KEPRO Overview of Service Planning

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PURPOSE & OBJECTIVES

1. Review Medical Necessity Criteria
2. Provide Rationale for Service Planning
3. Review Service Planning Definition and Guidelines
4. Discuss Components and Provide Examples
5. Review of Scoring Tools

KEPRO

- KEPRO is an Administrative Service Organization contracted with three Bureaus within West Virginia Department of Health and Human Resources (DHHR):
  - Bureau for Medical Services (BMS)
  - Bureau for Children and Families (BCF)
  - Bureau for Behavioral Health (BBH)

- KEPRO, in conjunction with the Bureau for Medical Services, is conducting this webinar training for fee-for-service providers.

Medical Necessity

MEDICAL NECESSITY CRITERIA

- Medical Necessity is services that are:
  1. Appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
  2. Provided for the diagnosis or direct care of an illness;
  3. Within the standards of good practice;
  4. Not primarily for the convenience of the member or provider; and
  5. The most appropriate level of care that can safely be provided.

Overview & Purpose of Service Planning

Why develop Service Plans?

- Promote positive outcomes for the member
- Guide the member and all service providers through the course of treatment
- Measure success/failure against a standard
- Provide means for documentation
- Inform members of the team
- Cover course of care for the member
  - Not just 90-day increments

Service Plan Definition

- Conducted when multiple programs and services need to be coordinated by a treatment team.
- One comprehensive plan that includes all services-- one plan with one date.
- Developed by the primary clinician.
- Only available for Coordinated Care.
- Development of the Initial Plan without the entire team is not a billable service.
  - Case Manager cannot bill TCM during team meeting.

Definition of Coordinated Care

- A team approach for providing multiple medically necessary programs and services to members who have severe and/or chronic behavioral health conditions.
- Treatment is usually provided on a more intensive basis (i.e. several times per week, if not daily).
- The treatment team consists of personnel ranging from paraprofessionals to physicians.
- Members generally have a case manager who is responsible for coordinating and facilitating the services.
  - Not necessarily a Targeted Case Manager (TCM); but rather a Case Manager who is coordinating multiple clinical services as part of the treatment team.

Who should be at the Service Plan Meeting?

- Service planning is a team approach, and all services to be provided to the member must be represented at the team meeting:
  1. Client and/or guardian
  2. A representative of every service being provided to the member must be present
  3. Physician (or Extender) or Psychologist (or Supervised Psychologist) or Approved Licensed Professional Clinician (LPC/LICSW) must be physically present when one of the following is met:
     - Member receives psychotropic medications from physician at the agency
     - Member is diagnosed with Major Affective or Psychotic Disorder*
     - Member is diagnosed with Autism
     - Member has an I/D Diagnosis
     - Member has major medical problems in addition to behavioral health disorder and receiving medications from the agency physician
     - The presence of the physician or physician extender has been specifically requested by the case manager or the member.
  4. If Physician/Psychologist/Licensed Clinician is not required to be present, s/he must review and sign the signature page within 72 hours.

  * See Reference for Diagnosis(es) requiring Physician/Approved Licensed Professional attendance

SERVICE PLAN SIGNATURE PAGE

- The signature page of the service plan must contain:
  1. Signature of every member of the team, including the member
  2. Credentials of all staff, included with signature
  3. Date of attendance for every attendee
  4. Start/stop times of attendance for every attendee
- In the event that an individual (i.e. DHHR guardian) did not attend, indication on the signature page that the individual was not present but invited is sufficient.
- If staff participate via Telehealth, it should be noted on the signature page.
- If Supervised Psychologist attends the meeting, the Supervising Licensed Psychologist must review and sign with credentials.

SERVICE PLANNING TIMELINES

- Initial Service Plan
  - Must be developed within 7 days of admission with the entire team present
- Master Service Plan
  - Must be developed within 30 days of admission with the entire team present
    - Can be developed earlier for services that occur multiple times a week (i.e. CFT, etc.)
    - IS must be developed with 7 days of admission with the entire team present
  - Developed by “lead” clinician
  - Outlines the course of treatment within the anticipated duration of the service
    - Not just for 90-day periods
- Service Plan reviews
  - Occur every 90-days thereafter with entire team
    - Reviews that occur out of timelines (i.e. late)
    - Any service provided during period considered an “invalid” service

THE SERVICE PLAN SHOULD GUIDE QUALITY OF CARE

- The Service Plan should be commensurate to the members previously assessed need(s).
  - If previously assessed needs are not included on the Plan, (i.e., due to prioritization of members issues), the clinical record should indicate why this is the case.
- Service documentation should be tied to the Service Plan component objectives.
  - The Service Plan should drive the clinical treatment the member receives throughout their care.
- The Service Plan should be consistent with the level of care the member is receiving.
  - Each service the member is receiving should be indicated on the Service Plan with sufficient component objectives to be commensurate with the length of time in treatment.
  - The Plans goals and objectives should be reflective of medically necessary criteria and service definition for associated services.

Service Plan Components & Examples

SERVICE PLAN COMPONENTS

1. Goals
2. Objectives
3. Methods/Interventions
4. Realistic Achievement Dates
5. Discharge Criteria

- All components reflect back to member's assessed behavioral health needs and meet service definition.

