Southern Tier Environments for Living, Inc.

Uniform Case Record Guidelines

STEL requires transition goals in our service plans agency wide. STEL recommends residents set a transition goal at the Service Plan. They should be stated in the resident's own words, i.e.-***"I will move to my own apartment by (month and year).*** Transition goals should be set for 12-24 months, because we feel our service delivery is most effective during that period.

As an agency, we have found it generally takes 18 months to transition someone to a less restrictive level of care, as we need to identify the setting, teach final skills, and identify resources needed.

Transition can be to a parallel setting as well, i.e. Family Care, SRO, Adult Retirement Center, STEL Apt, or for our elderly in poor health; a Nursing Home. Transition goals will be attained when a resident transitions from the program.

ADMISSION NOTES:

1) The Admission note will be completed the day of admission

2) **Criteria for discharge**: Indicate the critical skills needed for discharge. Include a discharge statement from the resident. Ask the resident, "where do you see yourself in 12-24 months". What skills do they need to be successful?

3) **Immediate Needs:** Based on the referral information and/or evaluation, describe the resident's needs or issues which must be addressed during the first 28 days of the program stay. These may include linkages to treatment, or to physicians, or applying for benefits, etc. Immediate needs should be client centered and unique.

4) **Alerts**: Select all alerts that pertain to consumer.

5) **Alerts, Barriers, Risks:** Enter in the text box any alerts, barriers, and risks identified from the referral packet and admission summary..

6) **Reason for Admission**: Indicate the reason for admission in text box. Use admission summary, and discussion with client. Ask the resident what led them to STEL, how can staff help them, what skills do they hope to gain in STEL, What are the warning signs for symptoms, how can staff support

them during that period, etc. If there is no admission summary available, then include a summary about the resident. This can include the following information: Psychiatric history, medical history, legal issues, financial information, available supports, etc. If previously in STEL, staff can refer to discharge summary.

7) **Current Diagnosis Info**: Identify DSM-5 code located on the physician authorization. The DSM-5 code in this section needs to match the physician authorization. Staff are to put a ****** sign in Awards next to the primary diagnosis. This is the diagnosis code that will be billed to Medicaid. If additional Axis information needs to be added, click on the "**add new"** link to add any additional diagnosis.
8) **GAF Score:** This score is located in referral packet. If there is no score, then leave blank.
9) **Immediate needs and Initial Services**- Indicate the four services staff will provide to meet the resident's immediate needs. STEL requires three of the four service provided include; Medication management (MMT), Distress Tolerance (SM), and completion of the Initial UR (RC). Objectives are to indicate frequency, behavior, and circumstance. (1x per month staff and Joe will complete a distress tolerance plan, when meeting face to face.)
10) **Needs**: Enter in the text box the initial services. Ex: 1x per month staff and Joe will complete a distress tolerance plan, when meeting face to face.

11) **Service/Plan**: Select the service code (Refer to list of **Reimbursable Services** in this packet for definition of codes). Indicate in the second text box the method, or staff action taken for each service to meet the identified needs.

    Ex: Staff will explain to Joe what a Distress Tolerance Plan is. Staff will use open ended questions with Joe to complete the plan. Staff will encourage Joe to utilize his plan when he is feeling distressed. Staff will provide Joe with a copy. Progress will be documented in the progress notes.

12) **Completion date**: At the top of the page, enter the date the admission note was completed. The admission note needs to be completed on day of admission. Therefore, this date will match the date of admission.
13) Print a copy of Admission note.
14) **Signatures**: Staff/Supervisors signatures and date signed are required. The staff completing the Admission note needs to sign on the date of admission. Obtaining a Resident signature is optional.

Initial UR

The **Initial Utilization Management Review** is conducted within 28 days from admission. The initial Utilization Management Review will have two parts. The first part is the **UM Functional Assessment**. The second part is the **Utilization Management Initial.**

Purpose: The Initial Utilization assesses to which a consumer is receiving appropriate services and being served at the appropriate level of care. The continued stay reviews will ensure that services are appropriate for skill and support building.

In the **Functional Assessment**, the counselor and the resident will need to evaluate each skill area together, and determine the level of independence.

- Using the scale above determine the appropriate skill number 0-3, or N/A.
- When doing the FA, in addition to asking the resident questions, staff should be asking them to demonstrate the skill and asking follow-up questions to accurately assess their skill level.
- If there is a discrepancy in the score between staff and resident in any area, then staff are to indicate that in the comment section.
- Once completed staff are to print.

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The second section titled **Utilization Management Initial**.

will then need to be completed.

