Person Centered Recovery Plans and Medical Necessity

Neal Adams MD MPH

October 1, 2010
BEAT THE CLOCK
Serving Two Masters

Understanding

**Person-centered**
- Recovery
- Community integration
- Core gifts
- Partnering
- Supports self-direction

**Regulation**
- Medical necessity
- Diagnosis
- Documentation
- Compliance
- Billing codes

Outcomes and Goals
The Road to Recovery...

- Person-centered planning
  - a collaborative process resulting in a recovery oriented treatment plan
  - directed by consumers and produced in partnership with care providers for treatment and recovery
  - supports consumer preferences and a recovery orientation
  - a strategy for documenting medical necessity

Adams/Grieder
Service Plan Functions

• Specifies intended outcomes / transitions / discharge criteria
  ▪ Clearly elaborates expected results of services
    o includes perspective of person served and family in the context of the person’s culture
  ▪ Promotes consideration and inclusion of alternatives and natural supports / community resources

• Establishes role of person served and family in their own recovery / rehabilitation
  ▪ Assures that services are person-centered
  ▪ Enhances collaboration between person served and providers
Service Plan Functions continued

• Identifies responsibilities of team members--including person served and family
  ▪ Increases coordination and collaboration
  ▪ Decreases fragmentation and duplication
  ▪ Coordinates multidisciplinary interventions
  ▪ Prompts analysis of available time and resources

• Provides assurance / documentation of medical necessity
  ▪ Anticipates frequency, intensity, duration of services

• Promotes culturally competent services
Service Plan Functions continued

- Supports utilization management
  - Services authorization, communication with payers and payment for services
  - Allocation of limited resource
- A contract with the people we serve!
of medical necessity throughout your documentation
“Apparently, Smith’s desk just couldn’t withstand the weight of the paperwork we piled on his desk.”
What Gets Looked at in an Audit

• Admission note

• Mental health/rehab assessment/re-assessment
  ▪ include a formulation, synthesis or understanding

• Individual treatment plan
  ▪ documenting changes over time

• Notes and other documentation directly relating to the selected service
  ▪ documentation of the date of service and the location of service delivery

• Professional and educational credentials for staff to support scope of practice
MEDICAL NECESSITY
IN PRIVATE HEALTH PLANS
Implications for Behavioral Health Care

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov
History of Medical Necessity

• Following WWII in early years of American health insurance era, insurers paid for whatever health services a physician recommended

• As health care costs rose, utilization review was introduced
  - verify coverage
  - independently assess treatment recommendations
  - made retrospectively

• Retrospective review proved to be ineffective
  - shift to concurrent and prospective review
Clear as Mud

• There is no Federal definition of medical necessity
• Only slightly more than one-third of States have any regulatory definition of medical necessity
• Meaning of “medical necessity” is most commonly found in individual insurance contracts
  • defined by the insurer
  • holds primacy in most determinations
Elements of Medical Necessity

- *Doing the right thing, at the right time, for the right reason*
- Standard of service and quality
- Five elements
  - Indicated
  - Appropriate
  - Efficacious
  - Effective
  - Efficient
5 Dimensions

① Contractual scope
  • whether the contract provides any coverage for certain procedures and treatments
  • such as preventive and maintenance treatments that are not necessary to restore a patient to “normal functioning”
  • this dimension preempts any other coverage decision

② Standards of practice
  • whether the treatment accords with professional standards of practice
5 Dimensions

③ Patient safety and setting
  • whether the treatment will be delivered in the safest and least intrusive manner

④ Medical service
  • whether the treatment is considered medical as opposed to social or nonmedical

⑤ Cost
  • whether the treatment is considered cost-effective by the insurer
New York

- N. Y. Soc. Serv. Law, § 365-a “medically necessary dental, and remedial care, services, and supplies” in the Medicaid program
  - necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap
  - furnished an eligible person in accordance with state law
UBH Definition I

- Health care services and supplies that are determined by the Plan to be medically appropriate, and
  ① necessary to meet the basic health needs of the covered person
  ② rendered in the type of setting appropriate for the delivery of the health service
  ③ consistent in type, frequency, and duration of treatment with United Behavioral Health guidelines
UBH Definition-II

- Health care services and supplies that are determined by the Plan to be medically appropriate, and
  - consistent with the diagnosis of the condition;
  - required for reasons other than the comfort or convenience of the covered person or his or her physician;
  - of demonstrated medical value.
Medical necessity starts with a practitioner evaluating a client or patient and authorizing or rendering services that fall within the scope of their license.

Medically necessary services are those that prevent the client from getting worse (either deteriorating or prolonging the illness) or developing new problems.
Ohio Definition

• The definition also asserts the role of medically necessary services in dealing not just with the symptoms or signs of an illness but the impact of the illness on the ability of the individual to function.

