Group Home Rehabilitation Services, under the Medicaid Rehabilitation Option (MRO)

What you always wanted to know about providing and documenting rehabilitation services provided at MRO Group Homes

DMHAS/DSS MRO Group Home Forum 9-26-13

DMHAS funded MRO Group Homes:

- Region I
  - Iranistan House, RNP (8)
  - Pathways GH (8)
  - St. John GH, Keystone (8)
  - Elmcrest GH, Keystone (12)
- Region II
  - Harbor House, BHCare (8)
  - New Haven Halfway House, Continuum of Care (13)
  - Dwight House, The Connection (8)
  - Gilead I, Gilead Comm. Svs. (9)
  - Gilead II, Gilead Comm. Svs. (8)
  - SCAP, Gilead Comm, Svs. (6)
- Region III
  - United Services (14)
- Region IV
  - CHD (8)
  - Northfield, Community Health Resources (8)
  - Harvest House, CMHA (8)
  - Robinson House, MHA (8)
- Region V
  - CASA De Rosa, St. Vincent DePaul (8)
  - Rogers House, CNV Help (6)
  - Wynnewood, CNV Help (6)

Three documents that provide the framework for DMHAS funded MRO Group Homes

- The State Plan Amendment, between the State Department of Social Services and Federal CMS
  (www.ct.gov/dmhas)
- DSS regulations (17b-262-758 to 17b-262-769)
  (www.ctdssmap.com)
- The Level of Care Guidelines which outlines the target population and the service expectations
  (www.ctbhp.com)

(Source: Paul Piccione, PhD, DSS)

Criteria for Admission

- Individual's skill deficits in the areas of self-care, illness management, and independent living as a result of their psychiatric disability result in the need for a non-hospital, 24/7 supervised community-based residence with on-site, non-medical, staffing twenty-four hours a day, seven days a week

- Client is able to **participate** in and benefit from rehabilitation services,

continued…

Criteria for Admission (continued)

- Primary diagnosis of a psychiatric disorder and functional impairment not solely a result of pervasive developmental disorder or Mental Retardation,

- Chronic, >6 months, presentation of a psychiatric disorder and

  - a **risk** of danger to self or others, and/or is gravely disabled, or

continued…

Criteria for Admission (continued)

- **Severe impairment of activities of daily living** as evidenced by symptoms such as severe neglect of personal hygiene, inability to attend to medical conditions, malnutrition or compromised nutrition/eating patterns, inability to maintain a habitable living environment, inappropriate social interaction or poor judgment; or
- **Severe reality impairment** such as command or threatening hallucinations or response to delusions, excess preoccupations or inability to sort out fantasy from reality, which could result in harm/risk to self or others; or

continued…

Criteria for Admission (continued)

- **Serious cognitive impairment** such as orientation to person, place and time, delirium, dissociative events, or
- **Inability to call for help independently**, or
- **Lack of awareness** of medication compliance needs.

(Source: Level of Care Guidelines)

Master Treatment Plan (MTP) (Ordering of Service)

- The MTP is a comprehensive plan of care not limited to MRO services. It can also address medication needs, therapy needs, psychosocial needs, special services, etc.

- The MTP, as an order for service, must identify that the individual has <u>significant skill deficits</u> that require the client to receive care in a 24-hour residential facility. Just listing a deficit, e.g. “housing,” is **not** sufficient to justify medical necessity.

Master Treatment Plan (continued)

- The MTP (order) must detail that the client requires 40 hours of rehabilitation services per month in a licensed (MRO) group home to address skill deficits such as medication compliance, interpersonal skill deficits, or activities of daily living in order to enable the client to live independently or in a less restrictive setting.

- The MTP (order) must be individualized, and identify the deficits to be addressed by the group home.

The MTP should address

- **Problem**: John cannot safely live alone, due to his inability to plan and prepare nutritious meals, maintain and clean his living environment, or manage his income.
- **Goal**: "I want to live in my own apartment"
- **Objective**: John will learn the skills he will need to live in his own apartment, e.g. shopping, cooking, cleaning, budgeting.
- **Intervention**: John will attend 40 hours of skill building rehab. sessions each month while residing in a supervised residential group home.

The MTP must be

- …..signed by a licensed practitioner of the healing arts (LPHA)
  - (MD, Psychologist, APRN, LCSW)
- …..reviewed quarterly by the signing authority in order to document the need for continued services.

Licensed Practitioners of the Healing Arts- LPHA

- Doctor of medicine or osteopathy
- Advance Practice Registered Nurse, APRN
- Clinical Social Worker, LCSW
- Psychologist, Lic.

