Therapeutic Day Treatment

Live Webinar Presented by:
Magellan of Virginia Clinical Department
August 23, 2016
The Purpose of This Training

• Provide an overview of the Therapeutic Day Treatment (TDT) program, service expectations, day-to-day operations, medical necessity criteria and documentation requirements
• Highlight changes made to the TDT Service Request Authorization (SRA) forms that will go into effect this fall
• Give feedback to providers on common administrative and clinical errors on SRA submissions
• Inform providers on how Care Managers (CM) are reviewing TDT requests and what CMs are looking for on submissions
• Discuss examples of evidence-based practices that may be useful within TDT
• Provide training and feedback on Individual Service Plans (ISPs)
• Discuss information required for Treatment Record Reviews (TRRs)
• Review the definition and purpose of Care Coordination and how it applies to TDT
• Provide resources to utilize when questions arise
Service Description

TDT is a combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills and individual, group, and family counseling offered in programs of two or more hours per day.

- CMHRS manual, Chapter IV, page 31

- Services can be year-round and provided in-school, after-school or in a summer program
- Services must be therapeutic in nature and align with each member’s ISP
Services Included in TDT

- Completing diagnostic evaluations, identifying treatment needs
- Consultation with teachers and others involved in the member’s treatment and observation in the classroom
- Planning and implementing individualized pro-social skills curriculums and interventions
- Monitoring progress in demonstrating the acquisition of pro-social skills
- Implementing cognitive-behavioral programming
- Planning and implementing individualized behavior modification programs and monitoring progress through collaboration with school personnel, family and others involved in the member’s treatment
- Family contacts, either in person or by telephone, occurs at least once per week at a minimum
- More frequently as clinically indicated and identified in the assessment and ISP
- Responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day
- A crisis response plan should be kept on site and in the medical record and reviewed throughout treatment
- Services should include a “debriefing” with the individual and family to discuss the incident
- Providing individual, group, and family counseling based on specific TDT objectives identified in the ISP
Services Included in TDT – continued

- Collaborating with all other community practitioners providing services to the member, including scheduling appointments
- If the member is on medication related to his/her behavioral health needs, education about side effects, monitoring of compliance and adherence to medication plan, referrals for routine physician follow up, and coordination with physician must be provided to the member and parent/guardian and documented

All covered services should be therapeutic in nature.

- A minimum of two or more therapeutic activities shall occur per day, including individual, group, and family counseling, and social skills training or psychoeducational activities
- If providers take members on “trips” into the community, at least two therapeutic activities need to occur to be able to bill
- The need for these “trips” should relate to the member’s treatment goals and be clinically justifiable on an individual basis
Examples of Services

• **Classroom observation:** observing how the member acts in the classroom and providing feedback
• **Debriefing:** following an incident, talking with the member about his thoughts and feeling related to the incident, discussing triggers, coping strategies, and what he could do the same or differently next time
• **Collaboration:** speaking with school personnel on a daily basis, speaking with the parent or guardian, collaborating with other providers (IIH, TCM, psychiatrist, etc.)
  o Providers should obtain a release of information for any outside providers or individuals involved in the member’s obtainment of treatment goals
  o Providers should understand the member’s treatment needs and how the various professionals and treatment plans impact each other
  o Providers may also learn of other areas of concern that should be taken into consideration during interventions. New concerns should be documented and the ISP needs to be updated.
• **Group counseling/social skills training:** ideas include, but are not limited to anger management, self-esteem building activities, feelings/emotional expression, peer relationships, conflict management, communication, meditation skills, coping skills, good touch/bad touch, discussing triggers for behavioral outbursts
• **Individual counseling:** LMHP-type can meet with the member as often as is medically necessary, as documented in the ISP
• **Family counseling:** LMHP-type can meet with the member/family as often as is medically necessary, as documented in the ISP
Limitations

• The program must operate a minimum of two hours per day and offer flexible hours (e.g. before school, after school or during the summer)

• A minimum of two (2) or more therapeutic activities shall occur per day
  o This includes individual, group, and/or family counseling and/or psycho-educational activities

• Services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C, or QMHP-E

• Therapeutic groups are limited to no more than ten (10) members

• Services may not duplicate those provided by the school

Please note that the following activities are not billable:

• Inactive time or time spent waiting to respond to a behavioral situation

• Transportation

• Documentation time
After-School and Summer Programs

After-School and Summer Programs are required to follow the same service requirements, expectations, and limitations as School-Based Programs.

