Residential Rehabilitation

Connecticut Mental Health Group Homes

November 5, 2004

Transition Timeline Issues***

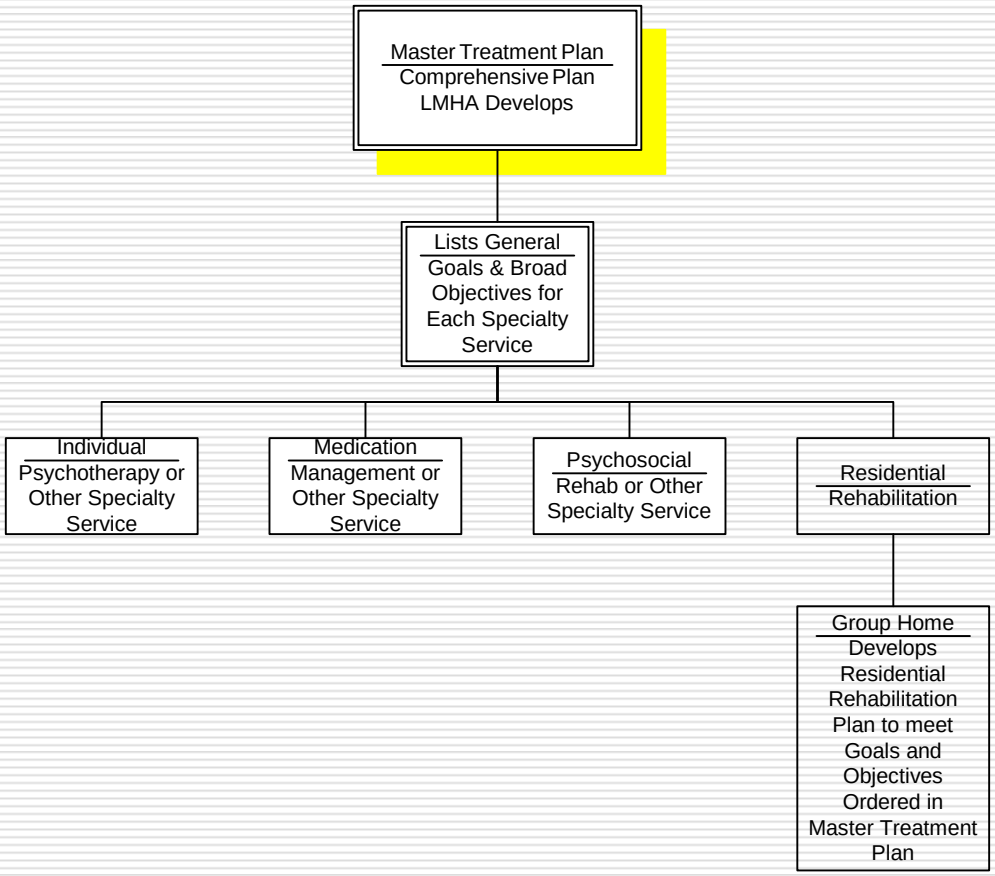
- If LMHA Assessment & Master Treatment Plan are completed by January 1, Group Home has 30 days to develop Residential Rehabilitation Plan.
- For new admissions coming directly from hospital, LMHA can conduct assessment & Master treatment planning after client is in group home and not jeopardize group home billing. Tight timelines.

Day Two Overview

- Residential Rehabilitation Plan
  - The Regs
  - The Plan: Goals, Objectives, Interventions
- Planning Operations
- Documentation
  - The Regs
  - Case Record
    - Residential Rehab Information
    - Other Information
  - Residential Rehabilitation Notes
    - Encounter Notes
    - Progress Notes

Residential Rehabilitation Plan

Relationship of Master Treatment Plan to Residential Rehabilitation Plan



The Regs: First 30 Days

- For up to 30 days of a PNMI client's initial stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with an initial assessment of need that is completed and signed by a licensed clinical staff person. This assessment shall, for up to 30 days of a PNMI client's initial stay, be deemed to meet the PNMI requirements for an individual residential rehabilitation plan

The Regs: Residential Rehabilitation Plan

- Develop an individual residential rehabilitation plan for each PNMI client . . . . not later than thirty days after the PNMI client's admission to the program. Such plan shall contain specific behavioral health goals and objectives that are based on each client's mental health diagnosis and diagnostic and functional evaluation and are targeted towards the maximum reduction of a client's behavioral health symptoms, restoration of functioning, and recovery, and shall identify the type, amount, frequency and duration of services to be provided.

The Regs: Residential Rehabilitation Plan

- A licensed clinical staff member employed by or under contract with the performing provider reviews and signs the individual residential rehabilitation plan. The first review and signature shall occur within thirty days of admission; each subsequent review shall take place at least every 90 days.

The Regs: Who is a MH Group Home Licensed Clinician?

