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# **COMMUNITY SUPPORT SERVICES**

**Overview for Executive Staff  
and other Stakeholders**

**2/23/15**

# Training Objectives

- What are Community Support Services (CSS)?
- What is psychiatric rehabilitation?
- Why implement a Medicaid / Rehabilitation service?
- In what ways will service provision and documentation change?
- What will be billable? What won't be billable?

# What are community support services?

“Mental health ***rehabilitation services and supports*** necessary to assist the client in achieving mental health ***rehabilitative and recovery goals*** as identified in the ***individualized rehabilitation plan***; including achieving and maintaining ***valued life roles*** in the social, employment, educational and/or housing domains; and to restore a consumer’s level of functioning to that which allows the consumer to achieve ***community integration***, and to remain in an independent living setting of his/her ***choosing***”.

- NJ State Plan under Title XIX of the Social Security Act

# What is psychiatric rehabilitation?

- Set of values & principles that guide staff attitudes and actions
- Set of methods that has been developed and refined since the late 1970's
- Lessons learned from early days of de-institutionalization:
  - Treatment that reduces symptoms is very important,
  - but not sufficient for optimal community adjustment
- Psych Rehab interventions are evidence-based or “promising” practices”

Anthony, Cohen, Farkas & Gagne (2002). *Psychiatric Rehabilitation (2<sup>nd</sup> edition)*. Boston, MA: Center for Psychiatric Rehabilitation, Boston University.

# Psych Rehab/Recovery Philosophy

## VALUES

- Self-determination
- Optimism about growth, learning, recovery
- Valued social roles
- Normalized environments
- Wellness
- Cultural diversity

## KEY PRINCIPLES

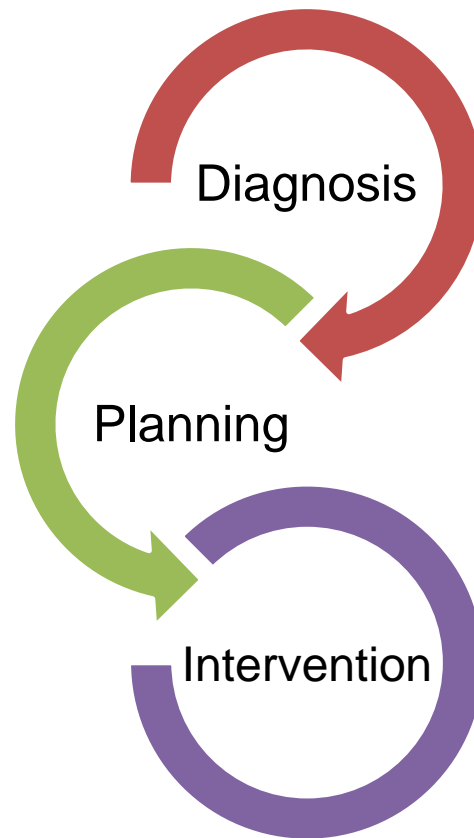
- Person centered
- Strengths focused
- Emphasis on goal-related skills training
- Utilization of natural supports
- Utilization of peer support

**Pratt, Gill, Barrett & Roberts (2014).**  
*Psychiatric Rehabilitation (3<sup>rd</sup> Edition).* San Diego, CA: Elsevier - Academic Press

# Psychiatric Rehabilitation Methods

- Engaging to build a supportive partnership
- Identification of goals that are:
  - Chosen by the person
  - Related to valued social roles and normalized environments
- Goal related assessments
- Goal related skills development
- Goal related resource acquisition

# Psychiatric Rehabilitation Process



# Rehabilitation Diagnosis





# Why implement a Medicaid service?

- Sustain community based services
  - Medicaid is an entitlement and provides sustainability
  - Eliminates vulnerability and fluctuations that often accompany state funding
- Realize and re-invest cost savings
  - Fund new or not covered services, individuals not eligible for Medicaid, expand bridge subsidy program

