A Guiding Light to Documentation for Paraprofessionals

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The Georgia Collaborative ASO
Introductions

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Documentation is a way to shine a light on an Individual’s recovery!
Why Documentation is Vital

- Impacts all required components of an Individual’s record
- Includes a reason for the contact
- Documents the Individual’s current presentation
- Shows the Individual’s relevant history
- Documents the Individual’s recovery story
Why Documentation Is Vital

- Displays the specific behavioral health interventions provided
- Documents the Individual’s response to the interventions
- Pinpoints unresolved issues from previous contacts and plans for next session
- Shows the next steps, decisions, and progress statement
- A resource for the Individual when they may not remember parts of their recovery history and story
“The Individual’s record is a legal document that is current, comprehensive, and includes those persons who are assessed, served, supported, or treated.”
What’s YOUR Barrier?

What’s getting in your way of quality, timely documentation?
Medical / Health record documentation:

- Official evidence of the supportive services you’ve provided
- Legal proof
- Record of service delivery
- Primary communication between providers
- Fosters quality service delivery
- Supports continuity of care
- Reduces risks and errors
- Records benefits vs risks of treatment/care
- Tool for engagement
Documentation must be:

• Written in a professional and timely manner
  • Best practice standards - within 24 hours of the activity
• Written as if the document will be published on the front page of a newspaper
• Written and signed by the person providing the services
Behavorial Health Documentation

- Identifying Info
- Assessments
- Diagnoses
- Medical history
- Plans
- Progress Notes
- Referrals
- Releases of Info
- Rights Notification
- HIPAA Notices
- Medication forms
- Lab results
- Correspondence
- Consent to Care
- Transition Plan
Individualized Recovery Planning
Individual Recovery/Resiliency Plan

What is an IR/RP?

- Record of agreed upon preferences, outcomes, goals, and objectives
- Record of planned approaches and interventions (how we’ll do it)
- Contract of who will do what and when (responsibilities)
- Planned changes along the way to the goal (changing levels of care)
Individual Recovery Plan (IRP)

• A “living and breathing” document
  • Changes as situations and desires change / updated regularly
• Guides our actions and direction
• Modified with changing desires
• Signed by Individual served / provider
• Done with not to or for
Delineating the Challenges

Functional challenge (Valued Roles in Community)

- Living, learning, working, social environment?
- Identifying needed supports?
- Identifying needed skills?

Basic support challenge?

- Food, clothing, shelter?
Goals should:

- Identify specific outcomes
- Be personal for the Individual
- Be simple and clear
  - Short and to the point
  - Easily understood
- Change as needed / desired
Spotlight on the IR/RP!

Parent: “I want him to stop all this aggression!”

What’s the goal? Identify the outcome!
What’s causing the aggression?
• Symptom?
• Skill deficit?
• Support deficit?

• Focus on positive!
Objectives are:
• Necessary steps toward the Goal
• Prioritized / categorized / associated
• Written in “everyday” language (keep it real)

**SMART:**
• **S**pecific,
• **M**easurable,
• **A**chievable,
• **R**ealistic and
• **T**ime limited
**Actions** necessary to achieve the objectives

- Consistent with achieving objectives
- Can be done by anyone involved
- Consistent with skill/competence/credential

**Examples may include:**

- Teaching skills
- Linking to supports
- Negotiating for or with Individual
- “Brainstorming” options
Progress Notes: Documenting your Work and their Progress
Progress notes are one of “three fundamental components of consumer-related documentation”, along with “assessment and reassessment and treatment/supports planning.” (page 307)

“Review of sequential progress notes should provide a snapshot of the Individual over a specified time frame.” (page 315)

Additionally:

Progress notes provide the primary method of communication between staff for coordination of quality care.
<table>
<thead>
<tr>
<th>Required Components of Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Linkage</strong></td>
</tr>
<tr>
<td>• Connects the assessment, IRP, and progress note intervention</td>
</tr>
<tr>
<td><strong>Individual Profile</strong></td>
</tr>
<tr>
<td>• Description of Individual’s current status</td>
</tr>
<tr>
<td><strong>Justification</strong></td>
</tr>
<tr>
<td>• Support for need of service</td>
</tr>
<tr>
<td><strong>Specific Service Provided</strong></td>
</tr>
<tr>
<td>• Detail of all provided activities or modalities</td>
</tr>
<tr>
<td><strong>Service Purpose</strong></td>
</tr>
<tr>
<td>• Reason Individual is participating in services</td>
</tr>
</tbody>
</table>
Required Components of Progress Notes

Individual Response to Interventions
- How the Individual was affected by the intervention

Monitoring
- Evidence that interventions are occurring and monitored for outcomes

Individual Progress
- Identifying progress (or lack of) toward specific goals/objectives

Next Steps
- Plan to support stability

Reassessment/Adjustment to Plan
- Acknowledging need to modify the IRP
Common Progress Note Formats

- **SOAP**
  - Subjective data
  - Objective data
  - Assessment
  - Plan
- **DAP**
  - Data
  - Assessment
  - Plan
- **BIRP**
  - Behavior
  - Intervention
  - Response
  - Plan
- **BIRPP**
  - Behavior
  - Intervention
  - Response
  - Progress
  - Plan
- **GIRP**
  - Goal
  - Intervention
  - Response
  - Plan
Quantitative Items (the basics):

1. Date of contact / service
2. Correct code
3. Time in/out and Units
4. Location of service
5. Content of note (What happened; BIRP, GIRP, etc.)
6. Your name and credential
7. Date you wrote and signed the note
8. Your signature
# ABC’s of Writing Progress Notes

## Qualitative (Content of the Note)

<table>
<thead>
<tr>
<th>Goal or objective being addressed (Why you are there; purpose of intervention?)</th>
<th>Interventions you provided (what you did relevant to plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any additional issues / needs / changes? (what’s new?)</td>
<td>Response to intervention (How did it go?)</td>
</tr>
<tr>
<td>Progress made (Toward the goals / objectives)?</td>
<td>What’s your plan for the next time?</td>
</tr>
</tbody>
</table>
Recovery interventions may include:

- **Linkage**: identifying and connecting to resources
- **Engaging**: building trust, commitment, rapport
- **Referring**: introducing to resources and services
- **Skill teaching/modeling**: introducing new knowledge and behaviors
- **Perfecting skill use**: ensuring new skills are used as desired/required for success and satisfaction
Recovery Interventions May Include

Development of community engagement and natural supports:

- Returning to school
- Job training or employment
- Becoming a mentor
- Choosing, getting, and keeping places to live, learn, work or socialize.
### Non-Billable Activities

<table>
<thead>
<tr>
<th>Accompanying</th>
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</thead>
<tbody>
<tr>
<td>Transportation</td>
</tr>
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</table>

**Generally:**
- Playing games
- Playing sports
- Watching movies
- Surfing the web

**If Individual is not present . . .**

**If Individual is asleep . . .**

**Anything that’s not directly related to goal attainment**

**Job training**

**Where intervention isn’t focused on Individual served**
Common Errors or “Dark Holes”

- “Wordy” notes that document a conversation but miss the interventions, response, and progress
- Documenting diversionary activities
- Activities outside our scope of practice / credential
- Doing for instead of doing with
Questions and Feedback

- Any questions?
- Any clarifications?
- What was your “Light Bulb!” moment today?
Questions and Feedback
Evaluate the Training
Thank you

For Georgia Collaborative ASO general inquiry or questions please email:

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