Changes to Residential Treatment Services

Changes to residential treatment services are designed to transition existing services into models of care with evidence based treatment approaches, standardized medical necessity criteria, and rigorous program requirements to create a youth and family-focused system that will match future managed care administration structures, oversight, and contracting requirements. The goal is to ensure that residential treatment is individualized, youth and family driven, and focused on the youth’s successful transition back into the community.

Changes to residential services include: A revised assessment process, revised program requirements, enhanced care coordination with Magellan, changes to the service review process, and updated Medical Necessity Criteria.

1 Revised Assessment Process prior to Admission

Magellan will serve as the single point of entry for all youth at risk of admission to a Psychiatric Residential Treatment Facility (PRTF) or Therapeutic Group Home (TGH). Youth will be assessed by the Independent Assessment, Certification, and Coordination Team (IACCT) to determine the appropriate level of care.

Residential providers who receive direct referrals should complete the Inquiry Form located on www.MagellanoofVirginia.com to initiate the IACCT process. For cases in which a youth was admitted to a residential facility under a different funding source, the Inquiry Form should be submitted within five days of the youth receiving Medicaid eligibility.

2 Revised Program Requirements

**Family Engagement**

Includes family psycho-educational training or coaching; transition planning with the family; family and independent living skills; and training on accessing community support.

Family engagement activities must be provided weekly. A family engagement activity does not include and is not the same as family therapy.

Family engagement activities must be individualized and tied to treatment plan goals. Full collaboration and partnership with youth and families in all aspects of treatment planning is essential.

If family engagement is not possible, barriers must be documented. The facility must collaborate with Magellan and develop alternate, individualized family engagement strategies. A revised Initial Plan of Care (IPOC) or Comprehensive Individual Plan of Care (CIPOC) should be submitted to Magellan for review.

**Therapeutic Interventions**

"Intervention" means scheduled therapeutic treatment such as individual or group psychoeducation; psychoeducational activities with specific topics focused to address individualized needs. Interventions should be tied to goals in the treatment plan.

Therapeutic Group home (TGH): Minimum of one intervention per 24 hour period including nights and weekends in addition to individual, group, and family therapies

Psychiatric Residential Treatment Facility (PRTF): Minimum of three interventions per 24 hour period including nights and weekends; can include family engagement activities.

Evidence-based practices should be incorporated to ensure positive outcomes. Trauma informed care includes individualized interventions that address the behavior and underlying causes.
Therapeutic Leave Passes

Therapeutic passes shall be provided as clinically indicated and promote discharge planning, community integration, and family engagement activities. Passes allow the youth and family to practice skills necessary for community tenure.

Consist of partial or entire days of time at home or time with family and away from group home or treatment facility.

Passes must be documented in the IPOC/CIPOC.

Twenty-four therapeutic passes are available per youth, per admission. Passes are not privileges, but are an important part of the therapeutic process. Therefore, additional therapeutic passes can be requested through Magellan.

Youth should be encouraged to attend important family events as therapeutic passes are an opportunity for youth and their families to build positive memories.

Focus on Permanency and Discharge Planning

Planning begins at admission and continues throughout placement.

Permanency and discharge planning should involve collaboration with youth and family/legal guardian, local Family Assessment and Planning Team (FAPT) if applicable, Community Service Board (CSB) or community-based provider, and the Magellan Residential Care Manager (RCM) and Family Support Coordinator (FSC).

It is important that every child served has involved family members who can serve as a permanent family.

Discharge plans must be submitted to Magellan for review and approval.

Once Magellan approves, the facility should arrange aftercare appointments (medical and behavioral health) to take place within 30 days of discharge.

Enhanced Care Coordination with Magellan

Promoting care coordination increases the likelihood of the youth’s successful return to the community and home setting. Therefore, Magellan created two new roles to enhance care coordination for youth in residential treatment and to provide continuity in care.

Residential Care Manager (RCM)

Assists in coordinating the residential placement and informs the facility of the assigned Magellan RCM and FSC.

Engages in care coordination to discuss the youth’s progress, family engagement activities, therapeutic interventions, strengths and needs throughout the course of treatment.

Reviews service requests and IPOC/CIPOC. Reviews the discharge plan to ensure aftercare services are in place and appropriate for the member’s needs.

Family Support Coordinator (FSC)

Provides education for informed decision making regarding treatment, and offers any other support to the family throughout the course of treatment.

Encourages and facilitates family engagement in any treatment option decisions.

Promotes family engagement throughout the course of treatment by collaborating with the parent/guardian.

Acts as a liaison between the facility and the family, and communicates family concerns and barriers to the RCM.
Changes to Service Review Process

The Residential facility will only need to submit the Service Request Authorization (SRA), the IPOC/CIPOC, and the rate sheet (if applicable). The Certificate of Need (CON), Child and Adolescent Needs and Strengths (CANS), and Adverse Child Experience Screening (ACES) should be kept in the Medical record.

There is one initial SRA and one continued stay SRA to be used for both TGH and PRTF. The SRAs have been updated and include questions related to the level of family involvement in treatment decisions and goal setting, IPOC/CIPOC alignment with CANS and ACES, therapeutic passes, family engagement activities, and discharge planning.

The initial request will be authorized for 14 days and continued stay requests will be authorized for up to 30 days. The RCM will review the IPOC/CIPOC for individualized/trauma informed interventions that are specific to the youth and family's strengths and needs, comprehensive discharge plan, and safety plan.

During each review, the treatment provider should be available to engage in a care coordination discussion with the RCM as well as respond to any care coordination feedback provided.

Highlighted changes to Medical Necessity Criteria

Medical Necessity Criteria (MNC) has changed and can be found in the Manual Supplements. Below are highlighted changes to the MNC. Please note that the below section only highlights changes and is not an exhaustive list. Refer to the Manual Supplements to view complete MNC.

Psychiatric Residential Treatment Facility (PRTF)

1. 24 hour ON-SITE nursing services are not required, however, 24 hour ACCESS to nursing services must be available.

2. Psychiatric reassessments must take place at least once a week. These face-to-face assessments shall be performed by an LMHP, LMHP-R, or LMHP-RS.

Therapeutic Group Home (TGH)

TGH Initial

1. TGH should be used for clinically appropriate reasons. The following are not clinically appropriate uses for TGH: A. an alternative to incarceration and/or preventative detention B. an alternative to parents’, guardian’s or agency’s capacity to provide a place of residence for the individual C. a treatment intervention when other less restrictive alternatives are available.

3. The need for this level of care is NOT primarily due to Intellectual Disability, Developmental Disability, Autism Spectrum Disorder, organic mental disorders, traumatic brain injury or other medical condition.

4. TGH is required to coordinate with the individual’s community with the goal of transitioning to a less restrictive care setting as soon as possible and appropriate.

TGH Continued Stay

1. Must continue to meet admission guidelines.

2. The desired outcome or level of functioning either hasn’t been restored or improved or member continues to be at risk of relapse based on history.

3. CIPOC goals cannot be met at a lower level of care.

4. Comprehensive discharge plan should include barriers to community integration and progress made on resolving the barriers since the last review.