1. In the initial UR include the transition plan from the admission note that was written in client's own words.
2. Diagnosis should auto populate from the face sheet.
3. With the resident, complete each section.
4. Question #4, staff may need to be discuss with the manager
5. Determine with the resident if the current level of care is an appropriate placement.
6. The resident and staff are then to identify any recommendations based upon Functional Assessment and input on Initial UR. This can be recommended services that need to be developed, or recommended actions. Example: Develop coping skills, learn how to cook, get photo ID, linkage to a dentist, etc.

7. Refer to attached Initial UR sample.

8. Evaluator needs to sign and date.

9. Acquire signature and date from consumer and encourage written comments.

10. Evaluator provides a copy of UR to consumer after it is reviewed by the Residential Manager/Assistant Residential Manager.

SERVICE PLANS:

1) The Assigned Rehabilitation Counselor will complete within 28 days of admission. The service plan can be completed early but never late.

2) Staff will always involve the resident in the Service Plan process. Staff will ask resident if they would like to include input from family/significant others in the Service Plan.

3) Submit a rough draft of the Service Plan to an Assistant Residential Manager or Residential Manager within 5-7 days of the Service Plan due date.

4) If the consumer is in-patient on the day the service plan is due, it will be completed on due date by the staff member, using information from the Admission Note, referral sources, and any service interventions provided during the month. The Service Plan is presented to the consumer for possible modifications/changes on the day of discharge from in-patient.

5) **Review of the Last 28 Days or Review Since last SP/SPR:** Include significant events, direct observation, treatment recommendations, medication, financial, behavioral issues, information based upon resident input, and any other significant information.

6) **Overall Rehabilitation Goal:** State the overall goal and the target date. This should be in the client's own words i.e. "I will move to the STEL apartment program by (month and year). Goal dates are from 12-24 months. Goals need to be a viable housing option. **Remember: The target date time frame starts from the admission date, and coincide with SPR's**. Ex: Admission is in January. Goal to move to apartments in one year is identified at Service Plan held in February. The goal would read to transition in January 2017, not February 2017(one year from admission).

7) **Criteria for Discharge:** Indicate the resident's criteria for discharge (critical skills needed for them to reach their goal). Ask the resident questions; "Where do you see yourself living in the future. "What do you need to work on to get where you want to be?" Staff may need to provide input, if resident is unable to identify critical skills.

8) **Utilization Review (if applicable):** Include the initial UR recommendations. A Copy of the Functional Assessment should be attached to the Service Plan.

9) **Outcome of Initial Services (Service Plan ONLY):** List the four initial services including the reimbursable code. Re-state the initial service word for word, and document outcome of each. Indicate the status of each initial service. (Attained or Extended).

10) When documenting RC service, list the scores in all Functional Assessment categories on the Initial Utilization Review.

11) **Additional Comments:** Include any additional comments.

12) **Collateral Statement from Consumer:** Residents should be encouraged to provide feedback on the plan, and to make a statement about plan. The staff may write a statement for the resident if the resident does not wish to write.

13) **Collateral Statement from Treatment:** Staff will review plan and request feedback from provider. Staff will provide a copy of plan to provider.

14) **Collateral statement from Family/Significant others:** If there is consent in place, family are encouraged to provide input into plan. If they don't provide input, then indicate the reason. ie: resident doesn't wish to have them involved, family declines, etc.

15) **Participants:** Include the participant's names, and relationship to resident. Include treatment providers and staff who provided input into the Service Plan.

16) **Completion Date:** This will be completed when plan is finalized.

17) **Goal:** Indicate the current goal and target date. See **GOALS** in this packet on how to write a goal. Date established will populate automatically at the completion of the Service plan.

18) **Assessment Statement/Rationale for Goal:** Indicate a rationale for new goal. Why did the resident choose this goal?

19) Objectives should be unique, and based on resident Functional Assessment needs, and/or staff's observation.

20) **Completion date:** This date needs to on or before the due date.

21) All signatures need to be hand written. RM or ARM needs to review and sign. Staff completing Service Plan must sign on the day the plan was completed; client signature must be obtained within seven days from date of plan.

SERVICE PLANS REVIEW:

1. The Assigned Rehabilitation Counselor will complete the first Service Plan Review within 90 days from the admission date. It will then be completed every three months thereafter. The service Plan Review can be completed early but never late.

2. Staff will always involve the resident in the Service Plan Review process. Staff will ask resident if they would like to include input from family/significant others in the Service Plan Review.

3. Submit a rough draft of the Service Plan Review to an Assistant Residential Manager or Residential Manager within 5-7 days of the Service Plan Review due date.