# Why implement a Medicaid service?

## Assure accountability:

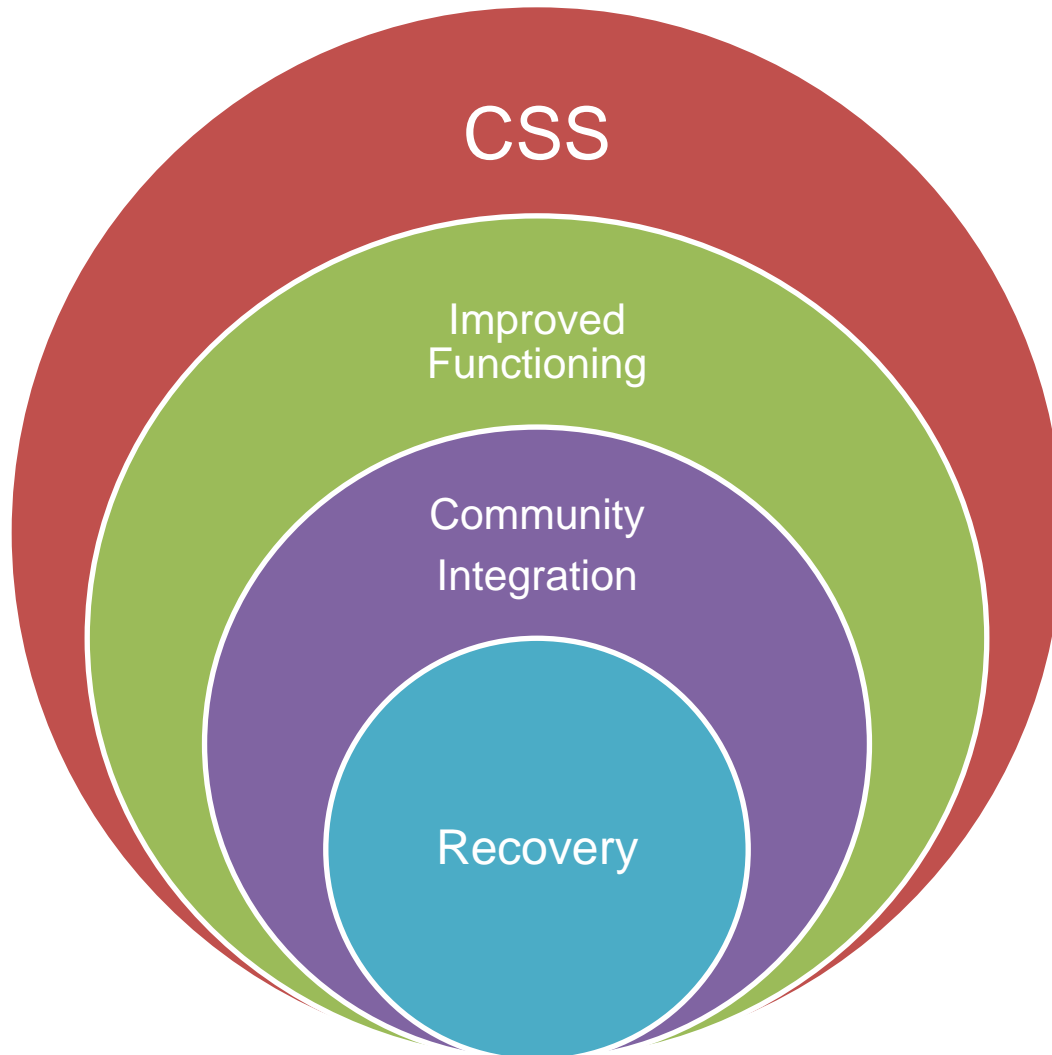
- Time spent with individuals should be meaningful and lead to desired improvements for the individual (e.g. reduced hospital days; increased independent functioning)
- Staff should account for services and activities provided
- When services don't result in desired outcomes, staff should try something else

