild memory issues noted.)

4. Social & Environmental Domain

Component	Required Data (Factual & Relevant to Treatment)
Housing Status	Type of residence (home, apartment, group home, homeless/shelter). Who lives with the client? **Note stability and safety.**
Support System	Identify primary emotional and practical support persons (family, friends, staff). **Note quality of key relationships.**
Vocation/Education	Current employment status (full-time, part-time, unemployed). Highest level of education. **Note any barriers to employment.**
Financial/Benefits	Primary source of income (SSI, SSDI, employment). **Note any financial strain/insecurity.** List Medicaid/Medicare status.
Legal History	**Check for current/pending legal issues** (e.g., probation, parole, custody, civil commitments).
Cultural/Spiritual	Note relevant cultural, spiritual, or religious practices/beliefs that may influence treatment.

5. Risk Assessment & Safety

Risk Factor	Assessment & Protective Factors
Suicidality	Denies/Passive/Active ideation? Plan/Intent? **Note the client's current contract for safety (if applicable).**
Homicidality/Violence	Denies/History of violence/Threats? Current targets? Access to weapons?
Self-Harm	History or current non-suicidal self-injury (NSSI).
Risk Summary	**Low/Moderate/High** risk rating. List key **Protective Factors** (e.g., strong family bond, motivation for change, consistent housing).

6. Diagnostic Impressions, Summary & Recommendations

Component	Summary/Plan
Diagnostic Impressions	**DSM-5 Diagnosis:** (Primary and secondary diagnoses, including V/Z codes for social/environmental factors).
Client Strengths	**List 3-5 concrete strengths** (e.g., *motivated, strong work ethic, intellectual capacity, good insight*).
4 P's Formulation (Optional but Recommended for CMH)	**Predisposing:** (Vulnerabilities, history) **Precipitating:** (Recent triggers) **Perpetuating:** (Factors keeping the problem going) **Protective:** (Strengths/supports)
Plan/Recommendations	**Initial Service Recommendations** (e.g., Individual Therapy, Skills Training, Case Management, Psychiatric referral). **Note next steps for Person-Centered Plan (PCP) development.**

Overarching Goal Minimize the amount of information collected during the intake process in Michigan's public behavioral health system
Subgroup Objective Develop a streamlined BPS assessment that meets state requirements and accommodates local needs/preferences

Desired future state: to conduct a warm, focused intake that ensures individuals and families feel heard, while collecting all data to satisfy state, federal, and accreditation standards. Using expert clinical interviewing and rapport-building skills, we'll ask each essential question once-eliminating duplication- and leverage health IT to auto-populate biopsychosocial and assessment data fields. To support this, we'll define a code dataset by population that aligns with all regulatory and accreditation requirements.

Recommendations of the BPS Subgroup

1. Enlist the work of a data scientist/data architect to ensure all elements are mapped.
2. Separate History/Train Staff: Separate clinical history and train staff on what to document to avoid cluttering the Presenting Problem. The note that "History relates to an ongoing service discussion, not an initial determination" should keep the initial BPS concise and focused on *current* needs.
3. Use External Tools: The use of standardized tools like LOCUS, MichiCANS, WHODAS 2.0, and PMLA allows the clinician to simply state the tool results and the corresponding service recommendation (e.g., LOCUS Level 3), instead of writing a lengthy narrative justifying the level of care.
4. BH-TEDS Integration: Many fields are noted as BH-TEDS connected (Veteran, Education/Employment, Housing). Since this data is often pulled from an initial intake form, the BPS only needs to *verify* and *synthesize* the information, not collect it all from scratch.
5. This comparison suggests that using checklists, data points, and structured summaries is the most effective way to address all the required elements in the BPS comprehensive document while keeping the assessment succinct.
6. The suggested outline represents the final recommendation for improving BPS efficiency while maintaining accreditor, regulatory, and payer requirements.

7. CMHs recommended to complete an analysis of existing BPS compared to BPS recommendations to discern areas of reduction via artificial intelligence (AI).
8. Vet and support AI findings for accuracy assurance.
9. Recommend one BPS format that can be affirmed and endorsed as a promising practice, by MDHHS.
10. Engage EMR vendors to create the uniform BPS template.
11. Recommend that a group of users work with their data system vendor to account for systemic upgrades for a new BPS for all CMH systems.
12. Ensure that CMH agreement is secured to proceed.
13. Account for accreditor and other variations as appropriate (i.e., courts, grants, etc.).

