Residential Services: Documentation

Introductions

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  - Provider Relations Manager/Trainer

Training Objectives

Participants will be able to:
- Describe the levels of support in the different residential services,
- Understand the primary reasons for clinical record documentation,
- Describe the relationship between assessment, planning, and progress noting,
- Describe and demonstrate the key components of a progress note that supports a Medicaid claim.

The Georgia Collaborative ASO

Residential Services Documentation

December 20, 2017
Mental Health Residential Services

- Current
  - Independent MH Residential Services
  - Semi-independent MH Residential Services
  - Intensive MH Residential Services

- Coming Soon:
  - Community Residential Rehabilitation I
  - Community Residential Rehabilitation II
  - Community Residential Rehabilitation III
  - Community Residential Rehabilitation IV

Independent Residential Services

- H0043 R1
- "Low level of residential structure" to continue recovery and increase self-sufficiency. Fully integrated in the community in a scattered site individual residence.
- Minimum: 1 F/F contact, in home, per week
- Various skills and supports to promote community connections, self-advocacy, education, employment, self-determination, and increased choice in all areas, including the living environment.
  - FY18 Provider Manual (Jan 1 2018) Pg. 224

Independent Residential Services

- H0043 R1

  - Documentation:
    - Proof of enrollment in service for each date/day billed
    - Proof that F/F contact was made each week
      - date of contact
      - time in / time out
    - Weekly summary/progress note
      - reflective of IRP implementation
      - progress toward goals/objectives
      - health issues / how they're addressed, appointments, etc.
      - scheduling and linkage to psychiatric, health, counseling, etc.
  - FY18 Provider Manual (Jan 1 2018) Pg. 225

Semi-Independent Residential Services

- H0043 R2
- Demonstrated need for 24/7 available staff support and moderate assistance w/residential responsibilities.
- Minimum:
  - on-site at least 36 hours per week,
  - available 24/7, able to respond to an emergency within one hour
  - at least three hours per week of skills training / personal support
- All same as Independent plus budgeting, shopping, meal planning...
  - FY18 Provider Manual (Jan 1 2018) Pg. 232
Semi-Independent Residential Services

- **H0043 R2**
- **Documentation:**
  - "Documentation Guidelines" in Part II, Section IV
  - Resident on date billed
  - Three hours of skills training each week
  - Weekly summary/progress note
    - reflective of IRP implementation
    - progress toward goals/objectives
    - health issues / how they're addressed, appointments, etc.
    - scheduling and linkage to psychiatric, health, counseling, etc.
  - FY18 Provider Manual (Jan 1 2018) Pg. 234

Intensive Residential Services

- **H0043 R3**
- **Documentation:**
  - Resident on date billed
  - Five hours of skills training each week
  - Weekly summary/progress note
    - reflective of IRP implementation
    - progress toward goals/objectives
    - health issues / how they're addressed, appointments, etc.
    - scheduling and linkage to psychiatric, health, counseling, etc.
  - FY18 Provider Manual (Jan 1 2018) Pg. 229

Intensive Residential Services

- **H0043 R3**
- **Individuals with frequent or lengthy hospital admissions or incarcerations.**
- **Highly supportive 24/7 AWAKE staff on-site at all times;**
- **Minimum:**
  - on-site at least 36 hours per week,
  - available 24/7, able to respond to an emergency within one hour
  - at least three hours per week of skills training / personal support
- **All same as Independent plus budgeting, shopping, meal planning...**
  - FY18 Provider Manual (Jan 1 2018) Pg. 228

Remember, you are documenting the story of my recovery!
What is Documentation?

Written material that provides:

- **Legal** documentation
- Official **evidence** of services & supports
- Primary **communication** for treatment team
- Record of **collaboration** with individuals served
- Record of **planned** outcomes, methods, interventions
- Record of **provided** interventions, approaches, reactions, efforts, adjustments, and progress
- A tool for **engagement**

Tips To Remember

**Documentation Should be written:**

- in a **professional and timely** manner
- to include all required components
- and signed by the person providing the services
- as if it will be published on the front page of a newspaper

**Tips To Remember**

**Documentation Should:**

- **Be Clear** to an uninvolved reader
- **Justify** and **support**
  - stated goals
  - planned interventions
  - adjustments to plans
  - interventions provided
- **Avoid** judgment statements or opinions / commentary
- **Should** consist of facts, actions, observations

**Documentation Includes . . .**

(*but not limited to:*)

- Presenting circumstances and concerns
- Strengths, needs, abilities, and preferences
- Assessment of relevant history, health, environment
- Plans *(Treatment, Recovery, Rehab, WRAP, etc.)*
- Specific interventions provided
- Individual’s responses to interventions
- Unresolved issues from previous engagements
- Next steps / decisions
- Progress toward planned outcomes/objectives
Assessments

Assessment / Reassessment
“Conceptualizing the story…”

The Behavioral Health Assessment (BHA) process is a comprehensive clinical assessment involving the individual, relevant supports,* and the practitioner providing services.

*individual-identified family, significant others, collateral agencies, additional treatment providers & other relevant individuals

Residential Assessment?

- What information do you gather / assess to determine how you support a person residually?
  - What might you need to know about a person’s abilities?
  - What might you need to know about resources / supports?
  - What are the person’s strengths?
  - What are the person’s preferences?
  - What are their needs?