- These programs should be therapeutic and use evidence-based practices
- Collaboration with the school, family, and other providers is required
- Community “trips” should be therapeutic in nature and identified in the member’s ISP
- Individual, group, and family counseling should still be provided
- The ISP must be updated between school and summer programs based on the activities being provided
- Transportation is not billable
Documentation

Progress notes should be individualized and case-specific.

• Each progress note shall demonstrate unique differences particular to the member’s circumstances, treatment and progress
• Progress notes should contain the member’s behaviors and incidents the member engaged in throughout the day
• Interventions provided to the member in response to the behaviors and incidents should be included
• The content of each progress note shall support the time/units billed
• Progress notes shall be documented for each unit of service provided
Medical Necessity Criteria
Clinical Elements – At Risk Questions

What places a member at risk for hospitalization or out of home placement?

• Has the member been screened within the past two weeks for escalating behaviors that are impacting the member’s ability to establish or maintain normal interpersonal relationships?
• Is the parent or guardian actively seeking out of home placement within the past 2-4 weeks? If so, what steps have been taken?
• Has another practitioner or representative recommended out of home placement?
• Have there been unsuccessful services within the past 30 days?
• Has FAPT been involved and recommended out of home placement?
• OR is the member at risk of being placed in a Level A, B, or C residential facility, Psychiatric Hospitalization, Juvenile Justice System/incarceration, foster care, treatment foster care, and/or an emergency shelter due to conflicts with the family or community?
Clinical Elements – At Risk Questions

What places the member at risk of being placed in a Level A, B, C residential facility, Psychiatric Hospitalization, Juvenile Justice System/incarceration, foster care, treatment foster care, and/or an emergency shelter?

- What is the medical necessity criteria for a Level A or B group home or Level C residential facility?
  - Is the member at imminent risk of harm to self or others? Does the member need 24 hour care to stabilize mental health symptoms? Have all lower levels of care been exhausted?

- What is the medical necessity criteria for psychiatric hospitalization?
  - Is the member at imminent risk of harm to self or others?

- Does the member have legal charges or is the member on probation?

- Are the member’s behaviors so severe that the parent or guardian has contacted social services to potentially relinquish custody?

- Has the member moved between foster homes due to behaviors?

- Has the member been placed in an emergency shelter due to mental health issues or behaviors?
SRA Examples – Documentation of At Risk

Does the individual have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community?

During the past 30 days, there has been an increase in negative behaviors due to the member’s grandmother and grandfather separating and the grandfather moving out of the home. Member has had difficulty complying with rules and requests, getting along with her brother and difficulty communicating her feelings and emotions appropriately (daily). Member’s biological mother has shown a decrease in calling member which is also affecting her negatively.

Does the individual have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community?

Member is currently at risk for out of home placement due to escalating behaviors within the community setting. Member has been increasingly aggressive and has gotten into 3 physical altercations within the last 30 days with peers in the community (July 4, 17, 20). The police were involved on the last altercation (July 20) because there was suspicion of possible gang activity. There were no serious injuries and no charges were filed, but the police officer recommend a CHINS petition be filed. Member’s mother has filed a CHINS yesterday In addition to the physical altercations, member also told his mother that he wanted to “kill himself” on July 21. His mother had the member assessed by crisis, but he was not hospitalized and discharged with a safety plan. At the time of the TDT intake, the member did not have a current plan to harm himself and has contracted for safety with this provider (plan attached).
Clinical Elements – Repeated Interventions

• Documented mental health, social services, or judicial system interventions from the past 30 days that have been tried and proved ineffective in treating the member’s behaviors/emotional issues and TDT is warranted

• School interventions **DO NOT** fall under repeated intervention criteria, unless they are mental health interventions (i.e. meeting with a LMHP employed by the school)
  - It is important to include school interventions to help the CM get a clear picture of the school behaviors

• Department of Social Services (DSS) and Child Protective Services (CPS) involvement due to social welfare issues **DO NOT** count as interventions
  - For example, the member was removed from family due to neglect

• Referrals or upcoming appointments to other services **DO NOT** count
  - As these have not been tried and shown to be ineffective
  - It is important to show that the provider is linking the member to services for additional needed services outside of TDT

• VICAP does not need to be included and is not considered an intervention, unless the member was deemed at risk of injury
Does individual exhibit behaviors that require repeated interventions by the mental health, social services or judicial system?

Member exhibits behaviors that are socially inappropriate (3-4 times daily) demonstrated by fidgeting with items, interrupting her teacher when she is speaking, making disruptive noises, blurting out, talking excessively. Member has gotten a referral for talking in class in the past 30 days.