Appendix I: Assessments Workgroup Recommendation Documents

Assessments Workgroup Executive Summary

Multiple stakeholders within the public behavioral health system have voiced concerns that the intake process is lengthy, often resulting in:

- Individuals and families being asked the same question multiple times
- Multiple visits being required to complete assessments prior to the start of treatment
- Clinicians entering duplicative information in several tools
- Individuals/families served experiencing the intake process as burdensome rather than welcoming and helpful

Members of the Minimizing Data Collection at Intake subgroup defined a desired future state as:

We'll conduct a warm, focused intake that ensures individuals and families feel heard, while collecting all required data to satisfy state, federal, and accreditation standards. Using expert clinical interviewing and rapport-building skills, we'll ***ask each essential question once—eliminating duplication—and leverage health IT to auto-populate biopsychosocial and assessment data fields****. To support this, we'll define a core dataset by population that aligns with all regulatory and accreditation requirements.*

This document summarizes:

- Preliminary findings from an initial crosswalk analysis of behavioral health assessment tools required by MDHHS for adults with severe mental illness, youth with severe emotional disturbances, and individuals with developmental disabilities.
- Potential visualizations to help stakeholders and decision makers understand the scope of the problem and the level of process redesign needed.
- Recommendations for next steps

The scope of this work is to prototype the crosswalk. Additional resources will be needed to develop a finalized product. This first iteration of the crosswalk highlights the similarities, differences, gaps, and redundancies across tools and aligns those findings with state and accreditation regulatory requirements. The goal of this analysis is to reduce duplication, streamline the assessment process, and improve the quality and efficiency of behavioral health evaluations for all populations served by the public behavioral health system.

Assessment Tools Reviewed

The following tools were reviewed and compared at the domain and item level, using exact language where applicable to ensure accuracy and utility:

- CAFAS (Child and Adolescent Functional Assessment Scale)
- PECFAS (Preschool and Early Childhood Functional Assessment Scale)
- LOCUS (Level of Care Utilization System)
- WHODAS 2.0 (World Health Organization Disability Assessment Schedule)

- MichiCANS (Michigan Child and Adolescent Needs and Strengths)
- ASAM Criteria (American Society of Addiction Medicine)
- C-SSRS (Columbia-Suicide Severity Rating Scale) - *not required by MDHHS or Accrediting body, but typically used as best practice
- Biopsychosocial Assessment Templates

Regulatory Alignment

This crosswalk incorporates content required by:

- CCBHC Assessment Requirements
- CARF Accreditation Standards
- Joint Commission Accreditation Standards

Please note that local CMH assessment and documentation protocols vary substantially from county to county. Therefore, this review cannot account for all locally required assessment domains or items. Each required domain or indicator was checked against the reviewed tools to identify alignment or gaps. Results are presented in the full Excel comparison and summarized in recommendations below.

Crosswalk Highlights (*Sample Excerpts*)

- Identical Language: CAFAS & PECFAS use nearly identical language for 'Mood / Emotional Status: Moderate Impairment'
- Clinical vs Functional Language: LOCUS uses level-based severity descriptors while CAFAS uses functional examples
- Partial Mapping: WHODAS covers 'School/Work Functioning' under broader 'Life Activities'
- Unique Domain: MichiCANS addresses 'Crisis Engagement' under service readiness
- Unique Domain: WHODAS includes 'Communication and Understanding' as its own domain
- Regulatory Mapping: ASAM aligns with CARF requirement for assessing physical health
- Regulatory Mapping: MichiCANS includes cultural/linguistic needs as required in CARF biopsychosocial requirements

