

Exhibit A

Psychiatric Home Health
Adult & Child
Level of Care Guidelines

2013 Revision

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A. HOME CARE NURSING SERVICES – Medication Administration, Pre-Pour and Skilled Nursing Visits (Adult and Child)

Definition

Home Care nursing services are services provided exclusively by a licensed home health care agency on a part-time or intermittent basis in the client's home. Medication Administration services (MedAdmin) may be provided by a Registered Nurse or Licensed Practical Nurse employed by a licensed home health care agency, when ordered by a Licensed Physician. Services include medication administration or medication pre-pouring by a Registered Nurse or Licensed Practical Nurse as well as skilled nursing visits.

A registered nurse may delegate the administration of non-injectable medications to homemaker-home health aides who have obtained certification for medication administration in accordance with regulations in the Connecticut General Statutes section 19a-490, unless the prescribing practitioner specifies that a medication shall only be administered by a licensed nurse.

Medication administration may be delegated when the registered nurse determines that it is in the best interest of the client and the homemaker-home health aide has been deemed competent to perform the task.

All home health services are to be driven by Recovery principles. Under that model, members are understood to be capable of movement toward self-sufficiency and independence, and therefore home health services are expected to assist the members in reaching their fullest potential including progress toward self-administration of medication when appropriate. With MedAdmin services, this Recovery model requires efforts to assist the member through skills transfer, education, and involvement of any and all available community resources, as appropriate. The extended, ongoing use of MedAdmin services should be considered an exception, and even in those cases in which long term services are required, the service provider(s) are expected to continue their efforts to assist with Recovery, autonomy and self-sufficiency.

A nursing MedAdmin visit includes the administration of oral, intramuscular and/or subcutaneous medication and also those procedures used to assess the client's behavioral health/medical status, as ordered by the prescribing practitioner. Such procedures include but are not limited to glucometer readings, pulse rate checks, blood pressure checks and/or brief mental health assessments. Medication can be administered while the nurse is present or the dose(s) can be pre-poured for client self-administration at a later time(s). Medication can be administered at a frequency appropriate to the client's needs. Documentation should include reasons why the client is unable to administer medication on his/her own. The visit also includes Recovery-oriented skills transfer activities and teaching of medication self-administration to the client or to the client's family member(s) or other available natural supports such as

roommates, friends or volunteers from community-based organizations such as church groups. If the client or supports are unable to benefit from teaching, such information should be documented in the medical record. Teaching should include skills transfer activities leading to testing for independence whereby the client is pre-poured medication over longer and longer periods of time and assessed for his/her ability to manage independent medication administration during the scheduled nursing visits. Areas for skills transfer include, but are not limited to, memory cueing, emotional regulation, assessment of the member's ability to recognize and report side effects of medication, medication education and teaching about potential consequences to non-adherence. Teaching may also include the use of available assistive technologies such as electronic medication boxes and tools to help remind the client to take medication at the appropriate times of day.

If, during the course of a scheduled MedAdmin visit, there is a change observed in the client's functional status and the client's prescribing practitioner must be notified, the MedAdmin visit may become a skilled nursing visit. If the MedAdmin visit is being performed by a Home Health Aide and a change in condition is observed, then the Aide will notify the delegating nurse who may perform a skilled nursing visit for assessment. This may occur even if a revision to the client's plan of care is not required. The client's medical record should be fully updated to reflect the change in medical/behavioral health observed during the visit, the additional skilled services provided to the client and revisions, if any, made to the plan of care. If this situation occurs and the services have been prior authorized, the provider should contact the CT BHP to request modification of the prior authorization, which was for medication administration only.

A medication pre-pour for a week or more may be considered a skilled nursing visit. Pre-pours must be performed by a nurse and may not be delegated.

The following criteria are for those individuals with a behavioral health diagnosis where the primary reason for the visit is psychiatric in nature based upon the list of approved psychiatric diagnoses provided by the Department of Social Services.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. Initial authorization will include up to 2 skilled nursing visits plus up to 60 units of medication administration for up to 60 days. Additional days and units may be authorized prior to the completion of the original authorized if needed. This schedule will allow for the assessment of the client's needs for future home health nursing care. The home health care agency will present the Home Health Plan of Care (CMS 485) as part of authorization for further treatment. Use of the Home Health Functional and Needs Assessment form (Attachment A) or similar documentation by the prescriber and home health care agency is encouraged. The Home Health Plan of Care must include Medication Reconciliation, planned interventions, individualized for the member to advance Recovery and Skills Transfer, and measurable goals related to the client's ability to independently self-administer medication, or the ability of family members or other natural supports to supervise self-administration. Time frames for concurrent authorizations are individualized according

to intensity of client need based upon the Home Health Plan of Care and the physician's order. Medication administration services may be concluded when either the client can independently administer medication or a family member or other support can supervise self-administration of the medication.

