Residential Rehabilitation

Connecticut Mental Health Group Homes

November 4, 2004

Day One Overview

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Day One Overview

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  - Pre-Admissions Master Treatment Plan
  - 90-Day Master Treatment Plan Reviews and Updates
  - Discharge Planning
  - Oversight for Duplication of Services

Part One: Service Definition

Psychiatric Rehabilitation (Medicaid Rehab Option)

- Federal Definition:
  - "Any medical or remedial services (provided in facility, home or other settings) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of the individual to the *best possible* functional level."

Psychiatric Rehabilitation and Medicaid

- *Restoration* of basic skills necessary to function independently in the community
- Redevelopment of communication and socialization skills
- Family education and other family services exclusively related to treatment or rehabilitation of the covered individual.

Residential Rehabilitation

- Provided in a PNMI of 16 beds or less.
  - Private Non Medical Institution = PNMI
- GOAL: Assist individuals with serious and persistent mental illness to achieve their highest degree of independent functioning and recovery

Population

- Primary diagnosis of SPMI so serious and disabling as to require care in a group home setting
- Stable enough to function outside of a 24-hour medically managed setting
- Able to participate in community-based treatment services
- Significant skill deficits in the areas of self-care and independent living *as a result of their psychiatric disability*
- Require a non-hospital, twenty four hour, seven day per week, supervised community–based residence

Medical Necessity for Admission

- Diagnostic assessment prior to entry by LMHA
- Clear formulation that ties diagnosis and current functioning to
  - Need for 24-hour, supervised group home level of care (PNMI)
  - Psychiatric rehabilitation goals that can be met at group home
  - Need for at least 40 hours of rehabilitation service per month

The Regs: CT Medical Necessity Definition

- "Medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring.

Medical Necessity: Federal Guidance

- Client must be active & voluntary participant
- Sufficient cognitive ability to benefit
- Services should be delivered at an appropriate intensity and as ordered in a treatment plan
- Services should be in the least restrictive setting that is available and safe

