

Intensive Residential Treatment Services (IRTS) Peer Review 2010

Executive Summary

The Community Mental Health Service Block Grant provides funds to conduct a peer review each year and Intensive Residential Services (IRTS) was selected for evaluation in 2010. This peer review was not intended to mimic a certification, licensure, or compliance assurance process. Instead, its purpose was to benefit providers by offering credible, independent suggestions for improvement from a panel of county, payer, provider, individuals accessing IRTS programming and family members – i.e., suggestions from persons outside the Department of Human Services familiar with IRTS services. A total of nine IRTS programs were ultimately selected (from the thirty-four sites providing IRTS programming) for this review.

Selected highlights from this report include:

- All nine sites reviewed offered at least minimal programming services, and met the basic requirements for assessment and documentation of service provision for publicly funded mental health services.
- Four of nine sites had limited weekend programming, if any at all.
- Interviews with program staff across the sites showed a group of staff who were demonstrated a dedicated, caring, and compassionate attitude toward their work.
- A focus on recovery was apparent in all nine programs. Five of the programs were exemplary in providing programming that emphasized a recovery approach – both in development of programming and expectation of the treatment service delivered.

IRTS in Minnesota

Over the past ten years, significant changes have been made in the public approach to treating mental illness in Minnesota. An array of services is being developed to emphasize more community-based and individually tailored services, and greater attention is directed to recovery-oriented treatment and rehabilitation. In the past, residential mental health treatment services were a combination of large state hospitals and long-term residential services, licensed and known as “Rule 36 facilities.” The Rule 36 residential facilities for adults with mental illness tended to be a long-term residence with treatment services.

In 2003, a variance to Rule 36 was developed to create standards that defined a more intensive level of mental health treatment with the expectation that persons with mental illness do prefer to live in a non-treatment setting, such as an apartment, and receive community-based services. A residential treatment service called Intensive Residential Treatment Services (IRTS) was designed, oftentimes in place of a former Rule 36 facility, to provide services utilizing a multidisciplinary team of clinical and non-clinical staff. Lengths of stay at the newly developed IRTS shortened as persons were provided a more intensive level of service and supported in a

transition plan to the community. Services are financed using a combination of payment mechanisms, including Medicaid, county and state funds, and third-party reimbursement. Services billable to Medicaid require treatment providers to follow federal criteria for medical necessity, and the state requires prior authorization of services beyond ninety days. Payment for room and board is funded through a Group Residential Housing (GRH) income supplement. Rates for treatment services are based on a cost-based rate approved by the state. In a cost-based rate payment arrangement, all associated costs of providing services are equal to the revenue generated.

In 2010, the state facilitated a series of stakeholder meetings to gather input on a revised IRTS variance. The updated variance went into effect on July 1, 2010 but is not believed to have affected this review.

The Peer Review Process

The 2010 IRTS Peer Review was not meant to be an inspection or an audit, nor was there a pass/fail component to the evaluation. Similarly, it was not associated with a certification process or licensing of the program. The expectation was simply that the review would benefit programs by providing credible and independent suggestions for service improvement by a panel of their peers. The definition of “peer” for the purpose of this review was expanded beyond the traditional “professional/another colleague” model to include other mental health providers, advocates, individual consumers of services, and family members.

For the purpose of the review, a formal interview tool was used which was made up of nine separate standards. These included: 1) Program Mission, Structure, Philosophy and Practices, 2) Service Provision, 3) Individualized Program Planning, 4) Physical Environment and Location, 5) Staff Recruitment, Qualifications, Supervision, Performance Evaluations, Training and Development, 6) Coordination with Other System Resources/Cooperative Efforts with Other Agencies 7) Organizational Capacity, 8) Program Effectiveness and Recipient Satisfaction, and 9) Family/Significant Other involvement.

Through a face-to-face interview process, review of files, and tour of the IRTS facility, reviewers assessed the program based upon the nine standards. The site review was done in a single day and was made up of five areas: program introduction, program review, documentation review, group interview with persons receiving treatment, and exit interview. Programs were asked to have the Treatment Director and/or Clinical Supervisor present for the review.