When a client transitions from a higher level of care to the community and he/she has an existing community-based prescriber (psychiatrist or prescribing community physician), a Physician's Order from that community prescriber must be included with the initial authorization request. If the Verbal Order is not signed by the prescriber, documentation of telephonic care coordination may be substituted.

If a Physician's Order from the community prescriber cannot be obtained because the member does not yet have a community provider, a Verbal Order from the referring physician may be substituted for up to 30 days. Subsequent authorization requests must include a completed CMS 485.

Level of Care Guidelines:

A.1.0 Admission Criteria

A.1.1 Symptoms and functional impairment:

- A.1.1.1 Must be primarily the result of a psychiatric disorder which drives the need for care, **AND**
- A.1.1.2 The psychiatric illness or condition is chronic and ongoing and not based on a temporary decline in function resulting from a situational or psychosocial stressor, and not based solely on a brief period of escalation of acute symptoms, **AND**
- A.1.1.3 Functional impairment not solely a result of Mental Retardation, **AND**
- A.1.1.4 Are best managed by a psychiatric ASO care manager, and do not exclusively require ongoing oversight of complex medical conditions by a medical ASO care manager.

A.1.2 Intensity of Service Need for Medication Administration one time per day or more

- A.1.2.1 Client's level of understanding of need for medication is limited by a behavioral health condition and requires provider observation/intervention in order to promote medication compliance **OR**
- A.1.2.2 Within the past 30 days, client has had an episode of medication non-compliance which led to decompensation and/or behavioral dyscontrol **OR**

- A.1.2.3 Within the past 30 days client has had an episode of serious overdose on medications or demonstrated a risk of impulsive, unsafe, independent self-administration of medication **OR**
- A.1.2.4 Client discharged from a supervised setting where client was not self-administering medication within the past 30 days and requires direction and teaching regarding medication, dose, time, therapeutic and side effects, drug-drug interactions, or food-drug interactions **OR**
- A.1.2.5 Client has had a change in mental status and/or behavior due to a behavioral health condition that may impact the safety of self-administration **AND**
- A.1.2.6 Client has no one in the home with the demonstrated ability to support/assist with medication administration

A.1.3 Intensity of Service Need for Medication Pre-Pour

- A.1.3.1 Client has not met requirements for medication administration (A.1.2), but a degree of disorganization or other functional impairment secondary to the psychiatric disorder exists such that the services of a nurse are required to pre-pour the medications for self-administration over the course of a week.

A.2.0 Continued Care Criteria for Medication Administration one time per day or more

- A.2.1 The client continues to meet criteria for medication administration and there is evidence of active treatment and care management as evidenced by:
 - A.2.1.1 Type, frequency, and intensity of services are consistent with care plan, **AND**
 - A.2.1.2 Client's recovery oriented Home Health Plan of Care (CMS 485) includes goals of medication monitoring/self-administration and a plan to support the client to independently manage his/her own medication, including a transition of reliance on Med Admin visits to community based services and social supports when possible. The Home Health plan and goals are to be updated **no less often than every 60 days, AND**
 - A.2.1.3 The Home Health Plan of Care includes updated assessment and documentation of client's knowledge base around the role of medication in stability and recovery, skills transfer activities, and assessment of the effectiveness of plan and progress towards measurable goals **at least monthly, AND**
 - A.2.1.4 The Home Health Plan of Care includes updated teaching of independent medication administration skills, development of skills for independent medication administration, use of

available assistive technologies, assessing for natural supports at home and in the community, and testing the client for independence in taking prescribed medication at least monthly, **AND**

A.2.1.5 Client and support network continue to demonstrate need for care at existing level. The tests for independence do not yet demonstrate success in skill acquisition and are documented in the care plan at least monthly.

A.2.2 If the client does not meet criteria listed above, continued daily medication administration may be authorized if any of the following are true:

A.2.2.1 Circumstances have changed in the client's support network such that those who have been taught to supervise medication administration are no longer available or able to take on that function **OR**

A.2.2.2 Client or client with assistance of support network is making progress, but have yet to achieve goal of consistent self-administration or supervised self-administration **OR**

A.2.2.3 The severity of the Client's impulse control or judgment places him/her at risk for harm to self or others in the absence of supervision of medication administration by a nurse, as evidenced by recent (within past 90 days) or recurrent events **OR**

A.2.2.4 Client has met maximum recovery potential at the immediate time and remains in need of ongoing services.

A.2.3 The client does not meet continued care criteria if:

A.2.3.1 The client is able to independently self-administer medication or the client has assistance from family members and/or other people in his/her support network that are able to supervise self-administration.

A.2.3.2 The client and support network refuse continued participation in treatment, including frequent absences from the home when medication administration visits are scheduled, in which case the home care agency will communicate with the client's treating physician(s) and CT BHP for other service referrals.

A.2.3.3 Documentation does not support the need for services outlined in Section A.2.1 or A.2.2 above including lack of current clinical information.