# Why Implement a Rehabilitation Service?

- CSS promotes community integration
- Aligned with the “Integration Mandate” of the Olmstead Decision
- Essential for successful execution of the Olmstead Settlement Agreement
- Community integration means not just living in the community, but actively participating (valued social roles)
  - Physical, social and psychological integration

# Why Implement a Rehabilitation Service?

- CSS's intended to provide both support and rehabilitation
- Intended CSS outcomes:
  - Restore, regain, strengthen skills and supports necessary to achieve chosen goals
  - Promote success and satisfaction in chosen environments and valued social roles



# Why change the system now?

- The system has been preparing for this change for some time...
  - First raised in the Governor's MHTF Report in 2005
  - More clearly articulated in W&R Transformation Action Plan in 2008-2010
  - Approved by CMS in 2011
  - Training of supervisors and staff began 2/14
- Medicaid billing of CSS services will begin late 2015 or early 2016

# The 6 CSS Service Components

## [from NJ SPA]

1. Comprehensive Rehabilitation Needs Assessment (CRNA)
2. Contributing to the development, implementation, monitoring and updating of the Individualized Rehabilitation Plan (IRP)
3. Rehabilitative Skill Development
4. Illness Management and Recovery
5. Crisis Intervention
6. Coordinating and Managing Services

# Begin With The Individual's Goals

- Recovery Goals
  - Identified by the individual
  - Address many parts of persons' lives
    - 8 Dimensions of Wellness
- Valued Life Roles
  - Tenant, worker, student, friend/member/partner
- Life in the community
  - Social integration
  - Engaged, active, valued community member



# #1: Comprehensive Rehabilitation Needs Assessment (CRNA)

- Explores person's aspirations, values and goals
- Assesses areas that may support goal attainment:
  - Current and desired social supports
  - Educational/vocational experience and interests
  - Existing advance directive or crisis intervention coping strategies
  - Other strengths and resources

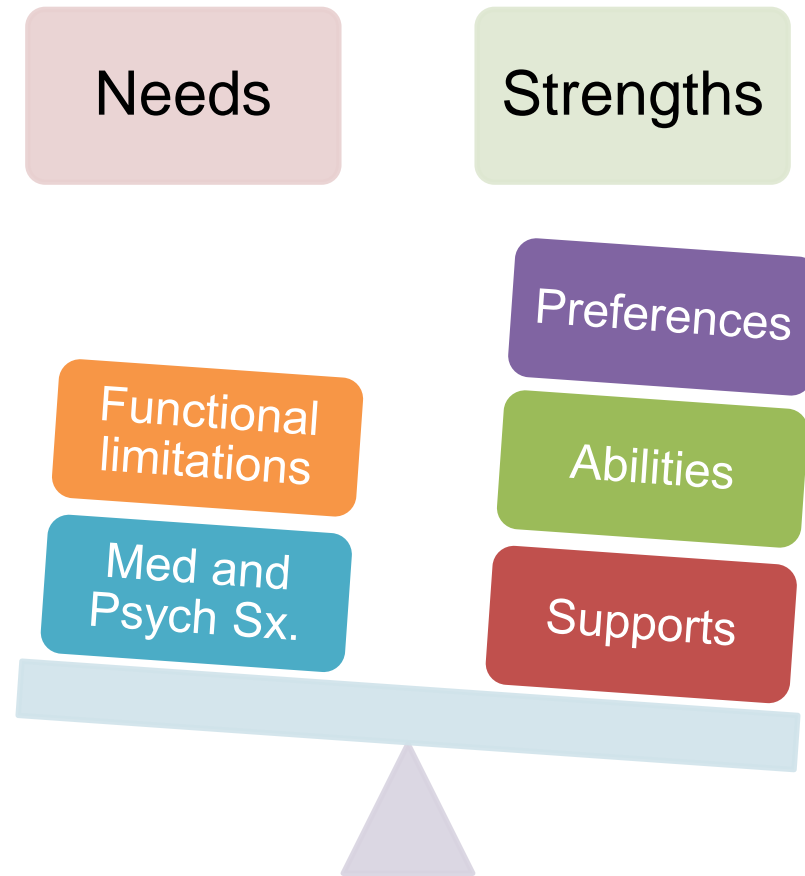
## CRNA (continued)