As part of the standard “Individualized Program Planning,” a review was completed of each of the facilities completion of the Mental Health Service Continuum as stated in the Minnesota Health Care Program (MHCP) Provider Manual. The components of the continuum are considered “best practice” and are considered necessary to the delivery of quality services. The six specific elements of the continuum are: 1) Diagnostic Assessment (DA), 2) Functional Assessment (FA), 3) Level of Care Assessment (LOCUS) 4) Individual Treatment Plan (ITP), 5) Service Delivery, and 6) Re-assessment. Review sites were asked to provide copies of the documentation components for two current residents at their program. Sites were allowed to choose which residents’ documentation was reviewed.

Peer Reviewers

The process to solicit reviewers and advisory group members included advertising with community mental health agencies, letters sent to IRTS providers, and communication with county social services directors. Phone interviews were completed with potential reviewers and fourteen were selected, with twelve reviewers participating in the review process.

Reviewers attended a required day-long state training prior to the start of the reviews. Careful consideration was given to organizing reviewer teams to include IRTS providers, providers with service experience or macro-level experience (e.g. County Social Services), individuals who had accessed IRTS services previously, and family members of individuals having had IRTS services.

Teams were made up of four reviewers each. All teams had a reviewer with experience from each of the categories identified. If a team had a fourth member, attempts were made to have a second IRTS provider on the team.

Sites Reviewed

Review sites were randomly selected. Selection was determined by geographic region; the state was split into three sections: Northern, Mid/Metro, and Southern. All eligible providers were identified by region, and due to volume it was decided that the Northern region would be represented by two sites, the Mid/Metro region would include five sites, and the Southern region would have two sites reviewed. (Note: There are thirty-four IRTS programs across the state, with some agencies administering more than one IRTS site).

Reviewed sites included:

Oasis **(July 23, 2010)** Golden Valley

ReEntry House, Inc. **(August 4, 2010)** Minneapolis

Community Options **(August 5, 2010)** Fridley

Safe Harbor **(August 6, 2010)** Owatonna

Hiawatha Hall – Family and Children’s Center **(August 10, 2010)** Winona

Gull Harbor **(September 1, 2010)** Moorhead

Arrowhead House **(September 8, 2010)** Duluth

Willow Haven **(September 10, 2010)** Lake Elmo

Guild South **(September 22, 2010)** West St. Paul

Reviewed Areas

At the end of each review, the reviewers summarized their observations along three main areas: Strengths, Areas of Need, and Other Findings. These three broad categories were then used to complete the Exit Interview with the providers.

Strengths

Strengths fell into five categories: programming, staffing, documentation, larger agency system, and coordination.

Programming Strengths

- Interviews with IRTS program staff demonstrated a staff dedicated to improving the lives of the individuals they served.
- Five of the nine sites had group schedules that would rotate programming topic areas. These sites also indicated they would add certain types of groups to adapt to the needs of the current residents.
- All nine sites offered groups using Illness Management and Recovery (IMR) and Integrated Dual Disorder Treatment (IDDT) Evidence Based Practice principles.
- Four of nine programs offer a daily morning and/or evening check-in which include a review of daily goals.
- All nine sites were able to identify discharge/transition planning having been initiated at the beginning of an individual's treatment stay.

Staffing Strengths

- All programs met the minimum requirements for staffing. Five out of nine programs exceeded the minimum requirements in regards to nursing time, number of mental health practitioners assigned per shift, and clinical supervision time.
- Programs that had more staff available to provide groups were clearly able to be more flexible with group schedules and group content.

Documentation Strengths

- Two of the nine programs did an exceptional job regarding documentation of treatment planning, including diagnostic and functional assessments.
- All programs had the required Medicaid documentation components.
- All programs had a mental health professional (MHP) on staff to complete the diagnostic assessment and/or diagnostic assessment update.

Agency/System Strengths

- The ability to tap into resources within a larger agency was clearly a benefit to these providers. Noticeable benefits included assistance and organization by a human resource department and the increased access to clinical supervision and consultation.
- Four of the nine programs access extensive training within their larger (parent) agency.

Coordination Strengths

- All programs coordinated services with a multitude of physical and mental health providers. It appeared (based on documentation and resident interviews) that this was being done as often as possible.
- Six of the nine programs did an exemplary job in coordinating with physical and mental health care, as well as with other community resources such as libraries, buses, and shopping.
- Coordination around physical health needs was apparent in all programs. This was primarily done by nursing staff.