Only LPHA can "order" MRO Group Home Level of care, attest to medical necessity, and sign the Master Treatment Plan

MTP Quarterly Reviews/Updates

- Provide a continued order for group home level of care and 40 hours of rehabilitation services
- Must relate to the client's progress/change, i.e., it should not continue to list a deficit area if the client has achieved the level of skill/knowledge necessary for independent living
- Do goals or major objectives need to be modified?

MTP Qtrly Reviews/Updates continued

- In order to maintain medical necessity, a client must be able to benefit from the residential rehabilitation received in the group home.

- Benefits are usually measured through a client's progress toward the goals and objectives specified on the Master Treatment Plan and the Residential Rehabilitation Plan.

- Progress toward those goals and objectives can be in small increments.

The MTP leads to the Residential Rehabilitation Plan

- The Master Treatment Plan (MTP) is written by the client's clinical provider and **"orders" the services and residential level of care**. It is signed by an LPHA and reviewed quarterly.
- The Residential Rehab Plan (RRP) outlines the services to be delivered **at the group home** to address the issues raised in the MTP.

Residential Rehabilitation Plan (RRP)

- The RRP is generated at the group home and is:
  - signed by a licensed clinician
  - informed by the MTP
  - documents goals, objectives, and interventions that address the deficits outlined in the MTP or in a functional assessment.

Licensed Clinicians

- Doctor of Medicine or Osteopathy
- Psychologist, Lic.
- Advanced Practice Registered Nurse, APRN
- Clinical Social Worker, LCSW

Additional licensed clinicians who are not LPHA:

- Marriage and Family Therapist, LMFT
- Registered Nurse, RN
- Professional Counselor, LPC

(source: DSS regulation 17b-262-759)

Residential Rehab. Plan (continued)

- The RRP must be developed collaboratively with the client.
- The RRP includes goals documented in the client's own words.
- The objectives should be behavioral, achievable, measurable, and time framed. Hint: You should be able to understand problem by reading objectives.

Residential Rehab. Plan (continued)

- The interventions should describe the activities that will be undertaken by staff to teach, model, coach, or otherwise help the client achieve goals.
- The interventions should include the format, (group, individual session), frequency, and intensity
- The RRP must be reviewed quarterly.

Covered Services

- Intake and assessment
- Development of Residential Rehab. Plan
- Development of Socialization Skill
- Behavioral Management training
- Supportive counseling directed at solving daily problems
- Psycho-education groups
- Teaching, coaching, and assisting with daily living and self-care skills
- Support with connecting individuals to natural community supports
- Orientation to and accessing self help resources

Covered Services (continued)

- Developing self-advocacy skills
- Health education
- Teaching recovery skills to prevent relapse
- Individual, family and group counseling
- Assistance in developing skills necessary to support a full and independent life in the community
- Other rehabilitative support necessary to develop or maintain social relationship to achieve full community reintegration

(Source: DSS regulation 17b-262-763)

Sample Resid. Rehab. Plan #1

- Problem: John cannot identify basic foods that are nutritious and affordable
- Goal: "I want to plan my own meals"
- Objective: John will learn to develop a menu and shop for specific nutritious foods for breakfast and lunch.
- Intervention: Attend the Identifying Nutritious Foods group on Tuesday and Thursday. (10 to 11 am)
- Intervention: Attend meal planning group each week. (6-7PM)
- Intervention: Attend shopping group on Friday (2 pm – 4 pm)

Sample #1 (continued)

- The RRP must address John's skill deficits identified in his MTP and identify objectives and interventions in steps corresponding to John's ability to understand.
- The example on the previous slide is a plan for John to identify, plan and shop for nutritious foods for two meals a day, breakfast and lunch.
- The interventions listed will result in John receiving 5 hours each week of education to address one objective of John's goal toward planning meals and living independently.

Sample #1 (continued)

- This objective will be reviewed within the next quarter and either continued or ended. If ended, the next step, i.e. “planning and shopping for dinner” or “cooking breakfast foods” may be written into his rehab plan.
- This example only details one of John’s goals. The RRP may include other goals, i.e. doing laundry or developing a food budget.
- *It is important to note that persons with difficulties that require MRO group home support, may not be able to learn more than 2-3 skills simultaneously over a given period of time.*

Sample Resid. Rehab. Plan #2

- Problem: Carmen manages increased symptoms of her anxiety disorder by calling 9-1-1- at least twice/wk
- Goal: “I want to stay out of trouble with the police.”
- Objective: Carmen will not call 9-1-1 when anxious
- Intervention: Carmen will attend Coping Skills group (30 min) twice/wk

continued…

Sample #2 (continued)

- Intervention: Carmen will keep a journal of her feelings before wanting to call 9-1-1 and review for 15 minutes weekly with Joe Staff to identify coping skills she used or could have used to avoid calling
- Intervention: Joe Staff will demonstrate and practice one coping skill with Carmen for 15 minutes, 2x/wk

The interventions will result in Carmen receiving 1 hour and 45 minutes a week of skill-building.