What is a Goal?

- An expected result or condition that is specified in a statement of relatively broad scope and provides guidance in establishing intermediate objectives toward its attainment.
- Goals are stated positively with an anticipated outcome/end result.
- Goals are client centered (member's name in the goal).
- Goals are related to member's documented assessed need(s).

GOAL EXAMPLES

Appropriate Example:

- ✓ Mary will improve her coping skills related to her depression in order to function more adequately within her environment and community.
- ✓ Steve will learn how to live a substance free lifestyle in order to return to his natural living environment.

Inappropriate Example:

- X Client will decrease the severity of her depression.
- X Client will quit using substances to stay out of jail.

OUTCOME OBJECTIVES

- Describe how the member will be different at the completion of treatment.
- Must be stated in measurable terms.
- Serves as a means to measure how close the member is to attaining the identified goal.
- Need at least one outcome objective for each goal included on the service plan.

OUTCOME OBJECTIVE EXAMPLES

Appropriate Examples:

- ✓ Mary will have zero (0) incidents of threatening to harm herself for three consecutive months by 1-20/20.
- ✓ Steve will have zero (0) positive urine drug screens for three consecutive months by 12-15-19.

Inappropriate Examples:

- ✗ Client will identify triggers for illicit substance use (11-15-19).
- ✗ Client will recognize relapse warning signs (11-15-19).

COMPONENT OBJECTIVES

- The treatment or “service” objectives.
  - The service that will be utilized is listed under each objective.
  - Objectives reflect service definition, as well as member’s documented assessed needs.
- Must be oriented towards achieving the goal.
- Specific, measurable, and demonstrate action, movement, or learning on the part of the member.
- Describe the steps (more than one) that the member will take towards achieving the goal.
- Amount of Component Objectives should be appropriate for attaining the goal and commensurate with time spent in services (reflected in the frequency of service delivery indicated on the plan).

COMPONENT OBJECTIVE EXAMPLES

Appropriate Examples:

- ✓ COMPONENT 1: Mary will learn (Therapy) and practice (SIC) at least three coping skills to manage her symptoms of depression. (12-15-19)
  - Individual Therapy 4 x month
  - SIC Individual 2 x month
- ✓ COMPONENT 2: Mary will explore at least three contributing factors to her depression by 1-20-20.
  - Individual Therapy 4 x month
  - Group Therapy 2 x month

Inappropriate Examples:

- X COMPONENT 1: Steve will learn and practice coping skills for urges to use by 11-30-15.
- X COMPONENT 2: Steve will explore irrational cognitions that contribute to giving in to cravings, by 11-30-19. Supportive Counseling.

DISCHARGE PLANNING

Purpose of discharge planning:

- To identify when the member is ready to leave a service or level of care.
  - Individualized for each member
- To describe a member's plans after discharge
- Can be between levels of care as well as discharge from the agency.
- Must be based on 2 clinical benchmarks (CAFAS scores, Beck Depression Inventory, etc.)
  - Can integrate Outcome Objectives as Discharge Criteria, as well.
- Discharge planning starts on "day one" of treatment

DISCHARGE CRITERIA EXAMPLES

Appropriate Example:

Steve will have zero (o) positive urine drug screens for three consecutive months. He will also achieve and maintain a 5 or lower on the Beck Depression Inventory (BDI-II).

Inappropriate Example:

Steve will complete the 12 week IS program.

METHODS/INTERVENTIONS

- The services and/or activities provided by the professional and/or facility and approved by the member.

- Designed to assist the member in attaining service plan goals and objectives.
  - For coordinated care members, all services provided must be listed on the service plan
  - If not listed on the plan, it is not considered a valid or "prescribed" service

- Ensure that the plan includes an adequate number objectives for each service to be commensurate with assessed need and length of time in care, as well as to allow for stepping of the plan related to each service.

- Must include the frequency of the service.

Service Plan Review

SERVICE PLAN REVIEW

- Occurs a minimum of every 90 days
  - Also may occur at critical junctures.
- Entire team is present
  - Lead clinician directs the meeting
- Review of all the member's goals and objectives
  - Determine if goals and objectives need to be continued, discontinued, or modified.
    - Confirm the Service Plan continues to meet the members assessed need and level of care.
    - Ensure achievement dates are active or current, or if they needed extended.
  - Determine if additional goals, objectives and/or services need to be added, or current ones amended,
  - Includes a summary of services,
  - Progress and/or impediments to progress and determine if cause is member based or agency based.
- Includes all meeting participants' signatures, credentials (when applicable), dates and stop/start times demonstrative of required attendance.

Consultative Retrospective Review Tools

SCORING TOOLS

- Service Planning is scored within the Coordinated Service being provided.
- All Coordinated Services must demonstrate that there is a current, valid Service Plan for the provision of the service:
  - 1. Ensure that all plans contain required signatures, credentials (when applicable), date and start/stop times.
  - 2. Ensure objectives must meet service definition and reflect the member's assessed need.
  - 3. Ensure achievement dates are current.
  - 4. Ensure that all plans are completed within the appropriate timeframes.
- If the members Service Plan is not current, or doesn't meet medically necessary criteria, scoring would be negatively impacted during a retrospective review.

QUESTIONS AND ANSWERS

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