Areas of Need

Areas of need and worth consideration for improvement fell into three main categories: programming, physical plant/physical location, documentation.

Programming Need

- Four of the nine sites had limited programming on weekends. Weekend groups that existed were around recreational activities. All of these sites stated they nonetheless completed their “one rehab intervention per day” requirement.
- Only four of the nine programs had group times that consisted of IMR and IDDT curriculum.

Physical Plant Need

- Three programs were located in very old residential homes, which could make mobility for some residents more difficult.
- Questions around privacy, security, and safety at four of the nine sites were raised by the reviewers.

Documentation Need

- Improvements need to be made consistently across all IRTS services reviewed around documentation of functional impairments as they relate to an individual’s mental illness. This includes updates to the functional assessment of information pertaining to current deficits.
- Two sites did not have a “Recovery” goal documented for individuals treated at the site.
- Only one program consistently linked assessment and functional impairment information to treatment plan goals and objectives. Improvement is needed to link assessment information to functional impairments related to symptoms of mental illness. Documentation of treatment interventions on progress notes needed improvement.

Other Findings

- All sites had already updated their policy and procedure manual to meet the new requirements of the variance that was put into effect on July 1, 2010. Two of the facilities stated they were still trying to incorporate all the changes.
- The change around all staff needing a face-to-face review of the weekly treatment plan meeting was met with varying difficulties and it appears some technical support would be beneficial regarding ways to meet the requirement.
- All nine sites stated finding housing options for individuals was a barrier for discharge/transition planning.
- Four of the nine sites had some form of direct access to psychiatric services.
- Concerns around time management for staff supervision and training were more evident in programs that did not have support outside of their program (i.e. a larger agency umbrella or contract with another agency).
- If an agency had access to more than one clinical supervisor it was more apparent in treatment philosophy and documentation standards.
- The rate for IRTS is determined by a cost-based system. Three of nine program directors reported lower than average pay, poor benefits, etc., (i.e. complaints).
- The case manager was the most common answer to “with whom do you coordinate care most often.”
- Five of the nine sites had staff members involved in other community programs and initiatives.

Resident Interview Themes

The resident interview focused on current individuals receiving services. Group size for the interview ranged from 2-5 individuals depending on the site. In total, 28 recipients were interviewed.

- All individuals interviewed stated that their basic needs were being met in the facility they were at.
- At five of nine programs, at least one individual stated there was not enough structure at the facility.
- Most individuals stated they were treated in a respectful manner. Those that did not indicated that it was a specific staff person, and not all staff, that they had this experience with.

- Although all individuals stated they felt they could talk to staff, not all were comfortable in doing so. The recommendation for a suggestion box or a way to submit written concerns was given to two of nine sites.
- Almost all individuals were able to discuss at least one goal being worked on as part of treatment services. Those that were not as clear were all newly admitted individuals.
- All individuals stated they were able to access staff 24/7. There was some variability regarding the knowledge of how all staff assisted them on treatment goals and staff ability to help with personal objectives.
- All individuals stated they met with staff at least weekly to review their goals. Individuals at five of the nine facilities stated they spoke with staff about their goals daily.
- All individuals stated staff members were coordinating with outside providers regarding their care and treatment.
- 98% of those interviewed reported having a county case manager that was working with them. However, due to geographic distance not all individuals were able to meet with their case manager as readily as they wished.

Closing Comments

The peer review for IRTS services met the intended goals. The reviewed agencies stated they felt the reviews were beneficial and helpful in their continued delivery of IRTS services. The reviewers also had very positive feedback in regards to the review process, and information gleaned.

Overall, the reviewers felt that IRTS services was being provided within the intended scope, and that it was a beneficial part of the mental health service array within the state of Minnesota.

The Department of Human Services wishes to extend appreciation to all who were involved in making the 2010 Peer Review of IRTS in Minnesota a successful project.

You may direct questions or comments regarding this report to Carol LaBine, MSW, LICSW, Quality of Care Analyst, in the Adult Mental Health Division at: (651) 247-3265 or by e-mail at carol.labine@state.mn.us.

