ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

Clinical Practice and Guidance Review
Interpretive Guidelines
FY16

These Interpretive Guidelines summarize the Clinical Practice and Guidance (CPG) tool items.

Sampling: For CPG, reviewers will randomly pull a sample of ten Medicaid and two non-Medicaid records from those already pulled for the Post Payment Review. Reviewers will be looking at documents created within the 12 months prior to the review.

Review of progress notes - For all areas that require a review of progress notes, look at notes (including concurrent documentation written with the consumer) with substantial content over the last three months of treatment.

Concurrent documentation - This type of documentation is considered evidence of consumer-driven treatment. Note in the comments section when you see this practice occurring in an agency.

Plans of Improvements - The purpose of the POI is to document the steps you plan to take/have taken to correct all issues identified during your recent CPG review that resulted in scores below the established threshold of 4.0. Your DHS/DMH Contract Manager will review the POI for approval, notify you if any changes are needed, approve/disapprove the POI, and will monitor compliance and progress of the approved POI. You may use the POI template, which is located on the Collaborative website under the Provider Information tab, or your own preferred format if it includes all of the specified elements identified on the POI template form. In addition to submitting a POI to your assigned DHS/DMH Contract Manager, you are asked to submit a **courtesy copy** of the POI to the Collaborative. Plans of Improvement need to be submitted within thirty (30) days from the date on the DHS/ DMH Clinical Practice and Guidance Review letter that is sent within thirty (30) days of the review.

The purpose of the Medicaid CPG review is to assure adherence to clinical standards and assess quality indicators through the provider agency's clinical documentation and practices. This includes a determination of clear and consistent inter-connection among the diagnosis, assessed needs, ITP provisions, and actual services and interventions delivered.

Reason Codes: **MEDICAID RECORD REVIEW**

1. **The current Individual Treatment Plan (ITP) reflects the individual's assessed needs and has been updated per consumer's progress and changing needs.**

The Mental Health Assessment (MHA) should include the individual's assessed needs. These needs should be addressed by the goals/objectives on the Individual Treatment Plan (ITP) and the ITP should be updated when the individual's needs change.

To consider: Do the goals and services identified on the ITP actually address the individual's needs?

Treatment plans should be updated as the consumer's needs change, not only every 6 months as required by 59 IL Admin. Code pt. 132. Changing needs could include significant life circumstance changes which could result in new treatment approaches. Previous goals/objectives may be appropriate to carry over from a prior treatment plan. Documentation in the progress notes or on the treatment plan should indicate that the goal/objective is being carried over and why. Goals/objectives that are repeated should have different interventions noted (not doing the same thing over and over and expecting different results).

Note: This item applies only to one chart (not across charts) and can be assessed based on one ITP. The item can still be assessed even if there are no ITP updates.

2. **There is evidence of changes in or re-evaluation of treatment needs and/or services during periods of sudden changes in functioning or symptoms.**

If there are progress notes in the record that document crisis/relapse/instability/side-effects or other changing symptoms, is the person getting in to see staff for an evaluation? This could include a psychiatric evaluation, if appropriate. Was there any change to the services offered to address the changes? If there is evidence that consultation with outside practitioners could be beneficial, but the consumer has not consented to this contact, there is evidence of discussion of the potential benefits of such consent with the consumer.

3. Treatment is consumer driven as evidenced in clinical documentation.

There is evidence in services notes about progress (+ or -) the consumer feels he/she is making towards his/her goals. (i.e. there is evidence of input from consumer and/or persons of consumer's choosing). If the person does not believe they have a problem or do not want a certain type of treatment, this is noted in the consumer record and does not show up on the ITP (It may be noted on the MHA that the person has a treatment need to address substance abuse, person may meet criteria for alcoholism, for example. However, the person states they do not feel that they have a problem with alcohol and therefore does not want to have any type of treatment for alcoholism. A consumer driven ITP would not have goals and/or objectives related to alcoholism in this instance).