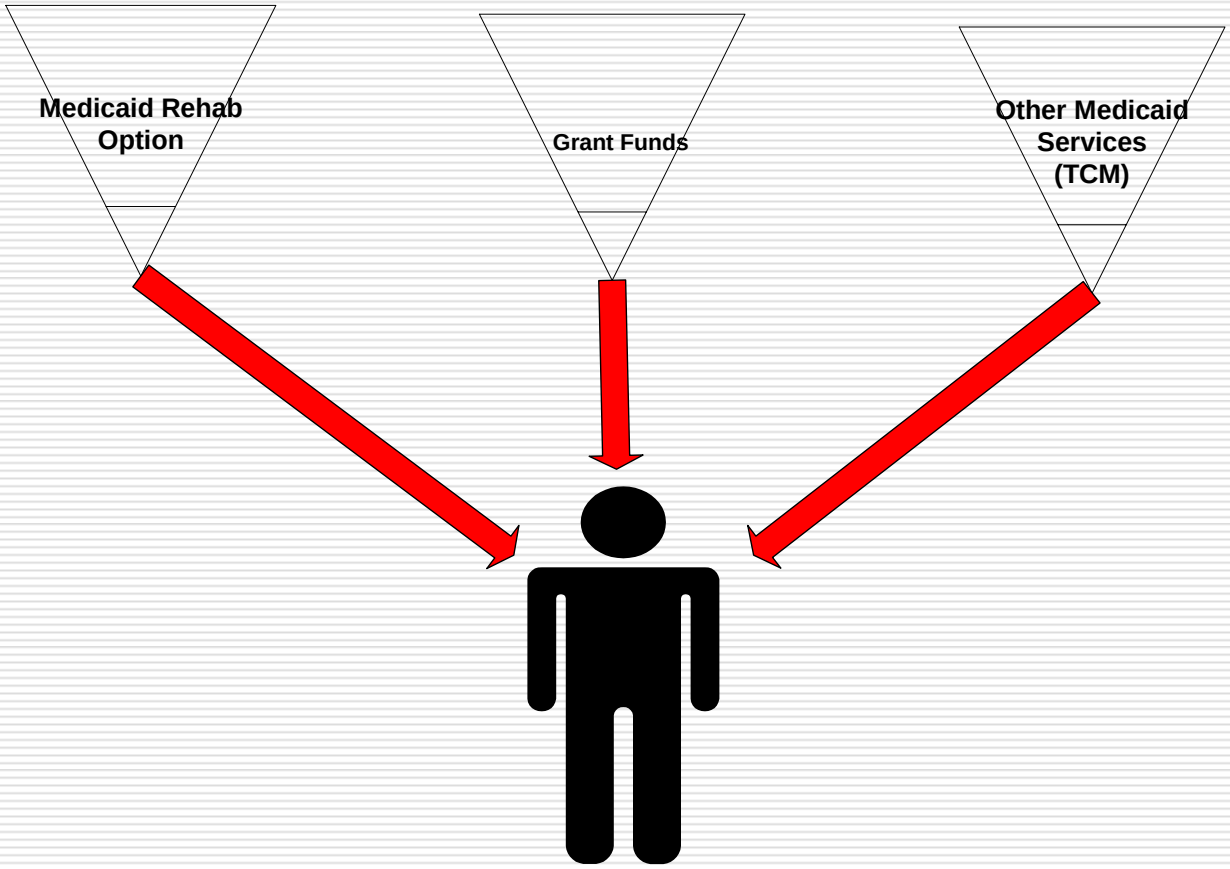
Authorization

- Admission will be prior authorized by CT Department of Social Services. This is separate from the assessment and medical necessity determination by the LMHA.

The Regs: Authorization

- Prior authorization, on forms and in a manner as specified by the department (DSS), is required for each admission to a mental health group home.
- The initial authorization period shall be for up to twelve months.
- If authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered for up to twelve months per request.
- In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure approval on the next working day for the admission.

Services and Funding



Services for Group Home Clients

- Clients living in mental health group homes may be receiving a variety of services, including:
  - Residential Rehabilitation under rehab option (at least 40 hours/month)
  - In addition to 40 residential rehab hours
    - Targeted Case Management
    - Services from LMHA and affiliate agencies or other programs
    - In-home assistance and habilitation

Covered Residential Rehabilitation Services *(Within 40 hours)*

- Intake and assessment
- Development of the Residential Rehabilitation Plan
- Socialization skills development
- Individual, family and group counseling
- Behavior management training and intervention
- Supportive counseling directed at solving daily problems related to community living and interpersonal relationships
- Psychoeducational groups pertaining to the alleviation and management of psychiatric disorders

Covered Residential Rehabilitation Services

- Teaching, coaching, and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem-solving

Covered Residential Rehabilitation Services

- Assistance in developing skills necessary to support a full and independent life in the community
- Support with connecting individuals to natural community supports
- Orientation to and assistance with accessing self help and advocacy resources
- Development of self-advocacy skills
- Health education
- Teaching of recovery skills in order to prevent relapse

Covered Residential Rehabilitation Services

- Other rehabilitative support necessary to develop or maintain social relationships, to provide for independent participation in social, interpersonal or community activities, and to achieve full community reintegration
- Ongoing assessment and service planning
- Supervise and monitor self-administration of medications

Exclusions to Residential Rehabilitation Services

- Socialization/Recreational
- Social events
- Academic Education
- Job Training/Vocational Services
- Transportation*
- Case management
- Case coordination
- Habilitation

Residential Rehabilitation Documentation

- Encounter notes for each rehabilitation intervention
- Each intervention must be at least 15 minutes to "count"
- Monthly progress notes developed and signed by licensed staff as part of supervision
- 90-day residential rehabilitation plan updates
- 90-day master treatment plan reviews/updates
- Each resident will need to have a Residential Rehabilitation case record that includes copies of more information than has been required in the past.
- Will not supplant the need for other documentation required for licensing.

Billing

- The group home will submit one monthly bill with one code for each Medicaid client who receives a minimum of 40 hours of residential rehabilitation services per month (or prorated for number of days in residence).
- The group home will directly bill EDS.
- Details on how to bill and track for billing will be covered in the December training.

Part TWO: LMHA Roles & Responsibilities

Overview of LMHA Functions

- Pre-Admissions Assessment
- Pre-Admissions Master Treatment Plan
- 90-Day Master Treatment Plan Reviews and Updates
- Discharge Planning
- Oversight to Prevent Duplication

LMHA Oversight Does NOT Require

- Assignment of a case manager, unless LMHA would do so anyway
  - Watch out for duplication with TCM at group home level

Pre-Admission Assessment

- Purpose:
  - To provide a diagnosis
  - To determine level of care
  - To provide the information that will form basis for the Master Treatment Plan and the Residential Rehabilitation Plan
    - Problem list
    - Strengths – very important in your system – what can you build on?
    - What has and has not worked in past
    - What are client's goals and commitment to treatment?