- Also assesses current or potential barriers to goal attainment:
  - Current psychiatric symptoms and recent psychiatric history
  - Concurrent PTSD and/or substance abuse diagnosis
  - Current or recent challenging behaviors
  - Criminal justice involvement
  - History of non-adherence to medication
- Based on person's current and past experiences
- Not based on an assumption made by staff as to how symptoms, deficits, etc. ***might*** impede goal attainment

# Comprehensive In Depth

- Knowledge
  - What does the person need to know to achieve goal?
- Skills
  - What does the person need to be able to do achieve goal?
- Resources
  - What does the person need to have to achieve goal?

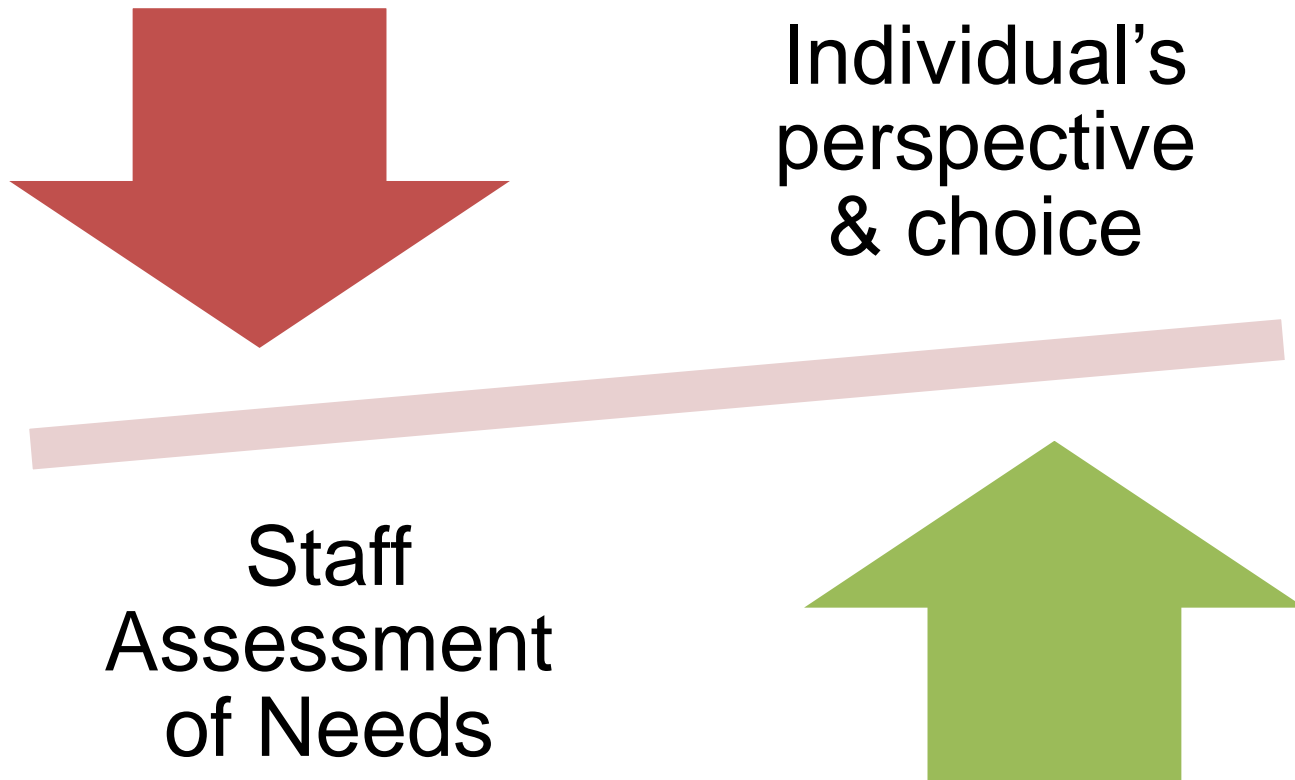
# Balance of Strengths & Needs



## #2: Individualized Rehabilitation Planning

- Individualized ***Rehabilitation*** Plan – not Individualized ***Recovery*** Plan
- The IRP is directly informed by the CRNA
- Person centered planning rather than staff centered planning
- IRP must be updated as needs change - or as staff gets to know more about the person
- Most interventions provided and documented and should be on the IRP
- Remember - updating the IRP is a reimbursable service

# Person Centered Planning



## #3 Rehabilitative Skill Development

- Emphasized in the NJ SPA
- Aimed at promoting community integration and restoring person to the maximum possible functional level
- At *minimum* skill teaching involves:
  - Discussions with the consumer about rationale for learning the skill
  - Breaking the skill down into its component parts
  - Modeling the skill
  - Watching the person use the skill and providing feedback on performance
  - Arranging opportunities to practice skill use in community settings
- This skills development approach is an EBP and with some exceptions is *not* what is happening in most SH/RIST programs