Efficiency Considerations

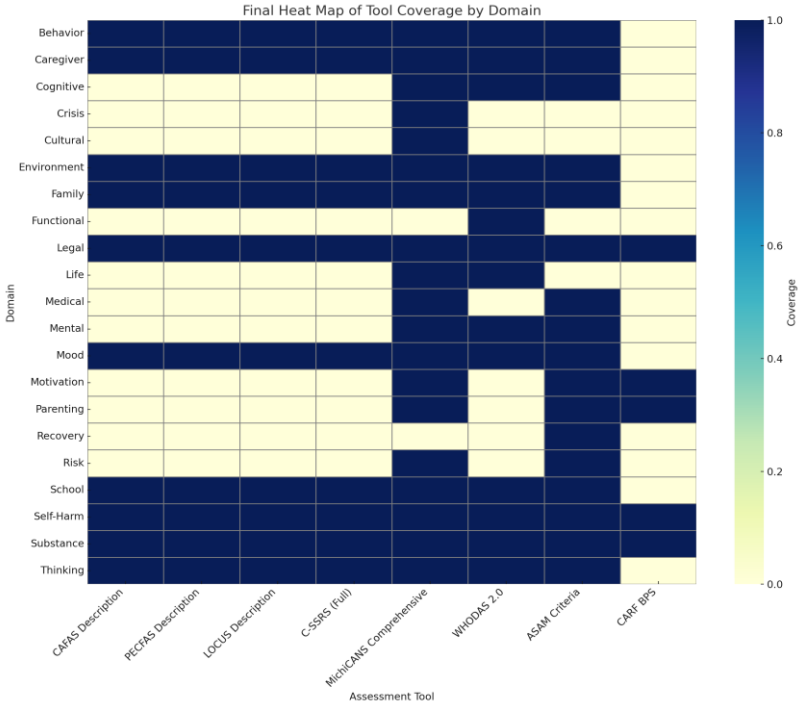
- Many tools overlap assessing common domains (e.g., risk, mood, functioning), which results in redundant data collection and a lengthier, less welcoming experience for those served.
- Tools like MichiCANS and ASAM cover broad biopsychosocial areas, reducing the need for multiple narrow tools. It may be possible **replace** the traditional BPS with these comprehensive tools, rather than be in *addition to* the BPS.
- Streamlining tool selection based on the required domains may reduce staff burden and allow for quicker access to services.
- CAFAS/PECFAS are redundant when broader tools like MichiCANS are already in use.

Visual Summaries and Comparative Tools

The following visuals are examples demonstrating how results of the final analysis could be presented to aid in the interpretation of findings and enhance communication across audiences.

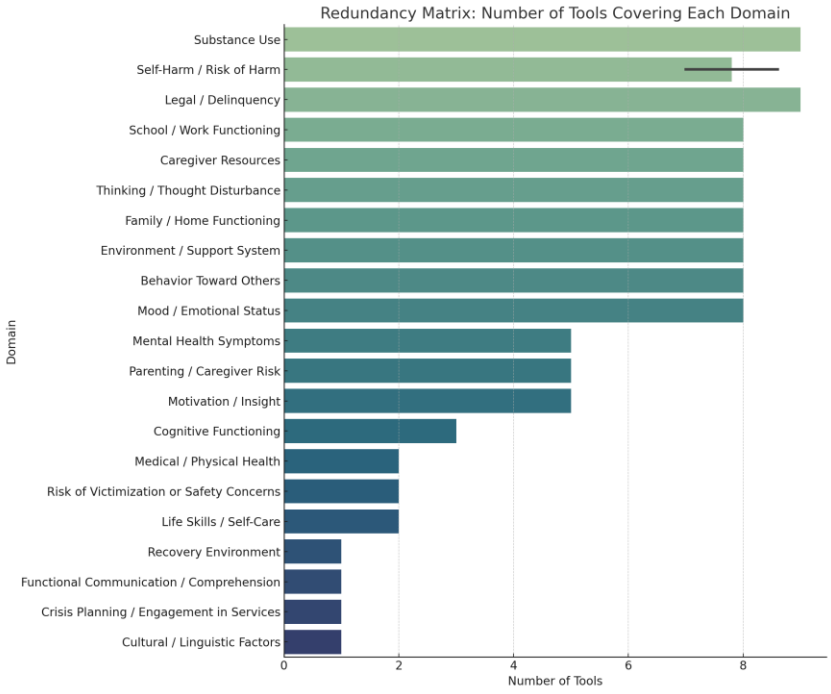
1. Heat Map of Tool Coverage by Domain

The heat map visualizes how comprehensively each assessment tool covers the standardized domains. Darker shades represent more detailed or comprehensive coverage. This allows stakeholders to quickly identify strong and weak areas across tools.



