PNMI 101
Part 2

- **Goal:** To be able to understand all standards required for PNMI compliance and how to ensure that the provided services are documented correctly.

- **Part 2:** Service Delivery / Progress Documentation Standards 25-35 = 40%
  - Standard 25 - Clinical and Milieu Services
  - Standards 26-30 – Progress Notes
  - Standard 31 – Daily Milieu Proactive Services
  - Standards 32-35 – Monthly Treatment Plan Progress Report (MTPPR)

Standard 25
Clinical and Milieu Services

- A **separate** progress note must be written for each service/session provided and meet minimum **frequency** AND **duration** prescribed in the treatment plan

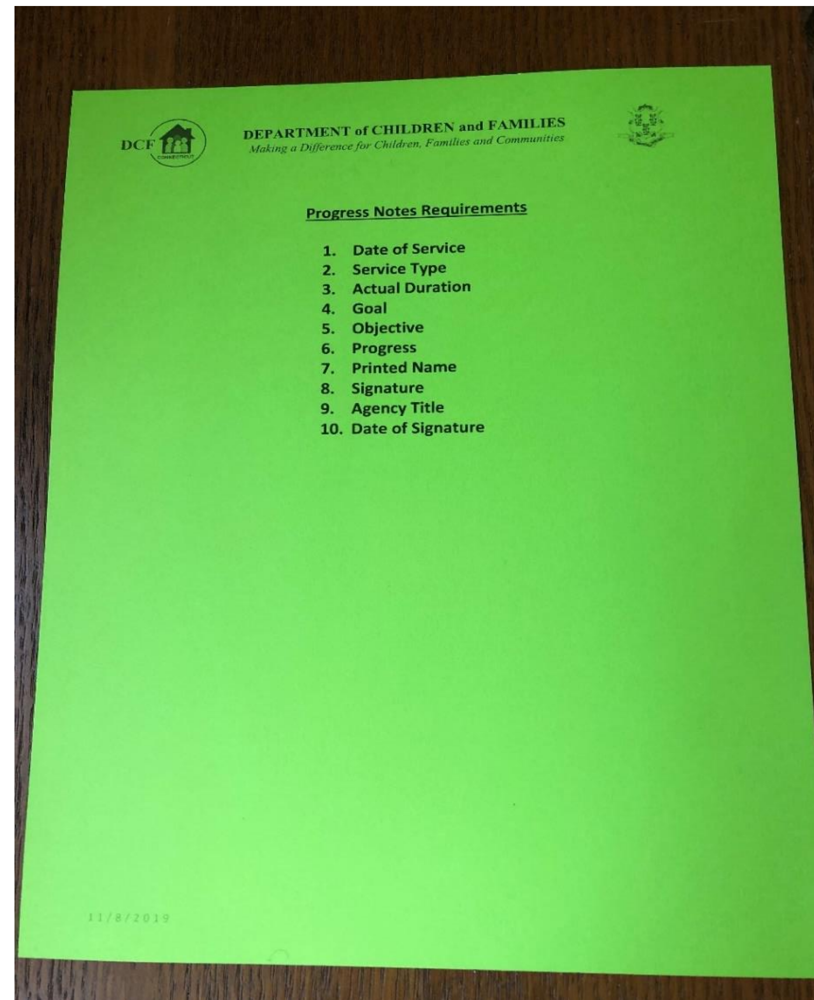
- If a service/session is not provided as prescribed, a progress note must be written indicating why
  - i.e.: AWOL, refusal, home pass, work, etc.

Standard 25
Frequency Compliance

CLINICAL SERVICE DELIVERY DETAILS	How often the ITP Frequency Was Actually Met	Combined Scheduled & Delivered Family Svcs	% of Plan Required Units of Service Delivered
Individual Therapy	100.00%		100.0%
Group Therapy	50.00%		100.0%
Medication Management	100.00%		266.7%
Family Therapy	66.7%	66.7%	100.0%

Standard 31 is included in the overall compliance calculation

Standards 26-30 Requirements (Green Sheet)



DCF

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Progress Notes Requirements

1. Date of Service
2. Service Type
3. Actual Duration
4. Goal
5. Objective
6. Progress
7. Printed Name
8. Signature
9. Agency Title
10. Date of Signature

11/8/2019

Standards 26, 27, 28, 29, 30
Progress Notes:
Milieu, Clinical, Outside

- Standard 26 - **Service Type** and actual **Duration** of the service
- Standard 27 - **Date** the service was given
- Standard 28 - FULL **Printed Name**, **Signature** with **Date** and **Agency Title** of person who delivered the service
and wrote the note
- Standard 29 - **Goal** and **Objective** addressed
- Standard 30 - **Progress** made towards goals and objectives

Clinical Progress Notes

- Purpose of the session related to each goal and objective
- Document youth's emotional state **and** participation
- Summary of the session, including specific interventions
- Statement of progress toward each goal and objective
  - Grade/Rate Progress (i.e.: poor, moderate, excellent, none…)
  - A statement to support the rating which includes documentation of any movement towards achieving the goal and objective utilizing your measurability language.