# What types of skills do consumers need to learn?

- Skills that promote success and satisfaction in their living environments
- Skills related to achievement of their chosen goals
- Including but not limited to:
  - Independent living / ADL skills
  - Social skills
  - Skills related to accessing & using health service (e.g. asking the doctor questions)
  - Skills related to accessing & using entitlements
  - Health and wellness promotion skills
  - Cognitive skills (e.g. problem solving)
  - Work readiness skills



## #4 Illness Management and Recovery

- IMR Training and Support includes co-occurring substance use disorders
- Symptom monitoring and support in learning to self-monitor
- Medication management
- Education and training about MI, SA, and the recovery process
- Relapse prevention
- Evidence based practices including: motivational enhancement, cognitive behavioral techniques and behavior modification techniques

## #5 Crisis Intervention

Face to face interventions short term interventions:

- Developing crisis plan and psychiatric advance directives
- Brief situational assessments
- Verbal interventions to de-escalate the crisis
- Assistance in immediate crisis resolution
- Mobilization of support systems
- Referral to other services needed

## #6 Coordinating and Managing Services

- Accessing
- Linking
- Coordinating
- Monitoring
- SPA is somewhat vague in this one

# WHAT CHANGES WILL YOU SEE IN THE WAY SERVICES ARE PROVIDED AND DOCUMENTED?

# CSS's are Goal vs. Illness Driven

- Medical necessity a requirement as with most Medicaid services, but illness and deficits do not drive the process or services
- Functional deficits and impact of symptoms are assessed within the context of if and/or how these may impact a person's goal attainment

