Who is MCTAC?
MCTAC Partners

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Agenda

› Importance of documentation
› Basics of effective documentation
› The “Golden Thread”
› Person-centered collaboration and documentation
› Documentation of assessments and diagnosis
At its core...

Documentation is a written account that tells the story of how the person receiving treatment’s needs were met by service providers:

- Who
- What
- Where
- When
- Why
- How it benefitted the client
If it isn’t documented well, it didn’t happen.
Purpose of documentation

- Coordination of care
- Shared decision-making
- Risk management
- Authorization and re-authorization of services
- Audits by licensing agencies
- Evaluation of results
- Facilitates Quality Improvement and Utilization Review
Risks of inadequate documentation

- Managed care company may request additional information, delaying authorization or re-authorization
- May result in denial of needed services
Documentation today needs to consider multiple masters. Providers need to consider managed care, state/licensing, and internal agency requirements. These may or may not overlap.
Requested formats

- Each managed care company has own rules for authorization/re-authorization process
  - Phone calls – question and answer
  - Treatment plans
  - Progress notes
  - Other

- Providers need to be skilled in:
  - Written documentation
  - Translating written documentation into oral presentation for phone conversation
Qualities of good documentation
Easy to read

- Name of person receiving services and provider signatures are easy to find
- Grammar/spelling
- Clear writing
- No unfamiliar words/acronyms/abbreviations
- Use of “ ” when quoting people
- No slang or curses (unless quoting the person)
- Legible (if handwritten)
- Timely (dated when occurred)
Meaningful, not overwhelming

- Concisely written (more is not better - quality vs. quantity)
  - Just the facts relevant to current treatment plan
    - May have additional information in own notes, but not included in documentation

- Goes beyond diagnosis
  - Describe functioning and functional impairment
    - How are symptoms/diagnosis impacting person’s life

- Notes can be shared/subpoenaed
  - Would client be upset if he/she read documentation?
I met SR at her residence. The front desk called repeatedly and she did not answer. I then went to his room and knocked repeatedly he did not answer, a young woman saw me knocking called his name twice and he appeared at the end of the hallway. He greeted me and asked me to come his room. He asked if I wanted to leave the door open and I said yes. We then sat at his table and I asked how he feels since his hospital discharge, he said ok. I asked him about his move to Boston, and he became agitated saying he does not know why he has to move to Boston. I asked him if he told his case manager that he does not want to move and he told me he doesn’t know me and doesn’t want to talk about it. I reminded him that we have worked together since February and he said he only met me two or three time. At this point the Substance Abuse Specialist joined our conversation. She greeted SR and asked about a pile of clothes in the corner. SR said he was going to do laundry. She said she just wanted to say hi and waited in the lounge. I reminded SR he knows Substance Abuse Specialist and he said no he doesn’t and became agitated. I asked him if he was ok he said yes. I said I was going to go and would see him soon. He asked for money. I reminded him that his case manager should help him acces his money and said goodbye.
I met SR at his residence. We spoke about how he has been feeling since his discharge from the hospital and about his upcoming move to Boston. SR says “I don’t know why I have to move to Boston. I don’t want to.” I suggested he talk to his case manager about his feelings about the move. SR asked for money, and I reminded him that his case manager should help him access his money.
Shows continuity of care

- Show progress over time
- Demonstrate how person’s needs were addressed across different services: community support, mental health, chemical dependency, medical, residential, etc.

Think of the service you are providing as a part of a bigger picture
Medical necessity – broken down

- Appropriately qualified practitioner
- Clinically appropriate services
  - Can’t be too strengths-based – needs to focus on symptoms (need for care!)
- At appropriate intensity and duration
- As prescribed in individualized treatment plan
- Designed to improve functioning and symptoms or prevent their worsening
- Based on an approved diagnosis and assessed need
Tips for demonstrating medical necessity

- Only document services that target symptoms/behaviors identified in the assessment
- If person is “stable”, no need for services
- Medical necessity should be documented each and every time
  (For people mandated to services, there may not be “medical” necessity, but goals should focus on the reason for the mandate.)
- Services to collaterals must still be for direct benefit of the person
- Person must have capacity to benefit from services
I met SR at his residence. We spoke about how he has been feeling since his discharge from the hospital and about his upcoming move to Boston. SR says “I don’t know why I have to move to Boston. I don’t want to.” I suggested he talk to his case manager about his feelings about the move. SR asked for money, and I reminded him that his case manager should help him access his money.

What is missing?

• Statement of progress/continued symptoms
• Interventions provided
I met SR at his residence. We spoke about how he has been feeling since his discharge from the hospital and his upcoming move to Boston. SR says he feels better since discharge, and his behavior is consistent with that (e.g., he has been talking with friends in the program regularly and asking for help when needed). I conducted our Risk Assessment and SR does not show any risk. SR says he is not happy about his upcoming move, stating “I don’t know why I have to move to Boston. I don’t want to.” I suggested he talk to his case manager about the move. SR asked for money, and I reminded him that his case manager should help him access his money. I probed further and he is getting his meals from his residence.
Care is justified if you can show a reduction in care will lead to an increase in symptoms.
The Golden Thread

Assessment data

- Diagnoses
- Strengths
- Goals
- Needs

Service plan

- Goals
- Objectives
- Interventions and Services

Interventions/services – documented in progress notes
Documentation must reflect the Golden Thread

- Interventions should all reflect service plan
- Service plan should reflect assessments and client’s goals and objectives
Person-centered practice

- Individual is the expert in their life
- Identify strengths, capabilities, interests, preferences, needs, hopes and dreams
- Are culturally and linguistically competent
- Involves significant others/key collaterals as appropriate
- Provide a systematic way to align what we do with what the person wants and needs
Do’s and don’ts of person-centered practice

- **Do** let the person lead the process and put them in the “driver’s seat”.

