# DHS/DMH Clinical Practice and Guidance Review
# Interpretive Guidelines
# FY12

This tool summarizes Clinical Practice and Guidance (CPG) items. The purpose of this 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.

**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 is an emerging practice where staff and consumers together document progress made during treatment. Include these in any review of progress notes, as this should be considered evidence of consumer-driven treatment. Note in the comments section when you see this practice occurring in an agency.

**Plans of Improvements** - Plans of Improvement (POI) will be required for any item that scores below 4.0 on the CPG Tool. Plans of Improvement are to be submitted to DHS/DMH Regional staff with a courtesy copy to the Collaborative (Illinois Mental Health Collaborative, 400 S. Ninth Street – Suite 201, Springfield, IL 62701, attn: Clinical Coordinator-Provider Relations). Providers have the option of using their own format for the POI report including all of the specified elements or using the DHS/DMH format (see appendix A). 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. DHS/DMH Regional staff may request a revised plan and will monitor progress.

**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 the Rule. 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 <u>treatment needs and/or services</u> during periods of sudden changes in functioning or symptoms.**

If notes 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. evidence of input from the consumer and/or persons of consumer's choice toward their progress of the goals). There is evidence of input from consumer and/or persons of consumer's choosing.

**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 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 and in the actual service and are prioritized based on importance/severity.**

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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 moving the individual to stable housing is an

assessed need for an individual with a history of homelessness, 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.**

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.

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