Collaborative Documentation Will Lower Risk!

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Ubiquitous Documentation Risk Areas

• Documentation Linkage – Medical Necessity
  • Core elements of documentation linkage and support for medical necessity and clinical quality
  • Service documentation that supports billing

• Care Coordination and Clinical Risk Management
  • Timely access to documentation by other Tx. team members
  • Documentation accuracy and clinical relevance
Recent RAC and Other Audits Have Taught US Nothing New!

We have failed to find a sustainable approach to basic documentation compliance …

With providers having time to “craft” progress notes in their offices…

Why can’t we get it right?

Obstacles to Documentation Compliance

• No consistent definitions of core clinical/documentation elements

• No consistent rules for application of core elements

• No consistent development/use of simple internal audit and provider self audit tools
Obstacles to Documentation Compliance

• No consistent focus in supervision on clinical relevance and compliance aspects of documentation

And…

• Clinicians are the ones who do all the documentation … and they hate it!

Solution

• Identify and apply the Core Definitions and Rules

And…

• Implement Collaborative Documentation
What is Collaborative Documentation

- Process where clinicians and clients collaborate in the documentation of Assessments, Treatment Plans, and Progress Notes.
- Documentation of Assessments and Tx. Plans is collaborative & concurrent.
- Documentation of Progress Notes is collaborative at the end of the session/interaction.

Collaborative Documentation

- There is substantial experience with CD and best practices for CD implementation
- There is significant evidence regarding the benefits of CD including:
  - Improved client engagement and involvement
  - Improved tx. plan adherence (e.g. medication adherence)
  - Vastly improved documentation timeliness
  - Creation of clinical capacity, etc…
How Collaborative Documentation Can Help!

• Collaborative Documentation integrates documentation into the clinical process
• Documentation becomes useful to the interests and values of clinicians
• Documentation becomes timely (real time) by default and so provides value for risk management and care coordination
• Because documentation is done with the consumer there is a focus on treatment plans (not just “post session” linkage to treatment plans)

How Collaborative Documentation Can Help!

• In order to document progress with the consumer the treatment plan needs to make sense and have objectives (measurable or observable outcomes) that the consumer can relate to.
• Client participation in Treatment Plan Development and Services becomes real and not just a signature.
• Interventions will naturally be stated in common sense terminology and phrases like “Used CBT”, “Helped client process past abuse” or “Provided empathic listening” will disappear.
Definitions and Rules

These rules and definitions are meant to address the most prevalent and poorly addressed documentation compliance risks and to support Collaborative Documentation.

They are not intended to address all documentation regulations and standards.

Assessment

Rule 1:
Substantiate all diagnoses in the assessment and Psychiatric Evaluations (Including Chemical Dependence Dxs.)

Rule 2:
Reconcile conflicting diagnoses. Otherwise the psychiatrist's diagnosis takes precedence.
Assessment

Definition 1
Identified Needs = Target BH Symptoms, Behaviors, Functional Deficits, Competencies, and Conditions related to the diagnoses and stated as baselines.

Rule 3
List Treatment/Rehabilitation “Targets” (“Identified Needs”) at the end of the assessment.

Treatment / Service Plan

Definition 2
Goal = General statement of desired outcome related to identified need. Answers the question, “What do we want the outcome to be as we address this need (Problem)?” (e.g. Maria wants to stop relapsing with alcohol)

Behavioral health goals are not “personal or recovery goals” (These can be appended to the BH Goal – e.g. “Maria wants to stop relapsing with alcohol so she can regain custody of her children”
## Treatment/ Service Plan

**Definition 3**

**Objective** = “Measurable or Observable Outcome related to a Goal and that we believe can be achieved as a result of our interventions/ work with the client.

Note: Objectives are not things we want the client to do or steps to be taken (e.g. not – “Client will take medication as prescribed; Client will attend sessions as scheduled”.)

<table>
<thead>
<tr>
<th>Symptom(s)</th>
<th>Functioning Level</th>
<th>Behaviors</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5</td>
<td>5.5</td>
<td>2.5</td>
<td>7.5</td>
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</tbody>
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## Treatment Plans

**Paradigm for Development of Objectives**

Identify a reasonable change from baseline that you expect interventions to attain in 3 or 6 months

- **Symptom(s):** (e.g. change in PHQ9 score from …to.; change in nature and frequency, etc.)
- **Functioning Level:** (e.g. change in DLA20 overall or specific scale scores from … to …. or description)
- **Behaviors:** (e.g. Change in intensity and/or frequency)
- **Competencies:** (e.g. ability to identify several triggers, ability to articulate/demonstrate coping skills, etc.)
Treatment Plan

Rule 4
One goal for each Identified Need (treatment target)

Rule 5
At least one objective for each Goal

Progress Notes

Rule 6
Prompt for and address required elements

1. Salient information provided by client
2. Significant changes in Mental Status
3. Goal(s) Objective(s) specifically addressed
4. Intervention(s)
5. Client Response
6. Clients Progress related to Goal(s) Objective(s) addressed
7. Plan
Progress Notes

Definition 4
Intervention (Method) = description of the strategies, discussions, training, role playing, etc. that were used during the interaction and were intended to help an individual reach one or more objectives.

Definition 5
Client Response = How the client responded during today’s session/intervention.

Progress Notes

Definition 6
Progress = level of achievement toward a specific objective(s) (measurable or observable outcome in the current treatment plan)

Definition 7
Plan = Includes things the client and provider agree will be done prior to the next intervention (e.g. homework, actions, strategies to practice, appointments to keep, etc.). Can also include things the provider agrees to do (e.g. speak to client’s case worker, etc.)
Collaborative Documentation

Applying the above Rules and Definitions while employing Collaborative Documentation will improve quality of care and sustainable compliance.

Recommendations

1. Train on the above rules and definitions
2. Have staff trained in Collaborative Documentation then implement
3. Apply the above rules and definitions consistently in auditing and supervision
4. Develop a “Self Audit Tool” for staff to apply
5. Have staff select sample charts that they believe have met all rules and definitions
6. Review (excellent for group supervision) to confirm that rules and definitions are being consistently applied.