Recovery Planning
Individualized Recovery Plans

Why do we need a “good” IRP?
• Identifies agreed upon outcomes or “destinations”
• Lays out the steps to achieve the outcomes
• Prioritizes, organizes, and sequences activities
• Identifies responsibilities and roles
• Includes all services/modalities planned/provided
• Reduces confusion and uncertainty in the team
• Drives the day-to-day actions/interventions

Individual Recovery Plan (IRP)

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

Recovery Outcomes May Include

Development of community engagement and linking to natural supports:
- Returning to school
- Completing job training classes
- Gaining employment
- Becoming a mentor
- (Choosing, getting, and keeping places to live, learn, work, and/or socialize)

Individual Recovery Plan (IRP)

Most people don’t walk in with goals; help them discover theirs!

Goals-
  ✓ Specific outcomes
  ✓ Clear and simple
  ✓ Expressing desire/wishes of individual
  ✓ Be in the individual’s words (understandable)
  ✓ Change as needed / desired

(People often need help setting goals)
IRP Objectives

Objectives-
- Required steps toward the goal
- Specific, Measurable, Achievable, Realistic and Time limited (S.M.A.R.T.)
- Understood by all involved
- Creating objectives is tough

IRP Interventions

Interventions-
- Actions necessary to achieve the objectives
- Consistent with the desired outcome

- Activities may include:
  - Identifying needs and resources
  - Teaching skills
  - Linking to supports
  - Negotiating for or with individual
  - “Brainstorming” options

Planning is Important!

What we need to reach our dreams:
- Goals & Dreams
  - Well-designed, Organized, Prioritized, Multi-step, S.M.A.R.T., Flexible, Individualized, Individual-driven, Coordinated, Plan that gets the person where they want to go.

What many get:
- Duplicated,
- Non-specific,
- Disorganized,
- Unprioritized,
- Inflexible,
- Uncoordinated,
- Single-step plans that go nowhere.

Progress / Activity Notes

Attend & participate
Progress Notes Must Contain:
- **Date** of contact / service
- **Date** you wrote and signed the note
- **Code** of service provided & billed
- **Time** in/out / **Units**
- **Location** of service (U7)
- **Description of interventions, response, progress, etc.**
- **Name** and **Credential** of provider staff
- **Signature** of provider staff

Progress Notes Should Contain:
- **Goal or objective being addressed** (purpose of intervention)
- **Interventions you provided** (what you did relevant to plan)
- **Any additional issues / needs / changes?** (what's new?)
- **Response to intervention** (How did it go?)
- **Progress made** (Toward the goals / objectives)
- **What's your plan for the next time?**

**Documenting: Progress Notes**

**Recovery Interventions May Include:**
- linking
- engaging
- referring
- educating
- advocacy activities
- skill teaching / modeling
- perfecting skill use

**Definitions**
- **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
Staying in our “Lane”

ACTIVITY TIME

1. Take out a piece of paper
2. Number 1-10
3. Next to each number, write the name of a skill that you currently teach

What is a Skill?

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral:</td>
<td>An action capable of being seen or heard by others</td>
</tr>
<tr>
<td>Purposeful:</td>
<td>Intentional; used for a purpose</td>
</tr>
<tr>
<td>Generalizable:</td>
<td>Applicable to a variety of circumstances</td>
</tr>
<tr>
<td>Perfectible:</td>
<td>Proficiency can be reached with knowledge and practice</td>
</tr>
</tbody>
</table>

Most always ends with “ing”

- Starting a conversation
- Introducing yourself
- Balancing my checkbook
- Negotiating a change in my schedule
- Demonstrating understanding
Watch Out for Imposter Skills!

- Sounds like a skill
- Doesn’t meet the criteria
  - Allowing
  - Arriving
  - Being
  - Maintaining
  - Complying
  - Doing
  - Participating

When in Doubt...

If a baby can do it...

Progress / Activity Notes: Avoiding Common Errors

- Code billed doesn’t match code documented
- Content of note doesn’t match code billed
- Incorrect date of service/date of entry
- Content does not support units billed
- Missing or incorrect credential
- Missing signature/missing printed name
- Out-Of-Clinic location missing
- Time-in/time-out missing
BA1  What does this astrik refer to?
Bourque, Anna, 12/13/2017

DJ [2]1  It is my understanding that there is not Out-of-Clinic option for Residential Services; in other words, no using U6 or U7 modifiers. I was thinking about not even mentioning this item.
Dixon, John, 12/13/2017
Common Errors in Noting

- "Wordy" notes that document a conversation but miss documenting interventions, responses, and progress
- Documenting diversionary activities
- Activities outside our scope of practice/credential
- What’s written doesn’t justify time/units

Remember To:

- Write your name and credential
- Date your signature
- Assure the correct date of service
- Assure the billed service is a match for what you provided and documented

Remember To:

- Document location of service
- Document the start and end times
- Record the units of billable service
- Be clear and concise

Evaluate the Training
<table>
<thead>
<tr>
<th>BA2</th>
<th>What does this asterisk refer to?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bourque, Anna, 12/13/2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DJ [2]2</th>
<th>It was to remind me to make a comment about it. I can take it out.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dixon, John, 12/13/2017</td>
</tr>
</tbody>
</table>
Questions and Feedback

The Georgia Collaborative ASO

Thank you

For Georgia Collaborative ASO general inquiry or questions please email: GACollaborative@beaconhealthoptions.com