• This speaks directly to rehabilitation services, which are primarily focused on maintaining or raising the functional level of the client.
Habilitation

The focus of treatment for persons with Developmental Disability service needs that provides Daily Living Activities, Behavioral Management and Symptom reduction (i.e., cannot take the client out of the house) to provide improved functionality in their environment to the highest level achievable per client.
Rehabilitation

The focus of treatment for persons with MH/SA needs that provides Daily Living Activities, Behavioral Management and Symptom Reduction (i.e., number and intensity of psychotic episodes) to restore the client’s individual level of functionality to the level he/she had prior to the onset of the illness.
WHAT TO DO
WHEN YOU DON’T KNOW
WHAT TO DO

KONG HEE
A Plan is a Road Map

- Provides hope by breaking a seemingly overwhelming journey into manageable steps for both the provider and the person served

“life is a journey…not a destination”
Elements of a Recovery Plan

• The person’s **goal**: what is the desired outcome of services?
• **Discharge/transition criteria**—establishing and end point
• How to overcome **barriers**?
• **Objectives** – what are the steps to reduce barriers and attain the goal?
• **Proposed type(s) of interventions** – who is going to do what to get there?
  ▪ proposed duration—when will things be accomplished?
  ▪ Purpose—what’s to be accomplished relative to the objective?
Building a Plan

- Request for services
- Assessment
- Understanding
- Prioritization
- Strengths/Barriers
- Goals
- Objectives
- Services
- Outcomes
Definition of a Goal

- Goals express the hopes and dreams of the client.
- Goals identify the hoped-for destination to be arrived at through the services provided.
The Essential Features of Goals

• They are BIG
  ▪ Long term, global, and broadly stated
  ▪ They are not necessarily measurable

• Written in positive terms
  ▪ built upon abilities / strengths, preferences and needs
  ▪ embody hope/alternative to current circumstances
Key Points about Goals

• A good goal inspires the individual to reconnect to their dreams.

• Goal development is an essential part of engagement and creating a collaborative working relationship.
Collaboration and Goals

• Reaching agreement on the goal is essential
  ▪ The provider understands and appreciates the importance of the goal.
  ▪ The goal has immediate meaning and relevance for the consumer.
  ▪ The goal becomes a shared vision of success.
The Right Balance

- Let client do what he/she wants
- Get client to do what I want

Recovery Zone

Neglect  Control
Importance of Understanding

• Data collected in assessment is by itself *not sufficient* for service planning

• Formulation / understanding is essential
  ▪ Requires clinical skill and experience
  ▪ Moves from what to why
  ▪ Sets the stage for prioritizing needs and goals
  ▪ The role of culture and ethnicity is critical to true appreciation of the person served

• Recorded in a chart narrative
  ▪ *Shared with person served*
Interpretive Summary Bridge

• Informative findings based on assessment data and the subsequent recommendations
• Perception of the individual on his/her SNAP (strengths, needs, abilities and preferences)
• Perception of the provider on individual’s SNARF (strengths, needs, abilities, risk and functional status)
• Provider insight into contribution and impact of individual’s psychodynamic, cognitive, familial, environmental and personality traits on current status, service goals and treatment outcomes
Interpretive Summary, cont.

- Provider & individual’s understanding of how illness/condition impacts function
- Provider and individual’s speculation and understanding of previous treatment outcomes
- Groundwork for recovery vision and future goals
- Prioritization of needs for service planning
- Individual’s readiness and motivation for change
Interpretive Summary Bridge

- Informative findings based on assessment data and the subsequent recommendations
- Perception of the individual on his/her SNAP (strengths, needs, abilities and preferences)
- Perception of the provider on individual’s SNARF (strengths, needs, abilities, risk and functional status)
- Provider insight into contribution and impact of individual’s psychodynamic, cognitive, familial, environmental and personality traits on current status, service goals and treatment outcomes
## Stages of Recovery and Treatment

<table>
<thead>
<tr>
<th>Ohio</th>
<th>Village</th>
<th>Prochaska &amp; DiClemente</th>
<th>Stage of Treatment</th>
<th>Treatment Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent unaware</td>
<td>High risk/Unidentified or Unengaged</td>
<td>Pre-contemplation</td>
<td>Engagement</td>
<td>• outreach&lt;br&gt;• practical help&lt;br&gt;• crisis intervention&lt;br&gt;• relationship building</td>
</tr>
<tr>
<td>Dependent aware</td>
<td>Poorly coping/Engaged/not self-directed</td>
<td>Contemplation/preparation</td>
<td>Persuasion</td>
<td>• psycho-education&lt;br&gt;• set goals&lt;br&gt;• build awareness</td>
</tr>
<tr>
<td>Independent aware</td>
<td>Coping/Self responsible</td>
<td>Action</td>
<td>Active Treatment</td>
<td>• counseling&lt;br&gt;• skills training&lt;br&gt;• self-help groups</td>
</tr>
<tr>
<td>Inter-dependent aware</td>
<td>Graduated or Discharged</td>
<td>Maintenance</td>
<td>Relapse Prevention</td>
<td>• prevention plan&lt;br&gt;• skills training&lt;br&gt;• expand recovery</td>
</tr>
</tbody>
</table>
Recovery Happens In Small Steps

• To be an effective road-map, plans need to clearly identify the smaller steps that get you to your destination.
• These markers along the way also offer opportunity to celebrate and acknowledge progress.
• Every gain made is additional fuel for the journey!
Barriers

• What is getting in the way of the person achieving their goal
  ▪ Why can’t they do it tomorrow
  ▪ Why can’t they do it themselves

• Our focus is removing/reducing/resolving barriers that are a result of the mental illness
Defining Objectives

• Objectives describe a significant and meaningful change that the individual can see or experience.
• Objectives are milestones – they designate the mini-goals along the way.
• Well-written objectives create opportunity for success, for seeing that the dream is really possible.
What Do Objectives Do?