- Doctor of Medicine or Osteopathy
- Psychologist
- Marriage & Family Therapist
- Clinical Social Worker
- Advanced Practice Registered Nurse
- Registered Nurse + 1 year MH experience
- Professional Counselor

The Regs: Residential Rehabilitation Plan

- After the first 30 days of a client's stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with a written individual residential rehabilitation plan developed in accordance with section 17b-262-749(e) of the Regulations of Connecticut State Agencies. This plan shall be reviewed and signed by the licensed, clinical staff employed by or under contract with the performing provider at least every 90-days thereafter.

Residential Rehabilitation Plan

- Builds on the Goals and Major Objectives outlined in the Master Treatment Plan
- Must tie back to the diagnostic assessment completed by the LMHA
- Only outlines the services the group home will provide
- Reviewed concurrently with Master Treatment Plan – must follow, not lead

Rehabilitation Planning

- Focus is on behavioral improvement and skills development *of the Client*
  - Tangible evidence of the effect of your work
  - The behaviors to be tackled need to be identified and prioritized
  - As behaviors are eliminated or reduced, new ones are added to the list and addressed

Rehabilitation Planning: The Major Parts

- Goals –The endpoints **for the client** not for the group home
  - Broad statements of desired behavioral change
  - Should relate to an identified problem or issue raised in the assessment and goal identified in the Master Treatment Plan
  - Examples:
    - Obtain employment
    - Live independently
    - Complete school
    - Stay sober
    - Keep children at home
- Discharge criteria for current level of care

Objectives

- Statements of observable, desirable, and whenever possible, measurable behavioral changes that demonstrate the elimination of or a significant reduction in an identified problem
- Directly relate to both the problems and the goals
  - Should be able to understand problem by reading objectives

Objectives

- Restoration to a functional state
- Should be simple to understand
- Should not describe process
  - Process: “Discuss reasons for acting out behavior”
  - Objective: “Decrease violent behavior. Stop fighting. Follow rules.”
- Focus on what can be accomplished in next 90-days

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

Interventions

- Strategies, methods, steps
- What kinds are most effective for this client and his/her problems?
- What kinds most effective for this client's belief system, cultural norms?
- What kind of intensity can the client tolerate?

Interventions

- What kind of intensity is needed to produce change?
- What MH service is best to implement the strategies outlined?
- Who will be responsible for overall care?
- Modality/frequency/duration

Rehabilitation Plan Reviews

- Based on intensity of service
- Review of progress towards objectives and goals
  - If lack of progress
    - Were services delivered as planned?
    - Were time frames unrealistic?
    - Did new issues surface that created barriers to progress?
    - Were problems prioritized correctly?
    - Was the treatment plan taken seriously?
    - Was it so vague that progress cannot be measured?

Treatment & Rehabilitation Planning Resources

- Curriculums and treatment planning guides – be careful with both not to adapt a cookie cutter approach
  - Software
  - Books

Residential Rehabilitation Planning Operations

- Who is the Team?
  - Client
  - Primary GH Worker
  - Group Home Licensed Clinical Staff
  - Other: Family, Friends, Other providers, LMHA staff, etc.
- What is the Purpose?
  - Develop reasonable 90-day objectives
  - Determine effective intervention strategies to assist client in achieving those objectives

Residential Rehabilitation Planning Operations

- What are the resources?
  - LMHA Assessment
  - Master Treatment Plan
  - Functional Assessments
  - Client Input
  - Family Input
  - History of Success and Strengths

Residential Rehabilitation Planning Operations

- Start from the LMHA Master Treatment Plan Goals and Major Objectives that are directly connected to the Diagnostic Assessment
- When building 90-day objectives for the Residential Rehabilitation plan, make sure that they are tied to the diagnosis, the assessment and the master treatment plan: Ask, “Does the client need to achieve this as a direct result of his/her psychiatric illness?”

Residential Rehabilitation Planning Operations

- Involve the licensed clinical staff earlier, rather than later.
  - They bring a critical medical necessity lens to the planning process.
- There may be other objectives on the plan that do not meet the medical necessity criteria for residential rehabilitation. Working on those is okay – they just do not count as Residential Rehabilitation services.

Residential Rehabilitation Plan Transition Issues**

- Begin now revising existing service plans to incorporate more rehab language
- If all GH plans begin January, update 1/3 of the plans within a month, and another 1/3 within 2 months, to stagger future updates.

Residential Rehabilitation Documentation

Documentation: The Regs

- The initial residential rehabilitation plan and all updated versions including the current one shall be maintained.
- A case record . . . . is maintained and includes, at a minimum: identifying information; social and health history; the reason for admission to the PNMI program; the individual treatment plan; identification of the care and services provided; a current list of all medications; and the plan for discharge and disposition of the PNMI client.
- All documentation shall be physically placed into the eligible PNMI client's case record in a complete, prompt and accurate manner. All documents shall be made available to authorized Department personnel upon request.

