Questions and Answers: A Conversation About Documentation Best Practices

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Who is MCTAC?
MCTAC Partners

Webinar Series Partners
Representatives from NYS-serving Managed Care Organizations
Overview of this series

- 6 part series: best practices for all types of documentation
  - What MCOs are seeing: tips and what to avoid
  - Foundations and establishing the need for treatment
  - Treatment plans
  - The progress note
  - Supporting high quality documentation as a supervisor
  - Office hours
- Survey feedback
- Questions
  - Chat at any time
  - Email
Overview of this series

- Information provided in this series reflects general best practices, and is based on the experiences of the individuals on the content development team.
- Current to the best of our ability as of today’s date, November 16th, 2016.
- Does not conflict with regulatory requirements, but may not be sufficient to be in full compliance.
- Information presented does not reflect official guidelines specific to any particular Managed Care Organization.
A conversation about documentation best practices

Learning Objectives

- Understand the importance of documentation for communication
- Review foundational components of effective clinical documentation
- Discuss best practices and tips from representatives from managed care companies serving NYS
- Recognize common “red flags” in documentation
A conversation about documentation best practices

› When MCOs review current documentation:
  • What are the best practices they’d like to see more of?
  • What are some red flags that concern them?
Documentation Definitions

- Clinical documentation/clinical record
- Provider: Individual providing services
- Member: Individual receiving services
- Progress Note vs. “provider post-it”
- Treatment/Service Plan
- Discharge and recovery planning
- Collaborative documentation
- Golden thread
Purposes of Documentation

Communication

- Identifies the service, how it ties to the individualized treatment objectives and goals, and describes progress and barriers in the road to discharge and recovery
  - Required for authorization
- Keeps a record of all the good work the provider and member are doing together
- Opportunity to show that you have a relationship with the member that is necessary, productive, and measurable
  - No one knows the member like you do
  - No one can read your mind

What is in the documentation that helps communicate to others reading it that the person should continue in services with this provider?
Purposes of Documentation

- Serves as a living record
  - Shows history, progress, and challenges
  - Records can be shared: member request, subpoena, legal guardian, other providers
- Separate from “provider post-its”
  - Provider post-its may have provider’s opinions, private aspects of a member’s life, details provider needs to remember for future work that do not belong in the record
What are some features of good documentation practices?
Effective documentation best practices

- Keep it simple
- Be concrete
- Establish baseline functioning
- Use clear, appropriate grammar and wording
- Keep it current
- Be specific
Keep it simple

- Long, detailed descriptions are unnecessary and overly time consuming
- Focus on highlights that are relevant to the treatment plan
  - Information that clearly communicates progress, identifies a potential barrier or strength, modifies a treatment objective, etc.
Keep it simple

• Example:
  ◦ Jaden came to her appointment flustered and stressed and said she’s been “all over the place” this week. She stated that her ex has been calling her “nonstop” to talk about their daughter, and that her daughter isn’t speaking to her right now because she took away her cell phone for sending “dirty texts” to her boyfriend. Jaden also mentioned that she hasn’t had any luck with the temp agency she’s been in contact with and feels like she is “never going to work again,” so she really needs her ex to not fight her on child support just because he doesn’t agree with how she wants to discipline their daughter.

• Better:
  ◦ Jaden arrived at her appointment 8 minutes late. She stated that she’s experienced several stressors recently related that have exacerbated her anxiety symptoms.
Be concrete

 › Describe what is being observed, what was stated
   • Example:
     ◦ “Client became aggressive” can mean many things to many people (shouting, pushing over furniture, throwing something…)
   • Better:
     ◦ “Client became aggressive—pushing papers onto the floor and slamming his fist into the desk” is very descriptive

 › What does this mean? What does this look like?
Use clear, appropriate grammar and wording

› When quoting the client, use quotation marks
› Avoid slang, abbreviations, inappropriate language and cursing unless it’s part of a necessary client quotation
› If documentation is handwritten, write legibly
  • For errors or deletions, use one line and provider initials rather than scratching out or trying to write over it
Keep it current

- History is important, but only if it reflects in the current focus of treatment.

- Does this information inform what we are working on in treatment today?
Keep it current

Example:

- Terry is a 55-year old Caucasian male. Terry stated that he was born in Pennsylvania to married parents, Elizabeth and George. Terry was the second of four children. Terry reported that, to his knowledge, his birth was uncomplicated and that he met all his major developmental milestones on time. Growing up…..
  - Potential interpretation: Oh boy….
Keep it current

Example:

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  ◦ Potential interpretation: Oh boy….

• Terry is a 55-year old Caucasian male. He is self-referred to the clinic and stated that he’d like to reduce his driving-related anxiety. He reported that he was in a fatal car accident when he was 8 years old where he witnessed the death of his brother.
  ◦ Potential interpretation: There’s an event in Terry’s past that is directly relevant to his treatment seeking today.
Be specific

Discuss how this service will meet the member’s individualized needs and goals
- Differentiate this services from others they are receiving or the need in general for some supportive services
- Example
  - Peter’s mother reports that Peter has been expelled from school and his probation officer is concerned about how much time he spends unsupervised. She stated that she is “at wits end about how to help him and too stressed to figure out what to do next.” Peter’s mother would benefit from the support provided in this service.

✓ Potential interpretation: Peter’s mother needs support from some service(s).