4. If the consumer is in-patient on the day the Service Plan Review is due, it will be completed on due date by the staff member. The Service Plan Review is presented to the consumer for possible modifications/changes on the day of discharge from in-patient.

5. Click the drop-down in the **Include** section and select **Service Plan.**

6. **Review of the Last 28 days OR Review Since last SP/SPR.** Include a summary of the 90 day review period, including significant events, legal issues, doctor appointments, emergencies, participation with treatment etc. (By default, AWARDS will pull in all the responses from your last SP/SPR.) **Be sure to delete old information and make any necessary changes/updates.**

7. **Overall Rehabilitation Goal** : Enter the current goal, and the status. If goal is changed or extended indicate the changes in this section.

8. **Criteria for Discharge**: Indicate what critical skills the resident needs in order to achieve their goal. Criteria should be updated at each SPR.

9. **Utilization Review**: Indicate recommendations from the last Utilization Review and the status of the recommendations. Status of recommendations should be updated at each SPR.

10.) **Collateral Statement from Consumer:** Residents should be encouraged to provide feedback on the plan, and to make a statement on plan. **This is to be hand written only**. The staff may hand write a statement for the resident at the client's request. Resident should initial the statement.

11. **Collateral Statement from Treatment:** Staff will review plan and request feedback from the provider. A copy of plan will be provided. If there is no response from treatment, indicate the dates of attempted contacts.
12. **Collateral statement from Family/Significant others:** If there is a consent in place, family/significant others are encouraged to provide input. If they don't provide input, indicate reason. ie: resident doesn't wish to have them involved, family declines, etc.

13. **Participants**: List any new participants, including resident, collaterals and staff, who provide input into Service Plan Review. (By default, AWARDS will pull in all the responses from your last SP/SPR.) Be sure to make any necessary changes/updates.
    1. Name
    2. Agency as Indicated
    3. Relationship to Resident

14. **Goal:** Manually enter extended or new goal if needed. If goal is the same, no further action is necessary.

15. **Assessment Statement/Rational for Goal**: If the goal has changed or been extended indicate why. If goal is the same, indicate progress made toward goal.

16. **Review of Progress/objective achievement**: Provide a summary of the monthly measurable progress since the last review. Indicate dates the services were provided, brief summary of what was done, and rationale for extending a service if applicable.
17. **Objective Outcome:** Select objective outcome based on how the client has done since last review.

    a) Attained
    b) No change
    c) Progress
    d) Regress

18. Objectives should be be provided for 6 months or less.

19. **Objective Status:** There are three options.

    a) Continued
    b) Revised
    c) Discontinued.

    1) %%%%% For target date extensions choose progress in **objective outcome**, and **Objective continued** in **Objective Status outcome**. Manually enter new target date. Ensure the **objective outcome** matches the status of the objective. An attained objective outcome will always have a discontinued objective status**.** STEL does not use the **Objective Revised option.**

20. **Method outcome** : Ensure the **method outcome status** matches the **objective status**.

21. **New Objective:** Enter the new objective. Make sure to add a rationale for the new objective. (See OBJETIVES section for how to write an objective.

22. **Method Service Code**: Enter method service code (see **Service Code Definitions).**

23. **Method:**. Indicate how the service will be performed. (See section on **METHODS** on how to write a method.)

24. Manually enter target dates for objectives and methods. This target date should match upcoming Service Plan Review.

25. Each Service Plan Review needs to contain a minimum of four billable services. This can be a combination of extended and new objectives, or new objectives only.

26. Ensure all current services are different codes.

27. Services should be unique, and based on resident Functional Assessment needs, and/or staff's observation.

28. Manually enter completion date at top of page. **If the staff member is not scheduled to work on the day the plan is due, the date will need to be changed to coincide with the last day the staff worked prior to the due date**.

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29. **Signatures:** All signatures need to be hand written. RM or ARM needs to review and sign. Staff completing Service Plan Review must sign on the day the plan was completed; client signature must be obtained within one week

30. Include all signatures and dates. Supervisor signature will be different from the staff signature. Supervisor signature should be obtained within the week.

GOALS:

1) Goals are established at the Service Plan. Target dates coincide with the date of admission. They should be a viable housing option, client centered and purposeful.

2) The target date should be written as a month and year.

3) Goals are 12-24 months. If the goal and the target date are unchanged, no further action is necessary.

4) Target dates can be extended, if resident is unable to meet the current target due date. If completing Service Plan Review early, be mindful of target dates, as they may change. Ex: SPR due in March, but, done in February, this would require a change of target date to coincide with future Service Plan Reviews.