Sample Rehab. Plan #3

- Problem: John is self-conscious about his dental hygiene, which keeps him from making friends. He has significant dental deterioration.
- Goal: “I want to take care of my teeth.”
- Objective: John will learn how to brush and floss his teeth daily.
- Intervention: Staff will review a dental hygiene instructional film with John and teach the importance of daily brushing and flossing. (1 session, 30 minutes)
- Intervention: Staff will teach John how to brush and floss his teeth and help him develop a self-monitoring checklist. (4 sessions, 15 minutes each)

Encounter Notes

- Encounter notes are required for each rehabilitation intervention
- Each intervention must be at least 15 minutes in duration to ‘count’ toward the monthly 40 hour requirement.

Encounter Notes Must Include

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

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: Ann Staff demonstrated folding of towels after removal from dryer. Client practiced folding.

Client Response: Client was able to maintain focus long enough to remove towels from dryer, fold them, and hang them on his towel bar successfully.

Signed: Ann Staff, Group Home worker

Monthly Progress Notes

- Once per month **and** as needed
- Developed and signed by MH Group Home Licensed clinician or Group Home Director
- Excellent opportunity to reinforce progress and review goals and objectives with client

Monthly Progress Notes (continued)

- Summarize interventions and response; outline progress (or lack of) toward goals and objectives
- Recommend modifications to residential rehabilitation plan (or master treatment plan) as necessary
- If significant issues are occurring that aren't on the plan –revise the plan

Skill Building Pattern

- SAY: Explain/describe
- SHOW: Demonstrate
- PRACTICE
- SHOW AGAIN (Return Demonstration)
- FEEDBACK and Correction
- PRACTICE Again
- INTEGRATE – Practice in progressively "more real" environments

Use of Skill-Building Curricula

- Provide structure/organization for skill development
- Skills are broken down into smaller steps that build towards mastery of targeted skill
- Allow for repetition/reinforcement in group or individual interventions
- Usually include: discussion points, homework, sample handouts, role-play and other exercises

Training and Supervising staff

- Persons employed in MRO group homes may be persons with lived experience (peers).
- They must have BA/S in human services field or a minimum of 2 years of experience working with persons who have a mental illness or behaviors that interfere with their daily functions.

Training and Supervising Staff (continued)

- All new hires should receive a comprehensive orientation that minimally details the requirement of the MRO, writing goals, objectives, and interventions, documenting interventions, monitoring and documenting progress, teaching and using curriculum.
- Direct Service staff should be offered continued training each year that address the rehabilitation process, clinical concerns and ramifications, stages of change, behavioral management.
- All staff must maintain certification in CPR and first aid.

Clinical Supervision

- All direct service staff must receive at least monthly supervision from a licensed clinician.
- All clinical supervision must be documented, and include the signature of the supervisor.

Clinical Supervision

- Clinical supervision includes:
  - one on one education and training regarding persons with mental illness;
  - support and guidance with interactions and relationships with particular clients;
  - boundaries;
  - understanding transference and other clinical topics;
  - ongoing training needs;
  - review of treatment planning and documentation.

Clinical Supervision

- Is not “administrative”
- Differs from “case management” or utilization review
- Does not consist of review of admissions, discharges, client appointments, etc.

Conclusion

- The group home level of care is not simply several similar people living together in a safe and caring residence.
- The persons referred to a group home LOC require and will benefit from rehabilitation to enable them to live independently in a less intensive setting of their choosing.
- The residents are similar in that they have a psychiatric diagnosis, but very different in personality, skills, knowledge, values, and backgrounds.
- They are not referred to a group home to languish but to be challenged and gain confidence through skill development and supported risks.

Other important stuff not previously mentioned

- The provider shall maintain all required records for at least five years or longer as required by statutes or regulation.

(*source: MRO Provider Manual and DSS Provider Enrollment agreement*)

Resources

DMHAS Website: http://www.ct.gov/dmhas

(Major Initiatives/Evidence Based and Best Practice Initiative/Group Homes) includes:

- Training Handouts such as:
  - This presentation: PowerPoint Presentation 9-26-13Rev 6-19-15
  - 11/4/04: Overview, LMHA Role, MTP
  - 11/5/04: RRP, Documentation (including medical necessity)
  - 12/2/04: Residential Rehab Interventions
- Sample Forms
- Resource/Curricula List and Sample Interventions