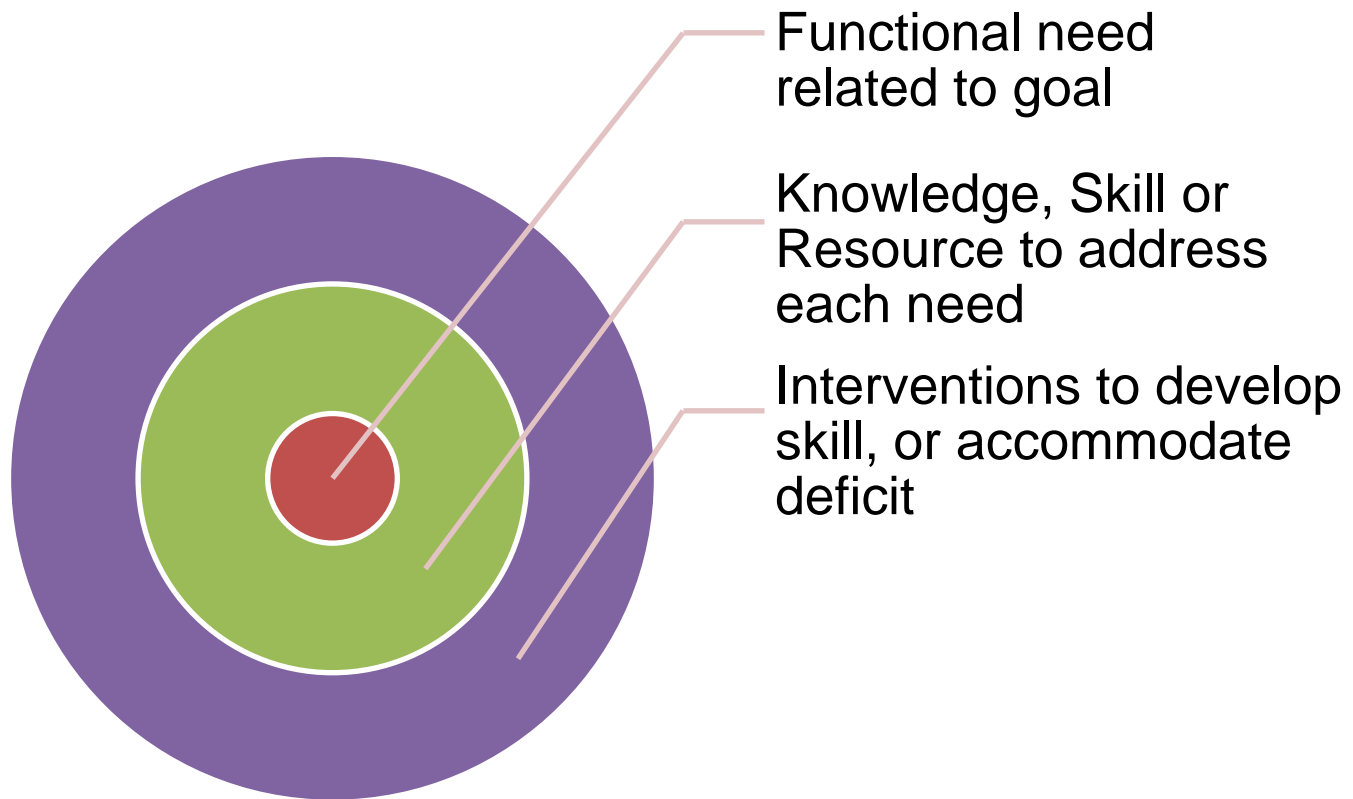
# Intentional Services

- Support staff have a plan for what service(s) will be provided before the visit
- Services provided relate to the person's IRP
- Each service provided has a specific and intended outcome
- Services are individualized and provided face to face
- Improve or restore performance (functioning)
  - Less care taking and “doing for”
  - More “doing with” and always finding & using the teachable moments

# Purposeful Visits

- Reframe and redefine staff visits to individuals
  - “Going to check in on Bob”, “Dropping off Mary’s meds” ...
  - “Bob and I are going to review how he is settling into his new apartment and if the coping skills he has been learning are working for him”.
  - “Mary wants to discuss taking less medications so we’re outlining questions for her to discuss with her doctor next week”.