Pre-Admission Assessment

- Critical who conducts the assessment and provides the diagnosis:
  - Psychiatrists
  - Psychologists
  - LCSW
  - APRN
- Medicaid billable as Code 90801

Pre-Admission Assessment

- Gathers historical & current data with a real focus on a rehabilitation model of care
  - Historical information is important in determining what skills have deteriorated and need to be redeveloped; what was the client's baseline at their highest level of functioning?
  - Current symptoms are important if they interfere with recovery; if the client does not know how to manage them; if the client is hampered by them in pursuing recovery.

Pre-Admission Assessment

- Functional impairments and behaviors should be a primary focus
- Support systems, beliefs, self-assessments of strengths are important because these are the assets the client brings to the recovery process
- Current signs and symptoms must be identified and their impact assessed. Also may be a focus of illness management.

Pre-Admission Assessment: Examples of strengths

- The client can read – critical strength that will play a large role in how you help this client redevelop his skills in various life domains
- The client is still in contact with a sister who visits him regularly and invites him to her home for holidays – the beginnings of a social network that can potentially be built on
- The client has her GED – prevocational work becomes a potential focus of recovery interventions

Pre-Admission Assessment

- Social and cultural assessments are important
  - Example: Client is Cape Verdean – meaningless to treatment team
  - Client is Cape Verdean and has a large, close extended family that “takes care of their own problems”. Parents state that in the island culture no one lives with anyone but their family. The family is not supportive of a residential placement for the consumer and have actively frustrated the attempts parents attempts to place their adult child.

Pre-Admission Assessment

- Most critical piece is the clinical formulation ("Summary of Findings and Recommendations")
  - Evaluates all the data collected by the team
  - References each dimension – physical, psychological, and social through the means of life domains – and impact on current client functioning/presenting problem
  - Lists strengths and challenges
  - Prioritizes needs/problems – Diagnoses are not problems
  - Justifies the diagnosis and LOC
  - Determines which problems will be addressed at recommended LOC – limits scope of interventions

Pre-Admission Assessment

- Just restating the client's history and data in abbreviated form is one of the most widespread documentation errors in behavioral health
  - Individualized meanings and consequences are critical in a recovery model
  - "So what" questions – so what does this mean, so what should we do, so what will show progress, so what should we do first?