Documentation: The Regs

- Treatment notes must be maintained for each rehabilitative service provided. The notes must include the service rendered, actual time the service was rendered, , location of service, the goal and objective that is the focus of the intervention, a general description of the content of the intervention to provide evidence that it is a rehabilitative service as described in **Section 17b-262-752 Covered Services** above, and the client's response to the intervention. Shift notes are not a substitute for treatment notes.

Documentation: The Regs

- At least monthly a progress note must be completed and co-signed by the licensed professional that describes the services the client has received over the past month, the client's overall response, and the client's specific progress toward their goals and objectives listed on the residential rehabilitation plan. The note should discuss any variance between the numbers and types of services listed on the residential rehabilitation plan and the numbers and types of services actually delivered. The note should also discuss any suggestions for changes to the treatment plan.

Documentation: Two Kinds of Rehabilitation Notes

- Encounter (Treatment) Notes
  - Real-time notes of interventions related to the Residential Rehabilitation Plan
  - May be completed by the person who performs the intervention
- Monthly Progress Notes
  - Summary of progress toward Residential Rehabilitation Plan Goals and Objectives
  - Completed and signed by Group Home Licensed Clinical Staff, in conjunction with other staff
  - Serves as documentation of progress and of supervision.

Other Things in Case Record

- If shift or other notes required for licensing by DPH, include them in case record, but in a separate section. They do not count toward the residential rehabilitation service hours.
- TCM Notes must be clearly distinguished. Strategies:
  - Different colored note paper
  - Different section
  - Different check off at top of page

Encounter Notes

- Minimum requirements
  - ✓ Date
  - ✓ Actual Time (Length)
  - ✓ Location
  - ✓ Individuals present
  - ✓ Goal/objective addressed
  - ✓ Type of service
  - ✓ General description of what was done
  - ✓ Client's response
  - ✓ Signature & Credential of providing person

Encounter Notes

- Rounding convention for tracking time
- If able to review and write with consumer, then documentation time counts as residential rehabilitation service
- If group interaction, an individualized note must be in each person's chart.
- Separate forms, rather than continuous record, may make encounter notes easier throughout day.

Encounter Note Example

Objective: Maintain own clothing by washing, drying, folding and putting away without prompting.

Date: September 5, 2004

Start Time: 9:45 am End Time: 10:12 am

Location: Group Home

Intervention: LG demonstrated folding of towels after removal from dryer. Client practiced folding. Client was able to maintain focus long enough to remove towels from dryer, fold them, and hang them on his towel bar successfully.

Signed: LG, Group Home worker.

Progress Notes

- Once per month **and** as needed
- Reflect the treatment plan including consumer reaction and choice
- Summarize interventions and response; Outline progress (if any) toward goals and objectives
- Recommend modifications to residential rehabilitation plan (or master treatment plan) as necessary
- Developed and signed by MH Group Home Licensed clinician;
- Excellent opportunity to reinforce progress and review goals and objectives with client.
- If significant issues are occurring that aren't on the plan – revise the plan!
- Face-to-face review time with client is counted as residential rehabilitation service.

Clinical Documentation: Overview

- Identifies:
  - Client's condition in behavioral terms that supports treatment
  - Presenting problem or need
  - Services provided to modify or eliminate problem behaviors
  - Condition at discharge
  - Problems to be referred or deferred
  - Justification of the outlay of resources

Clinical Documentation: Compliance Issues

- Should not be duplicative – watch this in your Master and Residential Rehabilitation Plan planning.
- Can be completed at least partially by the client or family – depression scales, health information, etc
- Non-judgmental – how do the behaviors create difficulty for the consumer
- Should foster communication – timely completion critical
  - legibility
- Should be written in language everyone understands – including the consumer
- Should contain only information you would want consumer and possibly their family/guardian to see

Documenting Medical Necessity: Federal Guidance

- Client must be active and voluntary participant
  - Documentation must be clear about client's participation in treatment
    - Besides being present- what else?
      - Did they show up?
      - Were they active?
      - Did they engage?
    - Signing treatment plans, progress notes

Documenting Medical Necessity: Federal Guidance

- Sufficient cognitive ability to benefit
  - Watch for:
    - Dementia – all kinds – fight if you think it is appropriate at early stages of disease
    - Mental retardation – except for mild and sometimes moderate
    - Autism
    - Other clients who cannot benefit – e.g. intoxicated

Documenting Medical Necessity: Federal Guidance

- Services should be delivered at an appropriate intensity and as ordered in a treatment plan
  - Be concerned with too little and too much – note requirement is for a minimum of 40 hours per month
  - Frequent non-compliance
    - If they have been able to stay stable without you why do they need you now? Shoot for optimal functioning.
    - Be also concerned with non-compliance with appropriate levels of care – good documentation to describe attempts to move clients

Documenting Medical Necessity: Federal Guidance

- Services should be in the least restrictive setting that is available and safe
  - Entire service array must be considered at the LMHA level. At the residential level consider the full array of rehabilitative services – not everyone needs 1 year of ADLs
  - Discharge notes – supply the end product in determination of cost-effective