# Focused Interventions





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## **Common Challenges**

# High Risk Home Based Behaviors

- Unwanted roommates (e.g. drug dealers have taken up residence, prostitution, non-criminal but unwanted)
  - How are staff currently responding to and addressing these types of situations?
    - How do these relate to or are similar to CSS component activities?
  - Assess safety and intervention needs
    - Possible CSS activities: CRNA, Contributing to the development of the IRP, IMR, Skills development, Crisis Intervention
    - Possible non-CSS activities: police intervention, negotiating with landlord without the individual present
  - What behaviors are contributing to this situation?
    - Assess skill and support needs and add to IRP

## **Serious and persistent SA that is jeopardizing housing**

- How are staff currently responding to and addressing these types of situations?
  - Similarities to CSS component activities?
  - Differences from what is available through CSS?
- Assess (potential) impact on housing
  - Ability to pay rent, utilities
  - Behaviors that are jeopardizing tenancy
  - Degree of preference for own apartment

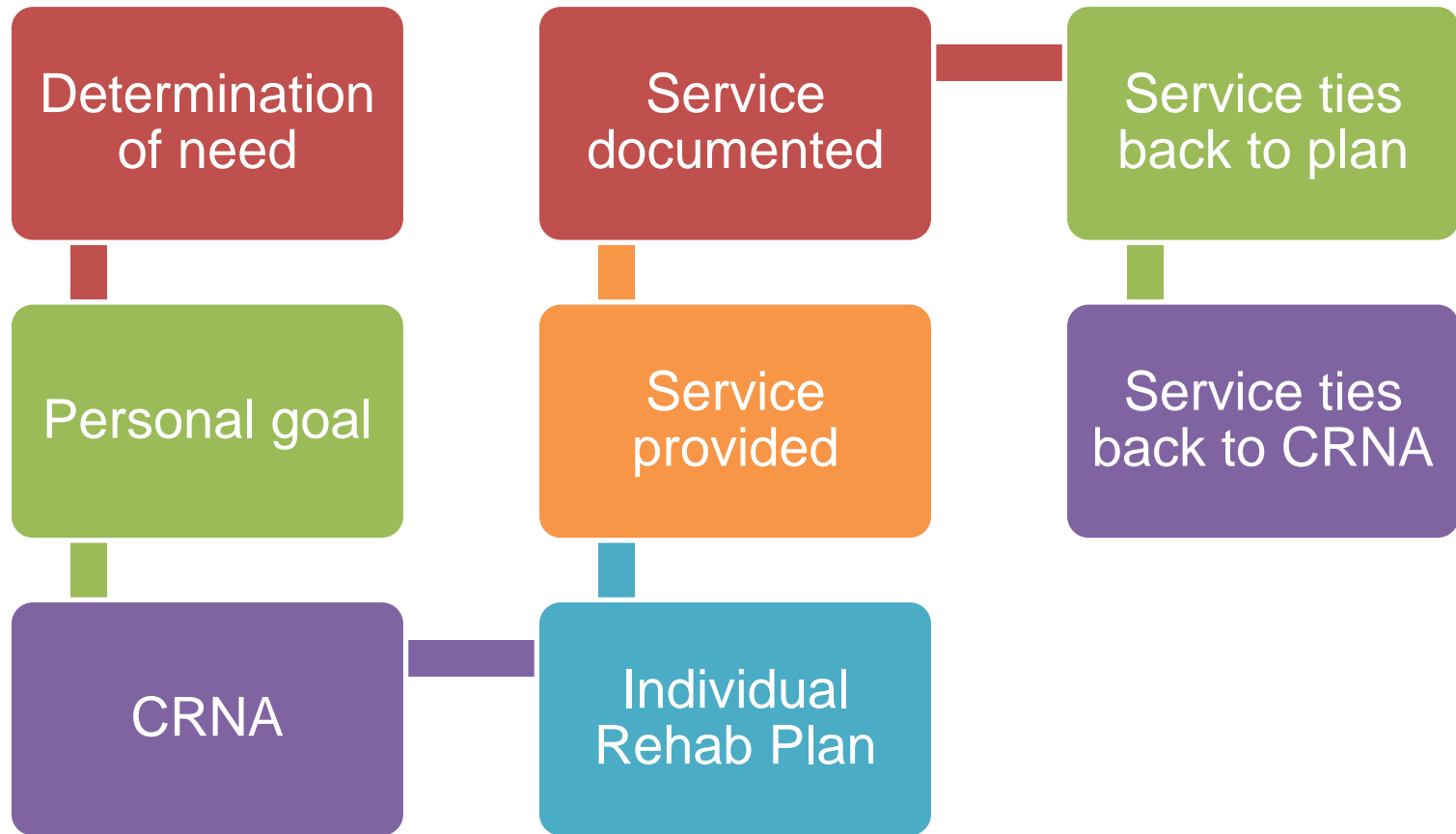
## Significant impairment for self-care

- Unable or unwilling to take care of personal grooming to the extent that it jeopardizes health
  - Explore eligibility for other services (personal care, home health, etc.). Make referrals. Assist person to competently use available services/resources.
  - Incremental movement from “doing for” to “doing with” to “doing with prompts and real time assistance” to “doing on own with feedback”

# Not interested, thank you very much

- No need or interest for rehabilitation services
  - “But I do need a ride to the grocery store”.
    - Assist to make other arrangements that can be sustained
    - Use time to explore possible areas of interest, assess/monitor progress towards current goals (e.g. “How’s it going with your girlfriend? Are you able to use the skills you learned?”)
    - No way around it, not billable
  - You have done your job.
    - The person is able to meet his/her own needs.
    - Regular monitoring of current IRP and other services received (e.g. monthly visits)

# “The Golden Thread”



# “The Golden Thread” AND Wellness and Recovery

- Easy to get lost in administrative and documentation requirements
- Agencies and DHS should be keeping their eyes on the prize
  - Remember WHY the CSS SPA was written
  - CSS is an important step in realizing system transformation