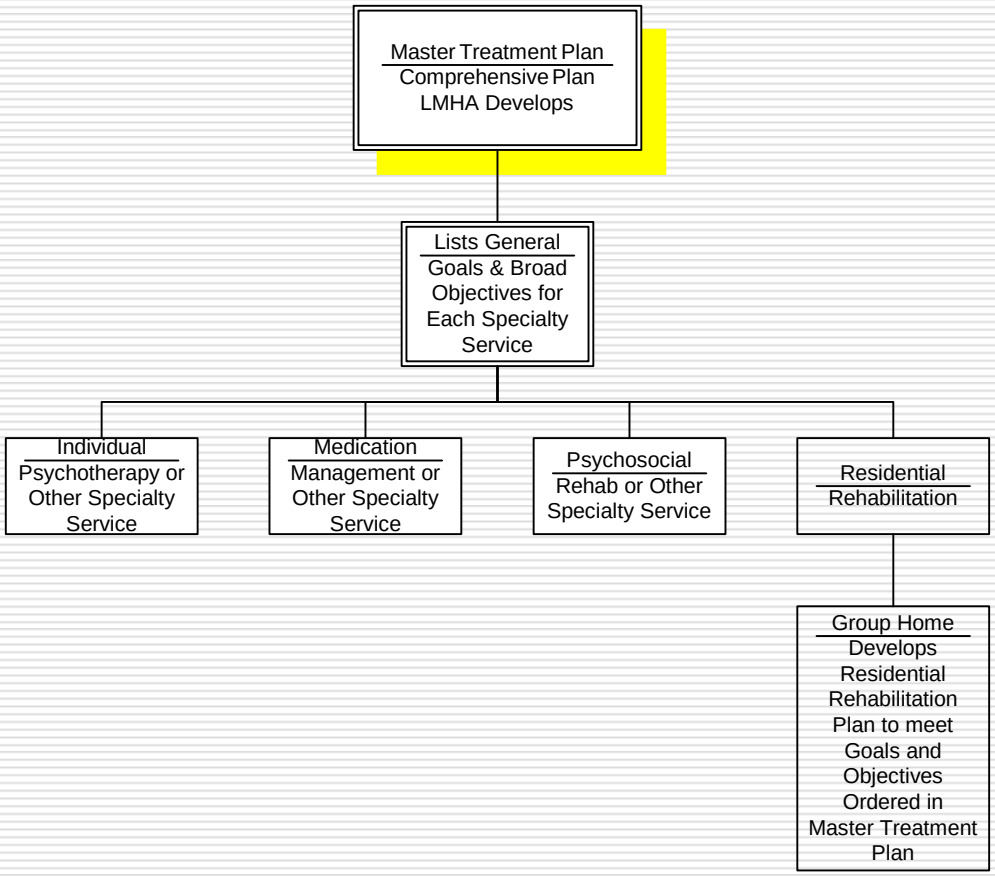
Pre-Admission Assessment: Examples

- Client is depressed as shown by her lack of hygiene, calling in sick to work, increased weight gain – symptom focus justifying diagnosis
- Client does not have good self-care skills as shown by his not bathing or changing his clothes – skill deficit
- Client does not like to participate in group activities and refuses to sit and stop talking, and is sent out of group at least 3 times per week – possibly both symptom focus and skill deficit

Assessment Leads to Master Treatment Plan

- Pre-Admission Assessment Defines:
  - Medical Necessity for Group Home LOC and
  - Goals for Residential Rehabilitation Services.

Relationship of Master Treatment Plan to Residential Rehabilitation Plan



Master Treatment Planning

- Comprehensive plan required regardless of payment source
- Orders level of care, and services within level, across providers
- Team involved: consumer, family, person doing assessment, team at LMHA, potential providers.

Master Treatment Plan Contents

- Long term results/Goals – mutually desired
- Shorter term (90 day) objectives to reach those goals
  - Strengths and challenges and how strengths used in achieving goals
  - Specific consumer or family skills that need to be developed
- Frequency and duration *(At least 40 hours/month of residential rehabilitation services.)*
- Auditor should be able to understand your overall strategy.

Master TX Plan Contents

- For each service, the provider recommended by the LMHA and chosen by consumer
- Always include a plan for addressing medical problems
- May want to include a plan for development of advance instructions, crisis prevention plan, and/or relapse prevention plan

Master Treatment Plan For Residential Rehabilitation Services: Goals

Goal 1	Maintain psychiatric stability through independent medication self-management
Goal 2	Achieve skills to live independently in community
Goal 3	Obtain volunteer or paying work
Goal 4	Maintain a network of friends and social contacts for socialization and support

LMHA Transition by January 1, 2005

- Need for Diagnostic Assessment
  - Completed by appropriately credentialed professional within last 6 months
- Need for Master Treatment Plan Ordering Group Home Level of Care
- LMHA obtains/develops, and transmits to Group Home

Master Treatment Plan Review

- Must be reviewed every ninety days to recertify medical necessity for all services
  - This is especially important for state-operated LMHAs
- If no current order, then residential (and other Medicaid) services not payable

Master Treatment Plan Review: Key Questions

- Has psychiatric condition changed, necessitating different level of care?
- Has there been any progress toward goals? Is client benefiting from rehabilitation services?
  - Do goals or major objectives need to be modified?
  - Does service mix, treatment strategy need to be modified?
- Are the right services in place to assist the client with making progress, or maintaining optimal functioning?

Master Treatment Plan Reviews

- If progress noted:
  - Should level of care change?
  - Should intensity change?
  - Should staffing assignments change?
  - How should problem list change?
    - Affect on goals?
    - Affect on objectives?

Treatment Plan Review Operations

- Establish Responsibility at LMHA
- Ensure LPHA oversight and signature
- Review monthly progress notes from MH Group Home
- Review other service notes
- Discuss with Group Home Primary Worker/Licensed Staff
- If change is required, convene meeting with Group Home Staff, Client and other providers to update as necessary

Treatment Plan Review Operations

- Each LMHA will establish procedures and flow chart for communicating with MH Group Homes and other providers about Master Treatment Plan.
  - Must send copy of Diagnostic Assessment and current Master Treatment Plan to Group Home for inclusion in their chart
- LMHA should track dates for Master Treatment Plans and plan to make sure that they are always current

Discharge Planning: LMHA Role

- Negotiate other levels of care for movement
- Prevent logjam at MH Group Home level
- Facilitate movement across levels of care and within levels of care
- Assess need for new services or more intensive application of existing services to facilitate movement
- Should be assessing progress toward meeting discharge criteria at each Master Treatment Plan review.