Regulatory Relief and Rapid Access in Article 31 Clinics

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Purpose

• Review updates to Part 599 regulations for Treatment Planning

• Discuss best practices in rapid access to clinic services, including pre-admission, admission, and assessment

• Realizing the opportunities for rapid re-engagement supported by current regulatory changes
Clinic Goals

• Rapid access
• Engagement for individuals and family
• Development of a meaningful plan for care and treatment
• Maximize wellness
• Promote recovery and resilience
• Support individuals in their natural environment
• Allow for rapid re-engagement
Why Regulation Updates

Treatment Planning changes support:

• Alignment of documentation with needs of individuals/families served

• Reduced documentation requirements to allow more flexibility for clinically driven work

• Focusing on Person/Family-Centered Planning
Part 599.10
Changes
Summary of Part 599.10 Regulation Updates

• Clarified the difference in requirements between Medicaid fee-for-service beneficiaries and for any other payer or plan

• Removed discharge criteria from contents of initial treatment plan

• Reduce minimum requirements of treatment plan reviews from 90 days to no less than annually

• Allows for Agency autonomy for the documentation of the treatment plan.

• Clarified Physician signature requirements for treatment plans/reviews/updates and requirements for the individual’s/family’s signature
Treatment Plans – FFS vs. MMC

- Medicaid Fee-for-service
  - Authorized/signed by a psychiatrist or other physician

- Medicaid Managed Care (MMC) or Commercial Insurance:
  - psychiatrist, other physician, or PNP if medication is prescribed
  - psychiatrist, other physician, licensed psychologist, PNP, LCSW, or other licensed practitioner if NO medication is prescribed
Initial Treatment Plan

Discharge Criteria
• Regulation change removes Discharge Criteria as a required element of the Initial Treatment
• Allows for focus on goal attainment vs. discharge criteria

Due Date
• Medicaid Fee-for-service (FFS)
  o Due within 30 calendar days of admission
• Medicaid Managed Care (MMC) or Commercial Insurance
  o Due date can be determined by the plan
  o If there is no requirement by the plan, the due date shall be 30 calendar days from admission
Treatment Planning: Timeline Change

- Full Treatment Plan Reviews are required **no less than annually**, or more frequently as determined by the treating clinician and the individual/family.

- Treatment plan reviews are due no less than annually **based on admission date** or the **most recently completed Treatment Plan Review** thereafter.
Treatment Plan Reviews: Using a Progress Note

Treatment plan reviews may be documented in a progress note if all Treatment Plan Review required elements are included.

OR

Agencies may choose to continue to document reviews in the current location in the chart (the Treatment Planning section):

• agency policies and procedures must be clear and consistent for all staff
Treatment Plan Update – Requiring Physician Signature

• New services are added (e.g., adding group psychotherapy to the treatment plan);

• Service intensity is increased (frequency or duration)

*See other payor signature requirements for non-FFS
Treatment Plan Update – No Physician Signature Required

• If only the goal, objective, intervention, or time periods for achievement need to be updated or changed, this can be completed within a progress note, NO full treatment plan review is required, and ONLY the signature of the clinician is needed.
Recipient Signature

- Participation of individual, and family or collaterals if applicable, MUST be documented in the record.
- A copy of a Treatment Plan is offered to individuals/families. This is especially important in the work with children and families.
- Emphasis is on the participation of the family/individual, not limited to a signature in the treatment plan.
Treatment Plans Overview

**Initial Treatment Plan:**
- Completed w/in 30 days of admission (or other timeframe set by payer)
- Discharge Criteria removed from required elements
- Signed by physician (or based on requirement for other than FFS payer)
- Participation of individual, and family or collaterals if applicable, MUST be documented in the record

**Plan Updates:**
- **Addition of New Services or Increase in Service Frequency/ Duration**
  - Full Treatment Plan Review completed
  - Signed by physician (or based on requirement for other than FFS payer)
  - Participation of individual, and family or collaterals if applicable, MUST be documented in the record

**Plan Updates:**
- **All Other Changes/ Edits**
  - Changes may be recorded in a progress note
  - Progress note must be signed by treating clinician
  - Participation of individual, and family or collaterals if applicable, MUST be documented in the record

**Treatment Plan Review:**
- Timeframe
  - Completed no less than annually or as determined by the treating clinician and individual/family
  - May be documented in a progress note
  - Participation of individual, and family or collaterals if applicable, MUST be documented in the record
Updating Policies & Procedures

- Regulation in effect on 8/19/20
- Clinics will need to update policy and procedures (P&Ps) operationalizing changes
- Consider EHR changes (use of progress notes vs. treatment plan for updates)
- Streamlined workflows
OMH Next Steps

• Update Standards of Care (SOC) by late fall
• Begin utilizing updated SOC during licensing visits as of January 2021
• Future webinars may be planned to further address these changes/concepts and providers' questions or concerns
• Update Clinic Guidance documents and FAQs
Rapid Access
Preadmission/Admission Assessment
Pre-Admission

• All services, including initial assessment and treatment may be provided during pre-admission **except** for testing and some crisis services
  • Preadmission should not delay treatment
  • Services can still be provided prior to admission even if admission criteria has not yet been determined
• Having an individual attend multiple appointments prior to receiving services may erode engagement and increase no shows
• Allow for **rapid access** to services
• **Engage** the individual/family
Admission

- If you have determined that the individual is eligible for services and the client is agreeable to clinic services, then admission is appropriate.

- All services including initial assessment, treatment, and testing may be provided after admission.

- Continued engagement the individual/family.
Screening/Assessment

• Should be an ongoing process

• Process should be individualized
  • Consider streamlined assessment process
  • Remove items that go beyond requirements or are duplicative

• Access information from other sources, like PSYCKES clinical narrative, referral sources, or other available assessments
Rapid Re-engagement
Rapid Re-engagement

If an individual is discharged from the clinic, regardless of reason, and returns to the clinic prior to one year since discharge date, they must be provided the opportunity for **rapid re-engagement**

Annual treatment plan review (vs 90 day minimum) support this at a documentation level
Q & A
Thank You!