5) If the target date is to be extended, manually type in new target date. The rationale for the extension should be documented in the **assessment statement/rationale for goa**l section.

6) If the goal changes, manually enter the new goal with target date. In the **assessment statement/rationale for goal** section, document why previous goal was discontinued and the rationale for the new goal.

OBJECTIVES:

2) Objectives need to be written behaviorally. A behavior can be seen or heard. Objectives are to be written in the following format: frequency, behavior, and circumstance. Each resident needs to have at least four objectives.

3) There should be only one action word per objective. See list of **ACTION WORDS** for examples.

4) Objectives contain frequency units so the resident action can be measured. A frequency unit is either number of times per week or month or percentage of times per week or month.

5) Circumstances are included after the behavior. A circumstance tells you with whom and/ or when a behavior is to be performed. For example, one time per month I will clean my bedroom, with staff assistance.

6) Objectives are discontinued if there is no detectable progress. If the resident has not achieved an objective within six months, we need to further define the underlying skill deficit. Ex: “cleaning bedroom” might be changed to “putting away clean clothing.”

7) If the resident has met the objective criteria, it should be attained, and a new objective developed at the Service Plan Review.

8) Refrain from using works such as **LEARN, IMPROVE, REVIEW** or **ATTEND,** as these are not observable and/or measurable.

9) See **ACTION WORDS** list and **LIBRARY OF OBJECTIVES** for examples.

METHODS:

1) In Method text box, indicate what will be performed, restating the objective. Ex: objective that reads "One time per week, I will complete my laundry, when meeting with staff" will be restated in the method as "One time per week staff and Bob, will meet to complete his laundry."

2) Indicate how the service will be provided. Ask yourself the question how will I provide training, or help the resident develop the skill. Be specific. If you are going to use worksheets, indicate where worksheets are located. (Life Skills workbook, internet, information provided from doctor or pharmacy etc).

3) The method section includes what staff action is needed to accomplish the objective. For example, if the objective reads- "1X per week, I will complete my laundry, when meeting with staff", the method section would start with – 1X per week staff and Bob will meet to complete laundry. Staff and Bob will gather his dirty laundry. Staff will provide transportation to laundromat. Staff will show Bob how to separate whites from darks, demonstrating how not to overfill machine. Staff will demonstrate how to add the proper amount of soap. Staff will then ask him to perform skill. Staff will demonstrate how to operate washer, and ask him to perform skill. Once wash is done, staff will repeat steps to using the dryer. Staff will teach Bob how to fold his laundry. Staff will be available for any questions or concerns Bob may have. Staff will document progress.

4) Method section will include all staff action to teach the resident how to perform the skill (explain how, demonstrate, tell, show, do, provide hands on assistance, etc). The method should show plenty of staff action, and be detailed, so that any staff member could provide this service.

5) The behavior in the objective and the method should match. For example: If the objective states. "Monthly I will develop a budget, your method activities need to focus on developing a budget. It shouldn't include following a budget, or doing banking.

6) For Method examples, **see LIBRARY OF METHODS.**

SERVICE LINKED NOTES:

1) Select the **Service Type** from the drop-down menu. If you choose a service type that is not part of SP/SPR, you will receive an error message, stating “sorry, no match found.”

2) Select the **Location** of the contact from the drop-down menu.

3) Select the **Date** the note happened from the drop-down menu.

4) Select the **Duration** of the note. A billable service needs to be a minimum of fifteen minutes.

5) Select the radio button for **Face to Face**

6) Select the **Start Time** from the drop-down menus including AM/PM

7) Select the **Contact Method** from the drop-down menu.

8) Select the radio button for **Service Plan Linked.**

9) The objective and method will already be typed for you.

10) Write the staff and client action that was performed to complete the service. Ensure that you follow the method when providing the service**.** Include some examples of the work that was done. Attach any worksheets, budgets, menus, written work by the resident, etc.

11) Include measurable progress, recommendations for change if needed.

12) If the frequency of the behavior is more than monthly (weekly, biweekly), non-billable contacts in the progress notes must be documented under **General Chart Notes.** We can only bill one time per month for each service.

13) Four service contacts are required for a full month billing (21 days total in program); two service contacts are required for a half month billing (11 days total in program).

14) Home leaves count toward number of days in STEL. Hospitalizations, Rehab, and Incarceration do not count toward number of days in STEL. The day of admission to any of these units DOES NOT count toward the number of days in the STEL. The day of discharge from any unit DOES count toward number of days in program.