4. Treatment provided builds on the identified strengths of the consumer.

Strengths should be used in assisting the consumer towards reaching his/her goals and objectives and their use should be found within the Individual Treatment Plan, MHA and progress notes. Strengths must be substantive and applicable to help meet the identified needs. The individual may have many strengths but those identified must be ones that will be used to build skills that will address assessed needs. Example strengths include, but are not limited to: empathy, motivation for treatment, sense of humor, supportive employer, supportive friends/family, substance-free family, extended family, caring children, non-enabling peers, intact family, participation in A.A., membership in a social club in the community, etc.

5. All treatment needs as identified on the Mental Health Assessment are being addressed in the ITP <u>and</u> in the actual service <u>and</u> are prioritized based on importance/severity.

Treatment needs that are identified in the MHA should be addressed in the treatment plan and resulting services. There are some needs that may be more important than others and these should be addressed first. For example, if the homeless individual has an assessed need of moving to stable housing this need should be prioritized and addressed quickly. It is acceptable for a provider to not address a need or to provide a service identified in the ITP if there is an explanation given.

6. **There is congruence between the information in the Mental Health Assessment and the Functional Assessment/ LOCUS/Ohio/Columbia Scales.**

   Congruency should be seen between the MHA and functional assessments such as GAF/CGAS and/or LOCUS and/or Ohio scales and/or Columbia scales. In the event that there is incongruence, documentation should be found within the clinical record to explain the incongruence. If the MHA documents severe problems, the functional assessments in the record should contain similar information/scores. An incongruence would be seen if the LOCUS scored the person as needing high intensity services, such as ACT, while the MHA reflects that the person functions very well and is participating actively in his/her community.

7. **There is evidence in the clinical record that primary health care coordination is occurring with the primary physical health care provider.**

   There is documentation of more than name and contact information of primary physician. Examples of documentation include: Consent(s) for the Release of Information, notes documenting interactions and/or appointments with the primary physical health provider, exchange of lab findings/reports, and/or letters to and from the primary physical health care provider.

   Note: If the consumer refuses to consent to integration of care by signing an authorization for release of information, there should be documented evidence of discussion with the consumer of the potential benefits of coordination of care. If the consumer does not have a primary healthcare provider, there should be documented evidence of discussion with the consumer of the potential benefits of a primary healthcare provider and assistance offered in finding such a provider.

8. There is documentation that the provider is assisting the consumer with utilizing natural supports in the community.

There is evidence of notes involving significant others, family members, and/or other natural supports chosen by the consumer. Documentation demonstrates the inclusion of natural support(s) in various aspects of service provision (such as MHA, ITP development/assessment/review). There may be notes regarding skills training, counseling notes, or other interventions, which address issues that might be barriers to the development of natural supports. If the consumer has not consented to involvement of any natural supports, there is documentation of discussion with the consumer regarding the benefit of including natural supports in goal attainment.

Note: Natural supports are something in an individual's everyday life that connects them to their community, NOT something obtained from an institution. These activities could range from group-based activities to individual activities in the community, such as connecting someone to local clubs, WRAP groups, volunteering, or helping someone find self-directed leisure activities. Agency staff may use a variety of approaches to assist the consumer with utilizing natural supports. Connecting someone to natural supports does NOT include connecting someone to other mental health service providers or agency-sponsored supports, such as agency-based leisure clubs.

Reason Codes: **NON-MEDICAID RECORD REVIEW**

The purpose of the two items below is to assess two aspects of services to non-Medicaid eligible individuals. DHS/DMH reimburses a limited range of services for non-Medicaid individuals. These items do not create the expectation that providers must provide services that are not reimbursed. The intention of these items is to give feedback and to recognize best practices to share across providers.

9. There is documentation that the provider is working to connect the consumer with benefits/entitlements (such as Medicaid benefits).

There is evidence of notes documenting that provider staff is working with consumers on linking them with benefits/entitlements that they could be eligible for and need.
This could include, but is not limited to, Medicaid, Social Security, WIC, Link card, etc.

10. There is documentation that the provider is assisting the consumer with utlizing natural supports in the community.

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