• Take into account the culture of person served
• Divide larger goals into manageable tasks
• Provide time frames for assessing progress
• These are the action steps the person takes toward their goal
Objectives and Medical Necessity

- Objectives address barriers to the goal.
- They also describe changes in behavior, function, or status.
  - relate back to functional impairments
    - how the work we are doing will reduce these barriers
  - identify key changes that the consumer wishes to accomplish
Objectives Should Be SMART

- Simple or Straightforward
- Measurable
- Attainable
- Realistic
- Time-framed
How to Write an Objective

• Subject
• Verb/Action Word
• What
• When will it be done/timeframe?
• How will it be measured?
• Person receiving services
• Will demonstrate
• Ability to use three coping techniques to address anger
• Within one month
• As measured by therapist observation
Objectives Are Not Interventions

- Objectives are the WHAT
  - What is the next step towards the goal?
  - What is the next significant milestone?
- Interventions are the HOW
  - How are we going to get there?
  - Interventions are the action steps taken to achieve the objective.
Five Critical Elements

• Interventions must specify
  • provider and clinical discipline
  • staff member’s name
  • **modality**
  • frequency / intensity / duration
  • **purpose / intent / impact**

• Clarifies who does what

• Include a task for the family, or other component of natural support system to accomplish
Jane

- Jane comes in to the mental health clinic for medications that help her with her depression and anxiety. In the past, she has been overwhelmed by sadness and would drink to “numb-out” and her drinking made it impossible for her to function at home or work. Feeling much better, Jane wants to get back into the workforce. She occasionally experiences relapses, but finds that she gets back on her feet more quickly now.
Jane’s Goal

• Goal: I want to work full-time.
Addressing Jane’s Barriers

• Objective 1
  ▪ Jane will be clean and sober for 30 consecutive days as measured by self-report.

• Interventions:
  ▪ Sam Smith, LCSW, will provide dual recovery groups once per week for one year to Jane so she can learn the tools to stay clean.
  ▪ CM will discuss how meetings went with Jane once per week in the community, and reinforce active participation in the group to assist her in achieving sobriety for 3 months.
  ▪ Jane will attend AA meetings 3 x per week for 3 months in order to develop a sober support system.
Addressing Jane’s Barriers

• Objective 2
  ▪ Jane will master two stress reduction skills within the next 60 days as measured by her self report of successfully resolving conflicts/problems without self-defeating behavior.

• Interventions
  ▪ Peer specialist will meet with Jane every other week in the community to practice stress reduction skills for 2 months
  ▪ CM will provide skills training on stress management one hour/once per week for 60 days.
Western New York Care Coordination Program

Set Up An Account

Click here to register and gain access to the Recovery Skill Builder. You will be able to view Kerl K as a free profile. You can also upgrade to a paid subscription in order to gain access to additional profiles starting at $3.99 per user.

To Use Recovery Skill Builder

Select one of the profiles on the right. You will be able to read the profile on the left side of the screen while you answer questions displayed on the right side of the screen. You will be given multiple answers to choose from; however, there is only one correct answer. Based on the profile and your knowledge of person-centered practices, medical necessity and stages of change, choose the best answer for each question.

Optimal learning will take place as you move back and forth to review the explanations for each answer. When you complete a profile, simply go back to the top and click on “Recovery Plans” and choose another profile to complete.

An individual plan has been compared to a road map that displays the path or direction of the journey for each individual and family. The individual plan should be a practical, understandable tool that the individual and provider can utilize together to steer the course in the journey of recovery.

- Adapted from Neal Adams, MD MPH and Diana Groder, M.Ed., co-authors of “Treatment Planning for Person Centered Care: The Road to Mental Health and Addiction Recovery” (2006)

Recovery Plans

Free Trial

Karl K

Standard Recovery Plans

David D
Janice J
Mary M
Mr. A
Mr. C
Ms. T
Oscar O
Sam H

PROS Recovery Plans
Specifically designed for providers of PROS (intensive outpatient care licensed in NYS only)

Sarah S
Harry H
Kevin K
Kathy K
Giotta T

Care Coordination Recovery Plans
Specifically designed for case managers

Sam
Mr. A
Contact Info

Recovery Skill Builder

www.carecoordination.org/recoveryplanning

Neal Adams MD MPH / Diane Grieder M.Ed.

www.personcenteredtreatmentplanning.com