Clinical Progress Notes Sample

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Clinical Progress Notes Examples:

- No Progress: Johnny has made no progress as he refused to engage in the session and discuss his inappropriate boundaries with staff.
- Poor Progress: Johnny made poor progress as evidenced by his inability to acknowledge his triggers and the impact his behaviors have on the others within the group home.
- Moderate Progress: Johnny made moderate progress. He described some of his emotions that he was experiencing but had difficultly connecting how his actions affected multiple domains of his life.
- Good Progress: Johnny made excellent progress He verbalized his coping skills and when to utilize them in the future

Standard 31
Daily Milieu Proactive Training

- Program Administration is responsible for ensuring that milieu staff are adequately trained to deliver the services identified in the treatment plan
- Including:
  - What is a service delivery
  - How to provide a milieu service
  - How to deliver the specific service, e.g. deep breathing, appropriate boundaries, etc.
  - How to document the service delivery
  - Progress Note Training available online

Standard 31
Daily Milieu Proactive Service

- There must be at least one note written **EACH** day the youth is in the program documenting either:
  - Service was provided
  - Service was not provided with an explanation
    - Refusal by youth (with documented concerted efforts to engage)
    - Not provided by staff
    - Youth not at program (i.e. home visit, AWOL, hospitalization, etc.)

If the youth is out of the program for multiple days, a note must be written EACH day specifying the reason

The full **Progress Note Training** is available online

Standards 32, 33, 34, 35

Monthly Treatment Plan and Progress Report (MTPPR)

- Standard 32 – All MTPPR's are in the record
- Standard 33 – Individual, Group and Family Therapy sessions provided match number of sessions reported
- Standard 34 –
  - Documentation in MTPPR **Symptomatology** and **Recovery & Resiliency** Sections Only
  - Goals and Objectives are present
  - Progress statement for **Each** Goal and **Each** Objective
- Standard 35 – All MTPPR's sent to the Area Office

http://www.ctbhp.com/providers/bulletins/2015/PA-2015-10.pdf

MTPPR PNMI Sections

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

PROVIDER ALERT

MTPPR GUIDE

Alert#: PA 2015-10

Issued: September 1, 2015

To: All CT BHP Residential and Group Home Providers

Subject: Updates to MTPPR Process

Dear Provider,

As you are aware, The CT BHP initial & concurrent authorization process for Residential and Group Home providers was revised and abridged in March of this year. This change impacted providers completing the initial telephonic review as well as the concurrent Monthly Treatment Planning and Progress Reports (MTPPR) in ProviderConnect. Although these modifications were made to alleviate administrative burden for the intake staff and to streamline the authorization process by reducing the number of fields and the amount of information required for the initial telephonic authorization of care, it has come to our attention that the abridged form has become problematic for the PNMI standards related to the treatment plan's goals, objectives and progress. Therefore, going forward, please begin documentation of the treatment plan's goals, objectives and progress in the Symptomatology box and continue documentation in the Recovery & Resiliency box. In order to meet PNMI standards the treatment plan **must** include and clearly label the **Goals, Objectives, and Progress** for each section. The combination of these two fields should allow for the input of 4000 characters, which will allow for a more comprehensive progress within the MTPPR. We thank you for your participation in the CT BHP network and we look forward to working with you in the coming months to continue to enhance collaboration within the behavioral health delivery system. If you have any questions, please feel free to contact the CT BHP Call Center at 1-877-552-8247.

Provider Relations Department, Connecticut Behavioral Health Partnership

http://www.ctbhp.com/providers/bulletins/2015/PA-2015-10.pdf

Begin documentation of the treatment plan in the **Symptomatology** box

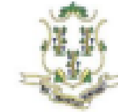
Continue documentation in the ***Recovery & Resiliency*** ***box,*** *which is further down in the review* and allows 2000 characters.

Recovery and Resiliency

MTPPR Sample

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities



Example MTPPR Progress Statement (Standard 34)

Remember to begin documentation of progress in the <u>Symptomatology Box</u> & continue documentation in the <u>Recovery & Resiliency Box</u>.

There is no need to write out all Goals & Objectives if they can be linked to the treatment plan. They can be identified in the progress narrative by G1, G1O1, G1O2, G2, G2O1, G2O2, G2O3 etc.

<u>Example:</u>

G1: Jack has demonstrated growth in maintaining a positive emotional state, evidenced by increased peer interactions, a decrease in oppositional behaviors & improved medication compliance. He has maintained safe behaviors as there have been no AWOL's, protective holds or police interventions during this review period. **G1O1**: Jack has willingly participated in all group sessions. He requires re-direction at times due to inappropriate social communication, however, more recently has been able to maintain composure in group. **G1O2**: Jack continues to require frequent prompts in order to engage in appropriate peer interactions; at times he requires intervention from staff to assist him in managing his behaviors. **G2**: Jack has continued to complete his hygiene 2x/day, without prompts from staff. He has been more engaged with staff & peers & participating in all daily activities. In contrast, this has led to the opportunity for staff to observe on-going inappropriate social interactions, resulting in an increase in teaching opportunities for staff & Jack to practice positive prosocial skills during group, individual therapy and within the milieu. Jack continues to struggle with unplanned changes in routine, time management and limit setting, specifically with use of his electronics. **G2O1**: Jack consistently takes his medications without issue. **G2O2**: Jack has continued to demonstrate an increase in his ability to communicate his needs with completing life skills/ADL tasks, to include being more receptive to household rules/expectations, particularly around household chores. **G2O3**: Jack has been able to complete hygiene without prompting and with minimal support from staff.