15) If a client residing at Perkins Hall gets hospitalized on 1/3/17, then discharges directly from hospital to DTA on 1/13/17 on respite only. A formal admission is then completed on 1/16/17 to DTA. Although client has only been in DTA for 16 days, and "appears" to be only eligible for half a month of billing, including days at Perkins but it is actually 21 days in STEL and therefore would be a full month billing.

16) All face-to-face restorative service contacts are required on separate days for each resident during the calendar month and should be provided at least 1X weekly.

17) In the event that a client is going to be transferring from one program to another, it is expected that the discharging program will have completed at least 2 service before the 11th, and 4 services by the 21st.

18) A service may occur at or away from the program, except that a contact may not occur at an OMH licensed outpatient program or any inpatient facility.

19) If a Service Plan Review is due mid-month, all four current objectives do not need to be completed prior to the review. However, four services are still needed, and can be a combination of extended or new objectives.

20) If a Service Plan Review is completed mid-month, ensure that you are not providing the same service code in the same month. Ex: A DLS service to clean room was completed at the beginning of the month, and attained at the Service Plan Review. A new DLS service to do laundry was developed and although different, it cannot be provided in the same month. Duplicate service codes are not billable.

21) Billable Services are to contain all of the staff action rendered in delivering the service. If there is little staff action, was it a reimbursable service? Ask yourself, was the service worth $600.

Utilization Review:

The **Utilization Review** is conducted 6 months from admission date and at

12 month intervals from admission date thereafter. All UR meetings that cover 6 and 12 month intervals need to have resident, the evaluator, and one objective person present. All UR meetings that cover intervals 24 months or greater need to have the resident, evaluator, and two objective people present. At the resident's request, significant others and treatment providers will be invited.

Procedure:

At the **Consumer Service Menu** click on the **Utilization Management Review**. In the drop down box identify the consumer, click continue, and click **Create new Utilization Management Review.**
Click on tab **Update Utilization Management Review Section.** Complete this section with the resident prior to UR meeting. Save. Do not proceed to the next section entitled **Outcome of Review** until after the UR meeting is held.

Preparing for UR:

Meet with the resident five to seven days prior to the UR meeting.

Staff member conducts the preliminary UR meeting with the resident, completing the Functional Assessment and the first section of the UR.

Orient the resident to the UR process (What, Why, Roles). Review meeting time, place, and the names of the people who will be attending the meeting. Identify who will facilitate the UR. The resident should be encouraged to lead their own UR. They may need guidance on how to do this.

Staff and resident work collaboratively rating skill areas. Any discrepancies in the ratings will be addressed in the comment section and discussed at the UR meeting.

Outcome of review will be completed by participants during the UR meeting.

The staff conducting the UR should review completed form prior to meeting.

The evaluator should make sure the resident is there for the meeting as scheduled. Please confirm the time and dates of the meeting with your manager.

Submit UR documentation to a Residential Manager/Assistant Residential Manager for review 2 to 3 days prior to UR meeting.

Conduct the UR Meeting:

1. Introduce everyone in attendance.

2. Review the purpose of the meeting as stated in the policy.

3. Explain the roles of the people present.

4. Review the client's understanding of the roles and purpose.

5. Provide copies of the UR and a list of current services for all those attending the meeting.

6. Orient to Functional Criteria.

    - Review rating scores to assess the consumer's need for staff support in different skill areas. Any discrepancies in ratings will be addressed.

    - .The Functional Assessment is used so that we can ensure an accurate assessment of their current level and help guide us in developing an appropriate, person centered Service Plan/SPR with the client It is not a grading system nor a rating by staff, and any words implying this should be discouraged. Ex: Jim and I determined that his skill level in this area is a 2. You want to avoid stating " **I** (the staff) gave Jim a 2 in this area."

    - Indicate the appropriateness of the ORG by comparing current levels of skill functioning to those required by the target level of care.

8. Summarize overall rating scores.

    - Discuss column totals.
    - Identify skills the consumer needs extra support in.
    - Discuss barriers to skill use and possible ways to overcome these barriers.
    - There may be a need to prioritize several different skill use deficits and address only those that are most pressing.

9. Discuss answers to questions 1-5.

10. Complete the outcome of the review.

Solicit recommendations of the UR Team on what services STEL can provide to assist with mental and/or physical health.

Document actions recommended by the UR Team as identified throughout the meeting.

Indicate the need for risk management, distress tolerance, and/or a behavioral contract/plan.

Indicate if continued stay or movement to another level of care is recommended by the UR Team based on information discussed.

Indicate if the consumer agrees with UR Team recommendations.

Acquire signatures from all persons contributing to the meeting and encourage a written comment from the client.

ENSURE THE CONSUMER IS AN ACTIVE PARTICIPANT IN THE MEETING