What’s unique about this service for this member at this time?
Establish baseline functioning

- Understanding what level of functioning represents a member’s goal or natural progression towards a goal state is important

- Example
  - Don is currently experiencing delusions, feeling like the world is “rigged” against him and that media and government are personally targeting him to keep him from being successful
  
  ✓ Potential interpretation: Don needs a higher level of care because delusions are an extreme symptom and likely indicate that he has more significant behavioral health needs than he is currently being treated for
Establish baseline functioning

- Better:
  - Don is currently experiencing delusions, feeling like the world is “rigged” against him and that media and government are personally targeting him to keep him from being successful. Don reports that these delusions are stable and have “always been with [him].” Since these delusions do not cause Don distress or interfere with his daily life functioning, experiencing these delusions without additional symptoms (previously noted) represents progress for Don.

✓ Potential interpretation: Don is progressing towards his individualized recovery goals through the support of this service.

- What does baseline or stability look like for this individual?
What are some red flags, or areas of concern that can come up?
Common red flags or areas of concern

- Documentation that is “cookie cutter”
- Including negative provider opinions or language
- Including private details that are not relevant to treatment goals
- When Treatment Plans/Service Plans and Progress Notes don’t clearly tie together
Avoid: Documentation that is “cookie cutter”

- Treatment needs to be individualized, so documentation that clearly isn’t raises concerns that the treatment wasn’t either

  ✓ Session 3: “Janet attended an employment support service session today, October 11th, 2016. We reviewed her resume and discussed how to begin a job search.”

  ✓ Session 4: “Janet attended an employment support service session today, October 18th, 2016. We reviewed her resume and discussed how to begin a job search.”

  ✓ Session 5: “Joshua was late for his appointment today, October 25th, 2016. During session, we role played interview questions he had prepared.”

  ✓ All 5 of this provider’s clients session 3 notes read “[Name] attended an employment support service session today, [date]. We reviewed [his/her] resume and discussed how to begin a job search.”

- Potential interpretations: Treatment is not individualized to unique goals, progress, and challenges. Did Janet even receive services on 10/25?
Avoid: Including negative provider opinions or language

- Including negative language or opinions is not only inappropriate, but may end up hurting the member and preventing them from achieving their goals.

<table>
<thead>
<tr>
<th>Example</th>
<th>Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>She’s never going to change</td>
<td>She is exhibiting a similar pattern of behavior as in previous similar situations.</td>
</tr>
<tr>
<td>He’s a complete mess</td>
<td>Many aspects of his life are causing him distress at this time</td>
</tr>
<tr>
<td>Dad doesn’t know what he’s doing with a toddler and should just let Mom have full custody</td>
<td>Leave provider opinions out of the record</td>
</tr>
</tbody>
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- How would the member/member’s family feel if they read this? Is this information critical to our work together? If I feel this way, how is it impacting my work with this person?
Avoid: Treatment/Service Plans and Progress Notes don’t tie together

- Progress Notes need to reflect objectives and goals described in the Treatment/Service Plan
  - Treatment/Service Plans may be viewed as obligatory, a check box to hit to meet regulations, while Progress Notes really reflect the work being done.
  - This is a problem. If it’s difficult to see the link between Progress Notes and Treatment/Service Plans, it should raise a red flag for providers and supervisors (and others reviewing your documentation)
    - What’s happening with the member is not what you originally thought you’d be working on
      - Revise the Treatment/Service Plan
    - Treatment has gone off track and the “crisis of the week” is taking over
      - Seek consultation and/or supervision around agenda setting
Avoid: Treatment/Service Plans and Progress Notes don’t tie together

- **Example**
  - Treatment/Service Plan Objective: Polly will increase her positive social interactions by attending at least 50% of scheduled recreation activities per week.
  - Progress Note: Polly noted that she has been feeling very anxious this week thinking about an upcoming visit with her family. We reviewed skills in her relaxation toolbox that have helped her in the past to reduce her anxiety, including deep breathing and meditation. In session, Polly successfully demonstrated her deep breathing and agreed to resume practicing for 5 minutes per day.
Avoid: Treatment/Service Plans and Progress Notes don’t tie together

Example

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What happens if my documentation doesn’t stack up?
Consequences of inadequate documentation

- **Consequences for the provider**
  - If insufficient information is provided, a decision about the case can’t be made
    - Additional clinical information may be needed
    - Delays in authorization process
    - More work for the provider

- **Consequences for the member**
  - Progress towards goals may not be carefully evaluated
  - Risk that the services is not authorized for the individual
What can supervisors do today to help support more effective documentation?
Supervisor Takeaways

› Read through the content
  • Check grammar and readability
    ◦ Send it back for revisions if it’s not adequate

› Ask questions
  • Ask providers to describe how activities in a session map onto the treatment plan
    ◦ If it’s not clear, they aren’t able to, crisis of the week took over, they don’t recall the treatment plan…time to sit with the treatment plan and the provider to refocus treatment

› Open dialogue about strengths and challenges
  ◦ Documentation reflects practice
  ◦ Practice should be person-centered
  ◦ Provider is a facilitator of the process
  ◦ Supervisor support provider in this role
Questions?

Please use the Chat box!
Join us next time

Foundations of Documentation and Establishing the Need for Treatment

November 30, 2016
12-1PM

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Daniella Labate, NYAPRS
Naomi Weinstein, ICL