MTPPR Tracking Tool

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

MTPPR Tracking Tool

Name: Pipo **Admit Date:** 1/1/18 **Additional Quarters:** 16

Treatment Plan Authorization Due		MTPPR Due	Reporting Period Start	Reporting Period End
Initial Plan Due:	1/1/18	N/A		
30 Day: Plan Due	1/31/18	Due	Start	End
		2/19/18	1/1/18	2/14/18
		3/21/18	2/15/18	3/16/18
90 Day: Plan Due:	4/1/18	Due	Start	End
		4/20/18	3/17/18	4/15/18
		5/20/18	4/16/18	5/15/18
		6/19/18	5/16/18	6/14/18
180 Day: Plan Due:	6/30/18	Due	Start	End
		7/19/18	6/15/18	7/14/18
		8/18/18	7/15/18	8/13/18
		9/17/18	8/14/18	9/12/18
270 Day: Plan Due:	9/28/18	Due	Start	End
		10/17/18	9/13/18	10/12/18
		11/16/18	10/13/18	11/11/18
		12/16/18	11/12/18	12/11/18
360 Day Plan Due:	12/27/18	Due	Start	End
		1/15/19	12/12/18	1/10/19
		2/14/19	1/11/19	2/9/19
		3/16/19	2/10/19	3/11/19

Treatment Plan Authorization Due		MTPPR Due	Reporting Period Start	Reporting Period End
900 Day: Plan Due	6/19/20	Due	Start	End
		7/8/20	6/4/20	7/3/20
		8/7/20	7/4/20	8/2/20
		9/6/20	8/3/20	9/1/20
990 Day: Plan Due	9/17/20	Due	Start	End
		10/6/20	9/2/20	10/1/20
		11/5/20	10/2/20	10/31/20
		12/5/20	11/1/20	11/30/20
1080 Day: Plan Due:	12/16/20	Due	Start	End
		1/4/21	12/1/20	12/30/20
		2/3/21	12/31/20	1/29/21
		3/5/21	1/30/21	2/28/21
1170 Day: Plan Due:	3/16/21	Due	Start	End
		4/4/21	3/1/21	3/30/21
		5/4/21	3/31/21	4/29/21
		6/3/21	4/30/21	5/29/21
1260 Day Plan Due:	6/14/21	Due	Start	End
		7/3/21	5/30/21	6/28/21
		8/2/21	6/29/21	7/28/21
		9/1/21	7/29/21	8/27/21

PNMI Quality Assurance

- Program Administration is responsible for ensuring a quality assurance process in place to support maximizing PNMI outcomes

Teamwork is the key to success

PNMI Quality Assurance Assessment Tool

PNMI QUALITY ASSURANCE ASSESSMENT TOOL

Program Name:		Youth Record Reviewed:
Date of Review:	Date of Admission:	Date of Discharge:

PNMI Standards/Requirement	Compliant		Correction Required
ITEM CATEGORY: GENERAL INFORMATION DOCUMENTATION			
Standard 1	Yes	No	
Child's Full Legal Name in Record **1.1** The child's full legal name [first name, middle name(s), and last or surname, without use of initials or nicknames] is entered in the case record on the face sheet			
Standard 2	Yes	No	
Child's Sex Is Noted in Record **2.1** The child's sex [male or female] is entered in the case record on the face sheet			
Standard 3	Yes	No	
Child's Date of Birth in Record **3.1** The child's date of birth is entered in the case record on the face sheet			
Standard 4	Yes	No	
Child's LINK Person ID Number in Record **4.1** The child's DCF LINK Person Identification Number (*as opposed to the Case Identification Number*) is obtained and entered in the case record on the face sheet			
Standard 5	Yes	No	
Child's Medicaid Number in Record **5.1** The child's CT Medicaid Number is obtained and entered in the case record on the face sheet			
Standard 6	Yes	No	
Child's Admission Date in Record **6.1** The child's date of admission into the program is entered in the case record on the face sheet			
Standard 7	Yes	No	
Child's Discharge Date in Record **7.1** The child's date of discharge from the program is entered in the case record on the face sheet once the child has been discharged.			
ITEM CATEGORY: AUTHORIZATION & EVALUATION DOCUMENTATION			
Standard 8	Yes	No	
Child's Reason for Placement in Record **8.1** The reason for the placement of the child is entered in the case record on the face sheet.			
8.2 The reason for placement must note the focal problem including the pre-placement condition(s) (For Example: psychiatric, behavioral, medical, etc. conditions) and circumstance(s) (For Example: family, social, etc. circumstances) specific to this child that necessitated the current placement.			

End of Part 2

Contact any consultant for technical assistance or questions.
All materials are available online:
https://portal.ct.gov/DCF/PNMI/Home