Exhibit A

Adult Psychiatric Home Health

Level of Care Guidelines

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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. This service 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 medication administration 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 once daily, twice daily, or more or be pre-poured for the client's use over the course of several days. If medication administration is required at least once daily, documentation should include reasons why the client is unable to administer medication on his/her own. The visit also includes 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 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. Teaching may also include the use of available assistive technologies such as tools to help remind the client to take medication at the appropriate times of day.
If during the course of a scheduled medication administration visit, there is a change in the client's condition and the client's prescribing practitioner must be notified, the medication administration visit may become a skilled nursing visit. 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.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. Initial authorization will include 1 skilled nursing visit plus 13 units of medication administration over a two-week period for once a day medication administration. Initial authorization for twice a day medication administration will include 2 skilled nursing visits plus 26 units of medication administration over a two-week period. This should allow for an opportunity to assess the client's needs for future home health nursing care. The home health care agency will present the care plan as part of authorization for further treatment. The care plan will include measurable goals and objectives 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 care plan and the physician's order. Skilled nursing visits will typically be authorized once for every 60 days for clients receiving daily medication administration. 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.

Level of Care Guidelines:

A.1.0 Admission Criteria

A.1.1 Symptoms and functional impairment include all of the following:

A.1.1.1 Diagnosable DSM Axis I Psychotic Disorder or Affective Disorder with psychotic features. Other diagnoses, including Axis II disorders will be authorized on an exception basis,

A.1.1.2 Symptoms and impairment must be primarily the result of a psychiatric disorder, excluding V-codes,

A.1.1.3 Functional impairment not solely a result of Mental Retardation, and,

A.1.1.4 GAF < 50

A.1.2 Intensity of Service Need for Daily Medication Administration

A.1.2.1 Client and/or family demonstrates a level of disorganization or other functional impairment secondary to the client's psychiatric disorder so that he/she is unable to independently administer medication according to the physician's prescription, or

A.1.2.2 Client's or family's presentation indicates the high likelihood of non-compliance with medication administration, or

A.1.2.3 Client is newly diagnosed with a Psychotic Disorder or Affective Disorder with psychotic features.

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

A.1.3.1 Client has not met requirements for daily medication administration (E.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 Daily Medication Administration

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 Treatment plan includes teaching 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 (see attachment), and

A.2.1.3 Progress toward treatment objectives in care plan is being monitored and the client is making measurable progress, but identified objectives have not yet been met, and

A.2.1.4 Progress towards independence is documented in care plan, or

A.2.1.5 Client and family continue to demonstrate need for care at existing level. Efforts to test for independence have been unsuccessful and are documented in thecare plan.

A.2.2 If the client does not meet criteria listed above, continued daily medication administration may be authorized if either 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 and/or family are making progress, but have yet to achieve goal of consistent self-administration or supervised self-administration.

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 family refuse continued participation in treatment in which case the home care agency should communicate with the client's treating physician and CT BHP for referral for Intensive Care Management.

A.3.0 Continued Care Criteria for Weekly Pre-Pour

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

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.

ATTACHMENT
SUGGESTED APPROACH FOR INDEPENDENCE OF SELF ADMINISTRATION OF MEDICATION

Reason to Test for Independence

When a client is on daily or more frequent visits for medication administration it is appropriate to promote independence in medication administration. Testing the client's ability to self-administer medication can be a good barometer in determining the degree of independence a client has achieved.

Practice

Clients who have undergone training and education related to medication administration and have demonstrated stability should be tested for independence in self-medicating. For new clients, it is appropriate to consider testing for independence within the first six weeks of medication administration if the client has demonstrated stability. This should be done with as minimal negative effects as possible.

As you begin reducing visits/doses make sure that you will see the client immediately prior to and after the missed dose. If the client is compliant and takes the medication on his/her own for that dose, you will repeat that 2 times over an appropriate time period. If this was successful, then omit another dose/visit (keep in mind you want to test at different times of the day). Score according to how compliant the client is with this status, looking for any changes that might well indicate de-compensation due to non-compliance. As long as the client continues to do well, and appears to be having no deterioration in mental status, continue to decrease visits/doses accordingly. Decrease no more than once per week. This approach should be individualized based upon client need.

All of the above is to be done in conjunction with family members or other available natural supports as well as any available assistive technology.

Conversely, if on the succeeding visits medications left with the client are still in the medication box, or if there is any deterioration in the client's mental status, stop the testing immediately and notify the physician of findings.

Example: A physician order must be obtained prior to implementing a plan for testing for independence. The nurse and client will discuss and agree to a plan to test for independence in self-administration of medication. Client is seen BID for medication administration. The first dose that is omitted will be on Wednesday morning. On Tuesday evening the nurse will inform the client that Wednesday morning's medication will be left for him/her to take on his/her own. The client is informed that the nurse will return on Wednesday afternoon to see how he/she did. On Wednesday afternoon, if the medication is taken as directed, the nurse gives the client positive feedback and continues the rest of the week as usual. The nurse reports the client's progress to the ordering physician and requests further reduction orders. The same routine can be followed the next week or further reductions may take place depending on the nurse's assessment of the client's progress. Further doses are left for the client to take independently over succeeding weeks.

Documentation: The nurse must document clearly as to why visits are being reduced. A statement at the visit immediately following the missed visit should be entered into the record stating, “The client is being tested for independence related to medication self-administration.” The nurse must document how the client did in medicating himself/herself on that “missed” visit.

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.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. Initial authorization will include 1 skilled nursing visit for initial evaluation plus the requested number of units, typically no more than 240 units (60 hours) of home health aide services over a 30 day period. Additional units will be authorized on an exception basis. This should allow for an opportunity to assess the client's needs for future home health aide services. The home health care agency will present the care plan as part of authorization for further treatment. The care plan will include measurable goals and objectives relating to client independence, unless such goals are medically inappropriate. Time frames for future authorizations will be individualized according to intensity of client need based upon the care plan 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 include all of the following:

B.1.1.1 Diagnosable DSM Axis I or Axis II disorder of Autism, Pervasive Developmental Disorder, Psychotic Disorders, Affective Disorders with psychotic features. Other diagnoses will be authorized on an exception basis.

B.1.1.2 Symptoms and impairment must be primarily the result of the psychiatric disorders listed above, and/or medical co morbidities which necessitate HHA assistance, excluding V-codes,

B.1.1.3 Functional impairment not solely a result of Mental Retardation, and

B.1.1.4 GAF < 50

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, or remembering to take medication so that assistance/observation/prompting 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 care plan;

B.2.1.2 Service plan includes continued assistance to the client and family or natural supports with activities of daily living;

B.2.1.3 Progress toward service objectives in care plan is being monitored and the client is making measurable progress, but identified objectives have not yet been met; and

B.2.1.4 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 evidence that the client will not be able to maintain functioning without sustained or significant deterioration if service is discontinued;

B.2.2.2 Client and/or family are 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;

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 family refuse continued HHA services, in which case the home care agency should communicate with the client's treating physician and CT BHP for referral for Intensive Care Management.

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.