A.3.0 Continued Care Criteria for Pre-Pour

- A.3.1 Client does not meet continued care criteria for medication administration (A.2.0), but continues to require the aid of a nurse to pre-pour medications for self-administration.

B. HOME HEALTH AIDE SERVICES (ADULT AND CHILD)

Definition:

Home health aide services are services provided exclusively by a licensed home health care agency on a part-time or intermittent basis in the client's home. This service may be provided by a Home Health Aide when ordered by a Licensed Physician. Services of a Home Health Aide include hands-on care or assistance with an Instrumental Activity of Daily Living (IADL). Specific services include but are not limited to assistance with personal care activities (ADLs) including bathing, oral hygiene, feeding and dressing as well as assisting the client with exercises, ambulation, and transfer activities. Home Health Aide assistance also includes the prompting and cueing necessary for a client to perform these activities. Home health aides may also supervise adherence to prescribed self-administered medication. Other activities may include performing normal household services essential to patient care at home, including meal preparation, laundry and homemaking activity, but only to the extent that such activities are directly related to the hands-on nursing. All Home Health Aide services are provided under the supervision of a Licensed Registered Nurse employed by a licensed home health care agency.

All home health services are to be driven by Recovery principles. Under that model, members are understood to be capable of movement toward self-sufficiency and independence, and therefore home health services are expected to assist the members in reaching their fullest potential. With Home Health Aide services, this Recovery model requires efforts to assist the member through skills transfer, education, and involvement of any and all available community resources, as appropriate. The extended, ongoing use of Home Health Aide services should be considered an exception, and even in those cases in which long term services are required, the service provider(s) are expected to continue their efforts to assist with Recovery, autonomy and self-sufficiency.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. The home health care agency will present the home health aide care plan as part of authorization for further treatment. The home health aide care plan will include measurable goals and objectives relating to client independence, unless such goals are medically inappropriate. If a client is receiving home health aide services more than once a day, the home health aide care plan for each shift must be submitted as part of the authorization request. Time frames for future authorizations will be individualized according to intensity of client need based upon the Home Health Agency Plan of Care and the physician's order. Services may be concluded when the client can independently perform ADL's, a family member or other natural support is able to assist the client, or it is established that the client requires a more intensive level of care in a setting other than home.

Level of Care Guidelines:

B.1.0 Admission Criteria

B.1.1 Symptoms and functional impairment:

- B.1.1.1 Must be primarily the result of a psychiatric disorder which drives the need for care, **AND**
- B.1.1.2 The psychiatric illness or condition is chronic and ongoing and not based on a temporary decline in function resulting from a situational or psychosocial stressor, and not based solely on a brief period of escalation of acute symptoms, **AND**
- B.1.1.3 Functional Impairment not solely a result of Mental Retardation.

B.1.2 Intensity of Service Need

- B.1.2.1 Symptoms of client's psychiatric disorder or co-morbid medical condition present a barrier to the performance of certain activities of daily living such as bathing, dressing, transferring, toileting or feeding, and remembering to take medication so that hands on assistance/prompting and cueing by a home health aide is required.

B.2.0 Continued Care Criteria

B.2.1 The client continues to meet criteria for home health aide services and there is evidence of active service and care management as evidenced by all of the following:

- B.2.1.1 Type, frequency, and intensity of services are consistent with Home Health Plan of Care, which documents the needs for assistance with hands on care, **AND**
- B.2.1.2 The home health aide care plan documents the need for continued hands on assistance to the client with activities of daily living, **AND**
- B.2.1.3 Duration of home health aide visit is consistent with the amount of hands on assistance with ADLs required by the client, **AND**
- B.2.1.4 Progress toward service objectives in the Home Health Plan of Care is being monitored and the client is making measurable progress, but identified objectives have not yet been met, **AND**
- B.2.1.5 Family members or other available social supports are learning to provide assistance with activities of daily living or are unable to consistently assist client with activities of daily living.

B.2.2 If the client does not meet criteria listed above, additional home health aide services may be authorized if one or more of the following are true:

- B.2.2.1 There is recent, objective evidence that the client will not be able to maintain functioning without significant deterioration if service is discontinued **OR**
- B.2.2.2 Client or client with family assistance is making progress towards independence with activities of daily living, but have yet to achieve the goal of consistently providing self-care **OR**
- B.2.2.3 Circumstances have changed in the client's support network such that those who have been helping with ADL's are no longer available or able to take on that function.

B.2.3 The client does **not** meet continued care criteria if:

- B.2.3.1 The client is able to independently perform activities that he/she had previously needed assistance for, or the client has assistance from family members and/or other people in his/her support network **OR**
- B.2.3.2 The client is unable to manage in the home even with the assistance of a home health aide and a higher level of care is necessary **OR**
- B.2.3.3 The client and support network refuse continued HHA services, in which case the home care agency should communicate with the client's treating physician and CT BHP for other service referrals as tolerated.

Note: Making Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases the patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.