# Performance Feedback Loop

- Effectiveness of activity and intervention evaluated immediately – not at the 3 month IRP review.
- Skills programing: Multiple and varied practice opportunities are created and arranged
- Interventions and strategies are adjusted based on performance
  - “Maintaining” is not a billable intervention
  - If it isn’t working don’t keep doing it!



# Billable or not billable?

## Billable

- Developing CRNA with consumer
- Developing IRP with consumer
- CSS interventions that relate to CRNA and IRP
- Intervention NOT on IRP with note that new need identified and intention to update CRNA/IRP
- Crisis services

## Not Billable

- Repeated provision of intervention NOT related to CRNA and IRP
- Working on CRNA/IRP without consumer
- Service provided after IRP expires
- Service that is not needed (e.g. person already has skill being taught)
- Ongoing provision of service with no functional improvement

# Creative Ways to Make it Billable

- Reviewed skill of “asking my doctor questions” in car on the way to Dr’s office
- Turned grocery shopping trip into healthy living skills development session
- Other ideas?
- Not everything will be billable!
- DMHAS will continue contract funding for some non-billable services

# Prior Authorization Process

- Documents medical necessity of CSS services
- CRNA
- Preliminary IRP
- 60 days post enrollment for new clients
- Phase in schedule for existing clients

# Documentation

- Model templates are needed for:
  - CRNA
  - Preliminary IRP
  - Ongoing IRP (needs to be a living document)
  - Progress notes that address IRP goals, which CSS service(s) were provided, duration of service, credentials of provider
- 10:37B Regulations will be out soon and will clarify what is needed
- Focus groups with providers to obtain feedback on model templates are also coming soon
- Regional documentation training sessions

# CSS Brings Change

- What stays the same
  - The goal to support and promote ***recovery*** and ***community integration***
- What needs to change
  - Staff practice and service delivery
  - Relationships between individuals and staff
  - Documentation practices
  - Business practices and operations of provider organizations

# Next Steps

- Ongoing CSS training for your direct care staff and supervisors
- Updating your documentation tools
- Updating your billing systems

# Wrap-up

- How was the information provided helpful?
- What questions do you have?
- How can DMHAS and Rutgers SHRP continue to assist providers in transition?

# Contact Information

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