- **Don’t** forget to include those that care about them - recovery happens in a social context.

*Supervisors should understand Person-Centered practice and reinforce these expectations as part of all service delivery.*
Documentation and person-centered care

“Important To”

- Use quotes whenever possible so the documentation clearly reflects their input
- Define what is important to the person
- Define desired changes in terms of specific, observable behaviors

“Important For”

- Define objectives the person needs to achieve to be a valued community member
- Address issues of health or safety
- Addresses willingness and motivation to invest in recovery
Documentation is also an opportunity to show the person’s progress toward recovery.
Collaborative documentation

- Evidence of a person-centered approach
- Concurrent documentation is one type of collaborative documentation. (There are other options as well.)
- Components of documentation
  - Assessment – know your questions!
    - *Be so comfortable with questions that assessment process feels like a conversation, not a form*
  - Treatment planning – if not collaborative, high risk of non-adherence
  - Progress notes – use final minutes of time with client to summarize together what has happened, and document jointly
Standardized forms (including NYSCRI forms) may make collaborative documentation a challenge. Use open-ended questions to document quotes and client’s perspective.
Documentation and Assessments

Background

‣ Referral source, background and reason for the referral

‣ Presenting problem:
  • Include any relevant risk/safety concerns
  • Using person’s own words, describe why they are seeking care
  • Using your words, describe why the person needs services
Documentation and Assessments

Client history

- Family, medical, behavioral health, education, work, social, trauma, etc.
  - Only include information relevant to treatment plan
- Describe what we need to know to best address person’s needs
Documentation and Assessments
Analysis and formulation

‣ What are the symptoms and functional impairments?
‣ What is the diagnosis?
‣ What services does the person need from us?
‣ How will these services improve their functioning?
‣ Why is this the correct level of care?
Diagnosis and documentation

- Diagnosis is important, but requires other information
  - How does symptoms/diagnosis impact person’s life?
  - How will treatment interventions improve functioning?

- Also include: safety/risk assessment information, current psychosis, etc.
Diagnosis: Schizoaffective disorder vs.

Diagnosis and presenting issues:

- Schizoaffective disorder. Symptoms include auditory and visual hallucinations and “deep depressions” that last for up to 4 months once or twice a year. Client says “this has been the pattern for the last 5 years.” Client explains hallucinations make it difficult to focus and to form close relationships with others, “which makes it hard to finish school and get a job.”
Standard components of initial authorization

- Who is the person seeking services and what is the relevant history?
- What is the problem the person is seeking help for?
- Are there safety concerns that should be addressed first?
- What are the person’s symptoms and how have these symptoms become barriers to overcome?
- What does the person need to successfully overcome these barriers? (Does your agency offer these services?)
- Why would these specific services be most helpful?
Example: Depression

› Who is the person seeking services and what is the relevant history?
   • 52y/o Hispanic female, symptomatic for 2 months and has family history of depression

› What is the problem the person is seeking help for?
   • “I’m not suicidal, but I feel sad most of the time and I don’t really enjoy anything any more.”

› What are the symptoms and how have these symptoms become barriers for the person to overcome?
   • Trouble sleeping, no appetite, low energy, and crying spells, interfering with relationships and causing client to miss work

› What does the person need to successfully overcome these barriers?
   • Supportive care, Cognitive Behavioral Therapy and anti-depressant medication (My agency provides these services.)

› Why would these specific services be most helpful?
   • CBT is an evidence-based protocol and research shows that it can be very effective for depression in combination with medication
   • Goal: “I want to get back to my life again.”
Example: PTSD

‣ Who is the person seeking services and what is the relevant history?
  • 18y/o African American/Caribbean male, symptomatic for 4 months after car accident

‣ What is the problem the person is seeking help for?
  • “Since the car accident I’ve been having nightmares and flashbacks. It’s gotten so bad I can’t go to school anymore.”

‣ What are the symptoms and how have these symptoms become barriers for the person to overcome?
  • Intrusive thoughts/flashbacks, avoidance, excessive fear and anxiety. Client is isolating at home and struggling with concentration and school attendance.

‣ What does the person need to successfully overcome these barriers?
  • Supportive care, Trauma-Focused CBT and possibly medication

‣ Why would these specific services be most helpful?
  • TF-CBT is an evidence-based protocol and research shows that it can be very effective with teens that struggle with PTSD
  • Goal: “I want to graduate with my class this year.”
Example: Heroin Dependence

- Who is the person seeking services and what is the relevant history?
  - 26y/o female, has 2 unsuccessful attempts at outpatient treatment within last 6 months, and has a seizure disorder

- What is the problem the person is seeking help for?
  - “Outpatient isn’t working for me and I need something longer term.”

- What are the symptoms and how have these symptoms become barriers for the person to overcome?
  - Daily use, at severe risk of medical complications due to withdrawal. Client is aware of dangers re. overdosing and how it might affect her medically.

- What does the person need to successfully overcome these barriers?
  - Medically Managed Detoxification followed by residential treatment (stabilization)

- Why would these specific services be most helpful?
  - LOCADTR 3.0 completed and client requires 24-hour medical supervision
  - Goal: “I’m ready to do whatever they tell me to do this time to get clean.”
What can you do?

Supervisors and direct care providers should review client records together to promote quality documentation.
References

References contd.

Please email questions to: Mctac.info@nyu.edu