Does individual exhibit behaviors that require repeated interventions by the mental health, social services or judicial system?

Within the last 30 days, member has attended outpatient therapy for 3 sessions. Member continues to receive psychiatric services and has been prescribed Risperdal 0.5 mg 1 time daily. His last appointment with his psychiatrist was July 25. Despite outpatient therapy and medications, the member’s behaviors continue to escalate, as evidenced by the member making threatening statements to hurt himself in the past 30 days.
Clinical Elements – Difficulty in Cognitive Ability

• Due to the member’s diagnosis/emotional disturbance, the member does not understand when he puts himself at risk of getting hurt and/or he does not understand that his behaviors are *significantly* socially inappropriate
  o This is not due to an Intellectual Disability or developmental delay
  o Behaviors need to be beyond the realm of age-appropriate

• It is important to show that the behaviors cannot be managed in the school without assistance or through a lower level of care such as outpatient therapy or psychotropic medication
**SRA Elements – Difficulty in Cognitive Ability**

Does the individual exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior?

Member exhibits behaviors that are socially inappropriate (3-4 times daily) demonstrated by fidgeting with items, interrupting her teacher when she is speaking, making disruptive noises, blurting out, talking excessively. Member invades peers personal space and lifts up her shirt to expose her belly while talking to male peers (weekly).

Does the individual exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior?

In the past 30 days, member has gotten into 3 physical altercations. During two of these altercations, member physically injured two peers (scratches, black eye) and reported that “they had it coming.” The member showed little remorse for his actions, and truly believed that his actions were appropriate because the peers teased him. Member experiences intense moments of anger at home and school. These episodes occur on average 4x per week. The last episode occurred on July 19. The episodes begin with heavy breathing, and escalate to yelling at adults, cursing, slamming books, tearing up school work/homework, breaking pencils and throwing them, flipping over desks, and throwing shoes. The episodes last for about 20 minutes, which has been an improvement as prior to TDT services, member would stay in this state for over an hour. The member does not see his behaviors as a problem, and reports that everyone should change how they act towards him.
Updates have been made to both the Initial and Continued Stay SRAs. The updated SRAs will be required starting this fall, with the date to be determined.
Outcome Measures

These outcome measures were developed to improve Magellan’s ability to evaluate the effectiveness and efficiency of the TDT program.

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<tr>
<th>Additional Information</th>
<th>Yes or No?</th>
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<tr>
<td>Has the individual used substances (including alcohol and tobacco) in the past 6 months?</td>
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<tr>
<td>Number of days absent in the school year</td>
<td>Number?</td>
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<tr>
<td>Number of days in out-of-school suspension in the last 6 months</td>
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<tr>
<td>Number of days in in-school suspension in the past 6 months</td>
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<td>Number of excused absences in the past 6 months</td>
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<td>Number of unexcused absences in the past 6 months</td>
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<td>Number of classes the individual is taking</td>
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<td>Number of classes the individual is satisfactorily passing</td>
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Initial and Continued Stay SRAs

Enhancements

• Is this an after school or summer program?
• Is the member receiving any other CMHR services and what kind of service coordination is being provided?
• How will TDT not duplicate the services provided by the IEP and/or self-contained classroom?
• Why can’t the member be managed in a lower level of care?
• Does the member have an Intellectual Disability or cognitive delays? If so, how can they effectively participate in TDT?
• What is the discharge plan? What is the discharge date? What services will the member be referred to? What are the barriers to discharge?
Continued Stay SRAs

Enhancements

• Providers will be required to submit the ISP for all continued stay requests
• What progress has the member made? What changes will be made to promote progress? Will the member be discharged if progress has been made? If not, why not?
Administrative Elements – Common Errors

• Requesting the wrong units and time frame
  o CMs cannot authorize beyond the maximum allowable timeframe of 6 months for 390 units
    – **CMs authorize TDT based on the clinical information submitted.** Shortened time frames can be authorized based on clinical necessity, maximum benefit, and discharge planning.
  o CMs cannot change end dates. If a provider enters the wrong end date and then would like to extend the authorization, the provider has to submit a new request for the date extension.