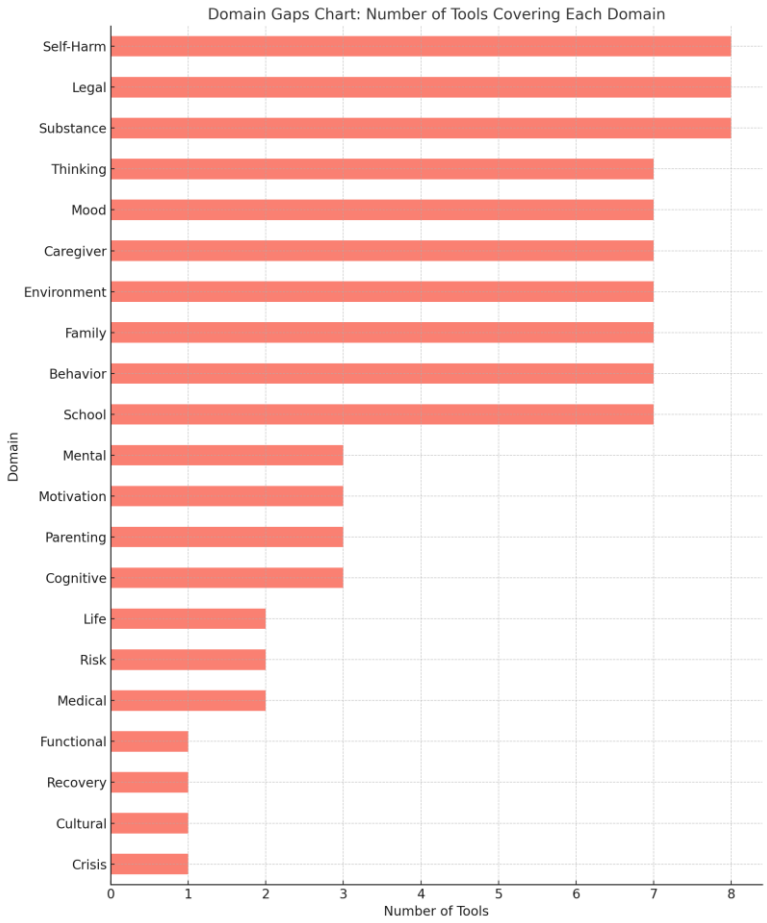
2. Redundancy Matrix

This matrix identifies where multiple tools capture the same domain or item. Redundant areas are highlighted to support recommendations for streamlining assessments.



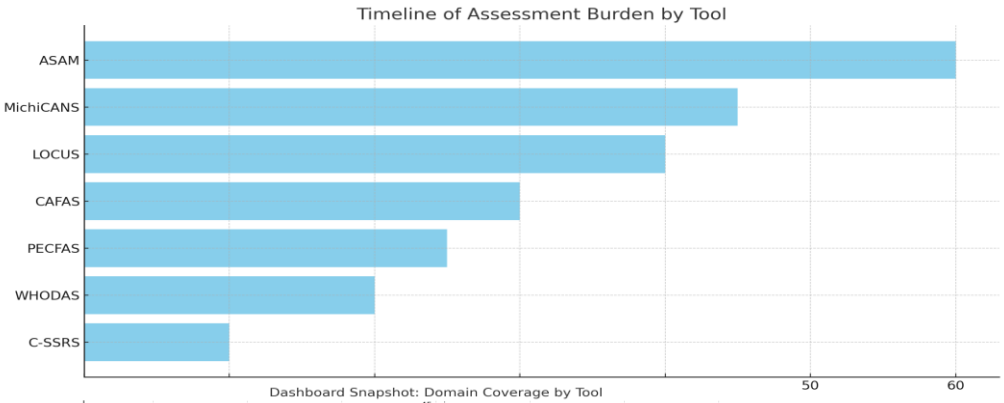
3. Domain Gaps and Overlap

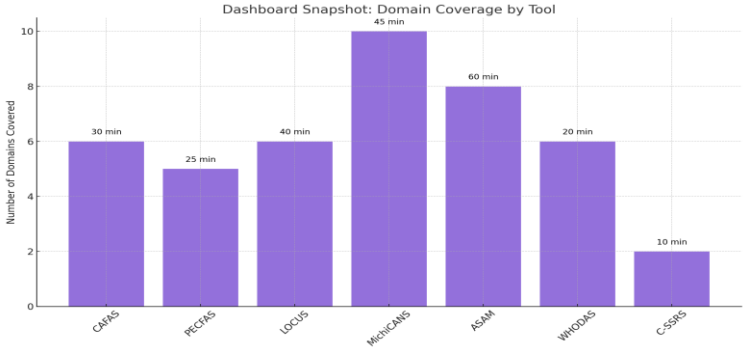
This chart presents domains that are underrepresented or missing across tools, helping prioritize areas for tool consolidation or supplemental assessments.



