MCCMH MCO Policy 2-004

Category: **CLINICAL PRACTICE**
Title: **RESIDENTIAL PLACEMENT SERVICES PROTOCOL**

Prior Approval Date: N/A
Current Approval Date: 10/17/13

Approved by: _____ 10/17/13
Executive Director Date

I. ABSTRACT

This policy establishes that Macomb County Community Mental Health (MCCMH) shall use the Macomb County Community Mental Health Residential Placement Services Protocol.

II. APPLICATION

This policy shall apply to all MCCMH Board directly-operated network provider employees, independent contractors, and volunteers; as well as MCCMH Board contracted network provider employees and volunteers.

III. POLICY

It is the policy of the MCCMH Board to ensure that consumers receive the level and intensity of service most appropriate for each individual; and to ensure that less intensive levels of care are available to each consumer.

IV. DEFINITIONS

A. See Exhibit A, attached hereto and incorporated herein by reference.

V. STANDARDS

A. See Exhibit A, attached hereto and incorporated herein by reference.

VI. PROCEDURES

A. See Exhibit A, attached hereto and incorporated herein by reference.

VII. REFERENCES/ LEGAL AUTHORITY

A. Medicaid Provider Manual (April, 2013)

B. Medicaid Policy Manual (April, 2013)

C. Michigan Mental Health Code, MCL 330.1708(3)

VII. EXHIBITS

A. MCCMH Residential Placement Services Protocol

Macomb County Community Mental Health
Services Protocol Related to Residential Placements

Purpose: 1) To ensure Consumers are being served at the most appropriate level and intensity of service and 2) to ensure that Consumers have opportunities to move to less intensive levels of care.

Recommendations for movement to different levels of care may be initiated by the Consumer being served, the case/care management service agency, and the MCCMH Access Center.

Applies to:

- ✓ MCCMH Direct-operated and Contract Case/Care Management Service Units
- ✓ MCCMH Residential (Group Home, TIP, SIP) Providers
- ✓ MCCMH Access Center

Case/Care Management Expectations[1] - The case/care manager is responsible to regularly assess each Consumer's level of functioning in order to determine the appropriateness for continuation at the current level of care. This must be done at the time of Assessment, Re-Assessment, Service Review and/or Person-Centered Planning. Movement toward less intensive levels of care should be discussed with the Consumer on a regular and on-going basis and treatment goals should address skill development (e.g., meal preparation, money management, laundry skills, hygiene skills, medication management, community navigation, etc.[2]) needed for more independent living. Discussions with the Consumer's natural supports, family and guardian, if applicable, is to occur on an ongoing basis to evaluate the availability of non-CMH supports. The Consumer and family/guardian should also be assured that the Consumer will continue to receive appropriate and medically necessary services and supports to ensure successful transition to and maintenance of more independent living.

Annual Assessments should be made to evaluate and address the strengths and abilities of each Consumer to move to a less intensive level of care. The assessment of each Consumer must identify the projected time frame for movement to a less intensive level of care and the skills to be developed within that time frame. Arrangements for placement, (appropriate and adequate living accommodations, aftercare supports (including SUD as

[1]See Medicaid Provider Manual, page 74-76 (April, 2013) for more information of Targeted Case Management

[2]See Medicaid Policy Manual, page 62-63 and 113-114 (April, 2013) for more information on Personal Care Services and Community Living Supports to be provided in Specialized Residential settings.

necessary, roommate identification, etc.) are to occur as the Consumer approaches completion of identified goals. Person-Centered Plans and Service Reviews based on these assessments are to be individualized, strength-based, trauma-informed and address the skills to be developed. Progress Notes for Case/Care Management contacts are to address and report progress on each of the goals identified in the Person-Centered Plan. Subsequent Service Reviews are to specifically address these areas and identify continuation, modification or completion of the goal(s). When the Consumer is not meeting goals as identified, goals must be reviewed and modified based on the Consumer's strengths, abilities, interests and desires.

As part of the service planning/service review process, case/care management staff shall encourage and assist the Consumer to develop a crisis plan to effectively recognize, manage, and prevent a mental health crisis. All staff working with a Consumer should be aware of triggers that may cause a crisis, warning signs, strategies to help de-escalate a crisis, and resources that may be available to assist in the time of crisis.[3] Crisis plans must be individualized and address possible crisis interventions short of calling 911 and/or seeking inpatient admission. Though hospitalization may ultimately be needed in some cases, the goal of an effective crisis plan should be to identify a possible crisis early and prevent the need for hospitalization.

The expectations of case/care managers in ensuring Consumers have opportunities to live in the least restrictive settings possible are consistent with the service responsibilities of case/care management including, assessment, planning, linkage, advocacy, coordination and monitoring as identified in the Medicaid Provider Manual. These expectations are also consistent with the Michigan Mental Health Code requirements that Consumers receive services in the least restrictive setting that is appropriate and available.[4]

Supervisory Expectations - Supervisory staff are expected to review the status of each case, as related to level of care at the time of clinical supervision, Service Review and Person-Centered Planning. Documentation review shall include review of Progress Notes, and any Person-Centered Plans or Services Reviews completed during the supervision period. Clinical direction is to be provided, based on review of the documentation, regarding short and long term goals for each Consumer, including functional readiness to consider less intensive levels of care. Supervising staff should also review Consumer crisis plans to ensure appropriate efforts have been made to identify crisis triggers and effective interventions.

Provider Expectations - Provider agencies/staff are expected to recognize and respect the consumer's right, ability and desire to live in the least restrictive setting. Accordingly, the provider and staff shall work with case/care management staff to identify, design and implement appropriate goals and interventions to support and encourage the consumer's readiness to live in the least restrictive setting appropriate. Staff should also be aware of the

[3]Excerpts from: Crisis Planning; NAMI, Minnesota

[4]Michigan Mental Health Code, Section 330.1708(3)

Consumer's crisis plan, crisis triggers and effective interventions for each Consumer.

Access Center

At the time of re-authorization, the Access Center is to review the documentation submitted by the case/care management staff for service authorization. Access Center staff is to determine appropriateness of current level of care based on the current functioning as identified in assessments, progress notes, Person-Centered Plans and Service Reviews.

In cases where the case/care management staff have identified a Plan for movement to a less intensive level of care and the Access Center concurs with that Plan, services at the current level of care are to be authorized through the time frame identified in the Person-Centered Plan.

In the event that the Access Center determines that the current level of care is no longer medically necessary based on the current level of functioning, the Access Center may issue a time-limited authorization for continuation of services at that level of care. All denials or reductions in authorization must identify the reason for that action. Any time-limited authorization must provide an appropriate and reasonable amount of time for case/care management staff to assist the Consumer to transition to an alternative placement. Services must not be abruptly discontinued without appropriate aftercare arrangements.

Provider Appeal[5]

In the event of a denial or reduction in residential services, Case/Care Management staff may initiate a Provider Appeal based on MCO Policy 2-006. Per Policy, "The use of such formal appeal mechanism is only to be initiated following informal attempts to clarify the decision and is not intended to replace normal day-to-day professional communication regarding planning for services to Consumers."

Due Process

In all cases of denial, termination or reduction of services, appropriate due process notices must be issued. Due process notification shall be issued only after all Provider Appeals (Informal and Formal) have been exhausted.

[5]See MCO Policy 2-006, Service Provider Appeals