• Not attaching the ISP

• Reporting an incorrect admission date
  o The date of admission is the day that the member began TDT services with the provider, which is not necessarily the first day of the authorization
  o Claims will not pay for any date of service outside of the authorization timeframe

• Wrong member information on the SRA
Clinical Elements – Helpful Reminders

When completing the SRA, remember:

- CMs are looking for behaviors from the past 30 days
- Provide dates of specific behaviors/incidents to support report of the behaviors
- Note where the behaviors are occurring – in the school, home, and/or community
- Note the frequency and duration of the behaviors
- Note the severity of the behaviors and symptoms
- Always include an update on the member’s progress for concurrent reviews – use measurable terms
- Accurately reflect what the VICAP recommended – if not known, contact assessor
- Any information reported to Magellan on the SRAs should also be found in the member’s record, i.e. on progress notes, quarterly reviews, SSPI, etc.
Evidence-Based Treatment Models
Peaceful Alternative To Tough Situations (PATTS)

PATTS is a school and community based aggression management program designed to help students engage in positive conflict-resolution skills, forgive transgressions, and reduce physically and emotionally aggressive behavior.

- The program is based on a trauma-informed approach that focuses on affect regulation and teaches cognitive skills, peer-refusal skills, appropriate conflict resolution skills, identification and verbalization of emotions, recognition of anger cues, calming techniques, and forgiveness.

- PATTS is designed to be delivered by teachers, school counselors, juvenile court workers, human service staff or others trained to work with youths.
FRIENDS Program

The FRIENDS Program is a cognitive behavioral intervention that focuses on the promotion of emotional resilience to prevent, or intervene, early in the course of anxiety and depression in childhood and adolescence. It is intended for both use as a self-development course and as an intervention.

• The program is delivered to participants through four developmentally appropriate versions (ages 4-7, ages 8-11, ages 12-15, and ages 16 and older).
  
  o *Each version is based on a theoretical model that addresses attachment, physiological cognitive, and learning processes that interact in the development, maintenance, and experience of anxiety.*
  
  o *Core elements are delivered through play-based activities and experiential learning for younger children and group discussion, hands-on activities, and role-play for older children and adolescents.*
**Teaching Students to be Peacemakers (TSP)**

TSP is a school-based program that teaches conflict resolution procedures and peer mediation skills. The program aims to reduce violence in schools, enhance achievement and learning, motivate pro-health decisions among students and create supportive school communities.

- Training is provided through 10-20 hours of instruction over several weeks.
- TSP is primarily designed for use in kindergarten through middle school but also has been used with high school students.
- Providers deliver the program using lessons that include case studies, role-playing activities, and simulations.
Several studies have shown the effectiveness of treatments for traumatic stress that are based on cognitive-behavioral approaches.

These approaches include:

- Teaching children stress management and relaxation skills to help them cope with unpleasant feelings and physical sensations about the trauma.
- Using “exposure strategies” or talking about the traumatic event and feelings about it at a speed that doesn’t distress the child.
- Creating a coherent “narrative” of what happened.
- Changing unhealthy and wrong views that have resulted from the trauma.
- Involving parents.
The ISP is a “living document” and should be reviewed and updated as often as necessary.

• The goals should be Person-Centered and align with the member’s identified needs and areas for improvement
• The goals and objectives should have realistic timeframes for resolution
• The goals should be measurable and realistic
• All planned interventions should be included
  o Individual, family, group counseling
  o Psycho educational activities
  o Community trips
• The ISP should show progress throughout the course of treatment
ISP – continued

The goal of TDT is to provide the member with the skills to be able to function independently in the school/home/community without the service.

• If the member is not improving, it is important to determine why;
  o TDT may be ineffective for a variety of reasons and the provider should explore other services and transition the member out of TDT
  o Objectives and interventions should be updated in the ISP to promote progress

• If a provider reports “No progress” or “Minimal progress” on the SRA or the ISP review, it suggests that something may not be working.
  o Providers should justify continued treatment based on the member’s response to interventions and adjustments made to the treatment plan
ISP – Safety Plans

All members in TDT should have a crisis/safety plan in the member’s file which can be included within the ISP.

• Intensity of the plan should be individualized and based on need
  - For members with SI/HI or other significant risk factors, a more thorough safety plan should be implemented
    - 24/7 crisis numbers provided to parent or guardian and member, numbers and locations of nearby hospitals, suicide hotlines
    - Warning signs, coping strategies
    - If member has threatened harm, have dangerous items been removed from the home or out of reach of the member (i.e. knives, ropes, etc.)?
  - Intensive safety plans should be reviewed with the parent or guardian and member on a frequent basis
ISP – Discharge Planning