4. Assessment Burden by Tool

The durations listed below are for illustrative purposes only. Data from the field should be analyzed to provide more accurate completion times.





Recommendations

1. Add CCBHC, CARF, and Joint Commission assessment requirement to crosswalk.
2. Conduct additional validation of AI results (manual review of initial mapping in crosswalk spreadsheet) and develop next iteration of analysis based on findings. See Appendix A for findings from initial round of validation.
3. Consider revising mapping logic from domain-based to item-based. See explanation under Domain Logic section in Appendix A.
4. Explore funding options for additional analyses. To move from our current prototype crosswalk to a fully functional and validated final product, funding is required to engage skilled data scientists and data analysts. Their expertise is essential to refine and operationalize the initial framework.

Appendix A

Findings from initial round of data validation of AI crosswalk. A small sample of items from the AI crosswalk were reviewed.

Missing items

CAFAS Description – only one behavioral example is included for each level of impairment (minimal/no, mild, moderate, severe), however there are actually multiple potential behavioral examples for each domain (for some domains up to 10 options). It appears AI summarized the behavioral items for each level of impairment, which does not capture the level of detail required by the tool.

LOCUS Description - It appears AI summarized the behavioral items for each level of impairment, which does not capture the level of detail required by the tool

LOCUS Medical, Addictive, and Psychiatric Co-Morbidity domain is missing.

MichiCANS Comprehensive – It appears AI summarized school behavior and school achievement items into one item in the "school/work functioning" domain (see cells G2-G5). However, these are two distinct items that need to be scored separately.

Severity Level – descriptors of severity levels vary. For example, the self-harm/risk of harm severity levels for CAFAS and PECFAS are not aligned with the actual levels identified in the tool (moderate and severe are identified on the mapping, but the actual tool include minimal/no, mild, moderate, and severe).

Domain Logic

The identified domains may not be the most appropriate set of domains to use as the foundation of this mapping. For example, recovery environment is listed as a domain (cell A54) but the related LOCUS items are not referenced here (cell E54), but rather in the environment/support system domain (cells E43-E46). Operational definitions of the grouping logic should be created to help the end user understand what is included in each domain.

Or perhaps the analysis should be structured not at the domain-level, but at the item-level. For example, column A would list each item from every assessment tool and the following columns would indicate if that same item was found in other tools. Mock-up of this format:

	A	B	C	D	E	F	G	H	I
1	Assessment	Population	Included in Joint Comm BPS	Included in CARF BPS	Included in CCBHC BPS	Collected as structured data	Answer type in Joint Comm BPS alligns with answer type in validated assessment tool	Answer type in CARF BPS alligns with answer type in validated assessment tool	Answer type in CCBHC BPS alligns with answer type in validated assessment tool
2	LOCUS Item 1	SMI	Yes	No	Yes	No	No	No	No
3	LOCUS Item 2	SMI							
4	LOCUS Item 3	SMI							
5	WHODAS Item 1	IDD							
6	WHODAS Item 2	IDD							
7	WHODAD Item 3	IDD							
8	CAFAS Item 1	SED							
9	CAFAS Item 2	SED							
10	CAFAS Item 3	SED							
11	PECFAS Item 1	SED							
12	PECFAS Item 2	SED							
13	PECFAS Item 3	SED							
14	MichiCANS Item 1	SED							
15	MichiCANS Item 2	SED							
16	MichiCANS Item 3	SED							
17	ASAM Item 1	SUD							
18	ASAM Item 2	SUD							
19	ASAM Item 3	SUD							
20									

Population

The current structure of the mapping does not allow for the stratification of data elements or domains by the population (I/DD, SED, or SMI) of the individual served. This needs to be included as the required assessment tools are population specific.

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