• Discharge planning begins at admission and should be discussed at intake
  o A projected discharge date should be indicated and individualized based on member need
    – Just because the ISP is only required to be updated once a year, at a minimum, it does not mean that every member’s potential discharge date is one year from the start of services
• The provider should begin considering and projecting potential aftercare services and also connecting the member to lower levels of care at the onset of services
  o Providers should not wait for services to be non-authorized by Magellan or a shortened time frame to be given to discharge the member
• The provider should address potential barriers to discharge
• The parent or guardian should be involved in the discharge process
Treatment Record Reviews (TRR)
Treatment Record Reviews

Diagnostic Evaluation
• Providers should show in the documentation that symptoms, frequency of behaviors, etc., correlate with the diagnosis that is on the SRA
• If the diagnosis changes, update the member’s record and communicate the change to the billing department so claims are billed accurately
  o It is also important to report any diagnostic changes to the parent or guardian
• The treatment needs should have member and parent or guardian input
  o It may be helpful to involve school staff as well for input
  o However, ultimately, these goals/needs should be based on the member

Family Contacts
• Discussion around treatment planning should be done quarterly, at a minimum
  o Changes should be made as often as is medically necessary and the parent or guardian should be notified
  o Parent or guardian should be receiving weekly updates, at a minimum, about the member’s progress
  o Parent or guardian should be involved in any significant incident during the school day, including, but not limited to, crisis incidents
Treatment Record Reviews – continued

Crisis response
• Ensure that SI/HI/risk checks with members are completed at the initial assessment, during reassessments, quarterly reviews, at discharge, and at least weekly for higher risk members
• If a member has a history of SI/HI/risk, ensure a crisis/safety plan is in place, and this is documented and revisited often
• All members should have a safety plan in place, even if it is minimal
  o For example, crisis numbers to call, coping skills to address

Medication management
• Medication lists should be current in the member’s record
  o Monitor and document compliance and education within the progress note
  o Include in the ISP as appropriate
  o If non-compliance is noted, the provider may need to alert the prescribing practitioner and assist the member in getting an appointment, if needed
Care Coordination
“Care Coordination” means collaboration and sharing of information among health care providers, who are involved with an individual’s health care, to improve the care.

Magellan Care Managers (CM) are licensed behavioral health clinicians (LPC, LCSW, RN) and provide a number of services to providers and members, including assisting with and facilitating care coordination. Many CMs have direct previous clinical experience in a variety of settings, including some of the covered services.
Care Coordination – continued

A Care Manager may call a provider to engage in care coordination of a case for the following reasons:

• The discharge plan is not realistic or individualized or there is no discharge plan
• No safety plan is mentioned when HI, SI, or other risk is reported
• Abuse or neglect is indicated, but there is no report of DSS involvement
• The ISP goals are not realistic, individualized, or measureable
• The parent is noted to not be involved or parent involvement is not mentioned
• The member has been in TDT for an extended period of time and there is no noted improvement
• A higher level of care may be needed based on behaviors
  o Discussion of how to access a higher level of care
• There is improvement and/or behaviors could be managed by the school or with a lower level of care
  o Discussion of lower levels of care and how to resubmit in the future if member escalates in the future
• Recommendation for step down, if appropriate
• Recommendation of engaging the member in other services
• Recommendation of services for the family
CMs reach out to providers to have clinical discussions during care coordination calls

- Magellan recommends that the Clinical Contact on the SRA is the person directly providing TDT services or the LMHP or LMHP-E overseeing the services
  - CMs having to speak with or leave messages with administrative or billing persons may create barriers to members receiving clinically appropriate services
- If the CM continues to document being unable to reach a Clinical person at the provider agency, this will be referred to Quality for follow-up

August 23, 2016
If you have questions about a SRA submission or questions related to TDT services:

- Call our customer service line at 1-800-424-4046 and ask to speak with a Care Manager on the child/adolescent team
- Join our weekly provider call on Fridays from 1-2 pm
  - Dial-In: 888-850-4523
  - Passcode: 743713
- Select Contact Us on the Magellan of Virginia website to submit an e-mail to the clinical team
Get involved!
• Go to the *Your Thoughts Matter* section on the Magellan of Virginia website and share your opinions and feedback with Magellan
• Submit an application for the Governance Board and Quality Improvement Committees with Magellan
  o Application is located on the Magellan of Virginia website under the *About Us* tab

Learn!
• Check out the Magellan Health Official YouTube page to watch and listen to Magellan recorded trainings and videos
• Search Magellan’s E-Learning Center at [www.magellanhealth.com/training-site](http://www.magellanhealth.com/training-site) for educational information, videos and professional learning opportunities
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