# Documentation Skills and Standards

Essential Skills for Documentation

**MEDI-CAL PEER SUPPORT SPECIALIST CERTIFICATION**

# The Value of Progress Notes

# The Big Picture

- The core elements of a mental health chart for Medi-Cal billing includes:
  - The Assessment
  - Treatment Plan
  - Progress Notes
- There needs to be a thread of connection between all for billing Medi-Cal.

# HOWEVER…

Sometimes services are required that are not on the treatment plan.

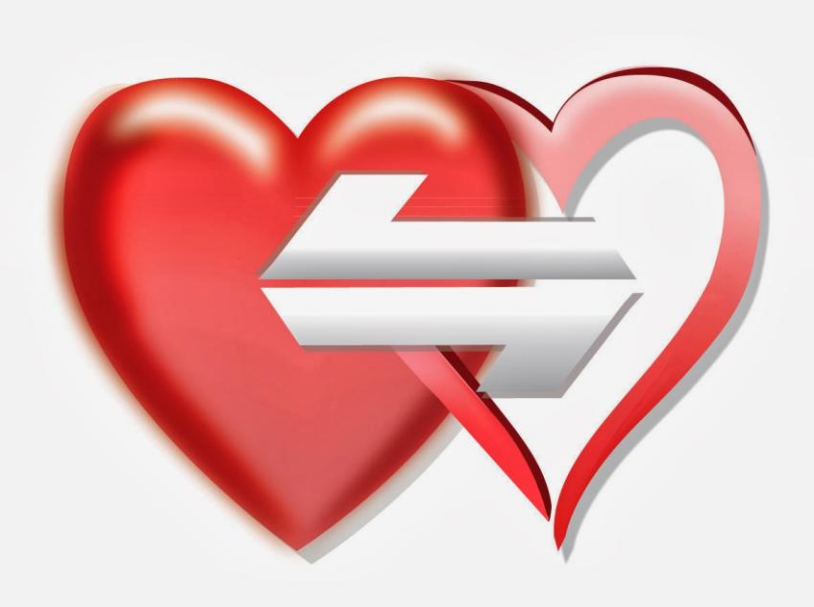
One or two activities pertaining to a new issue is fine. However, if it looks like there is going to be more work together on a new issue, the treatment plan needs an addendum.

The treatment plan is a living, flexible document!

# Quality Care

The health records support communication amongst healthcare providers.

A person in care may receive care from one or more healthcare providers that work together to best meet the goals of the person in care, thus making documentation a necessary component of quality health care.



# Legal Document

Progress notes serve as a legal record describing treatment provided, including for reimbursement purposes.

# Revenue Generation

- Medi-cal billing is a key source of revenue for the system.
- Rules and regulations are there to protect against abuse and fraud.
- The county sets up a Compliance Plan to abide by these rules.
- For services to be billable, the client must meet medical necessity.

# What's wrong AND What's right

Medical necessity focuses on the diagnosis, symptoms and impairments that create barriers for the individual.

As we do our work, we focus on reducing or eliminating the barriers and identifying strengths.

# Language

**Labeling**

- He's a bipolar (schizophrenic, borderline, etc.)
- She's delusional.

**Person-First Language**

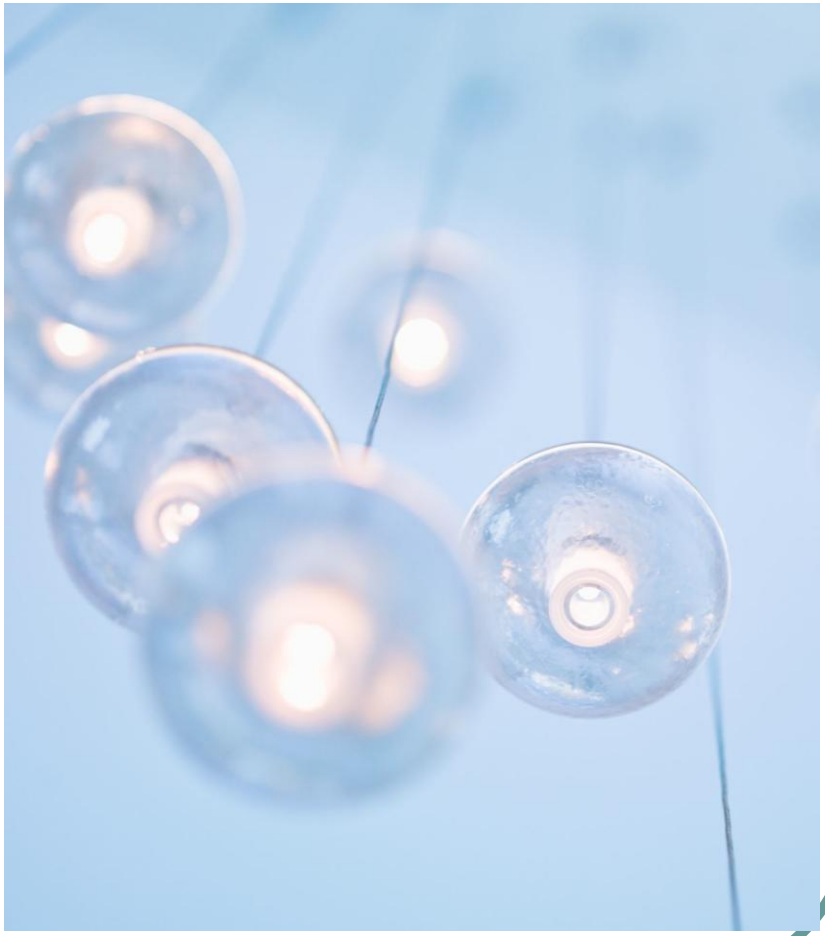
- He has a diagnosis of bipolar disorder.
- She experiences the TV talking to her and telling her she is special.

# Key Things to Consider

- Use descriptive, non-clinical terms
- Avoid jargon and acronyms
- Write in person-centered, person-first, non-stigmatizing language that is easy to understand.
- Write as if the client is looking over your shoulder.

# Key Things to Consider

- Focus on the mental health and/or substance use disorder intervention(s) provided during the encounter.
- Documentation should be accurate, precise, and timely.
- Clearly document the behavioral health intervention.



# Key Things to Consider

- Identify next steps for the person in care, their support system, and/or the certified Peer Support Specialist.
- Adhere to confidentiality regulations.

# What is “medical necessity”?

- Specifies the criteria for Med-Cal reimbursable services
- There are three criteria
  - Allowable diagnoses
  - Impairment in functioning criteria
  - Intervention-related criteria

# Medical Necessity: Diagnosis

Licensed clinicians evaluate and diagnose individuals coming into our system.

Non-licensed professionals document observations of symptoms and behaviors that may relate to the diagnosis.

# Medical Necessity: Impairment in Functioning Criteria

- A significant impairment in an important area of life functioning OR
- A probability of significant deterioration in an important area of life functioning

# Important Areas of Life Functioning That Can Become Impaired

- Occupational
- Social
- School
- Danger to self/others
- Activities of daily living

# Medical Necessity: Intervention Criteria

- The focus is to address the identified impairment
- The expectation is that it will benefit the consumer by
  - significantly diminishing the impairment
  - or preventing significant deterioration in an important area of life functioning
- The condition would not be responsive to physical healthcare-based treatment

# The Role of the Direct Service Provider

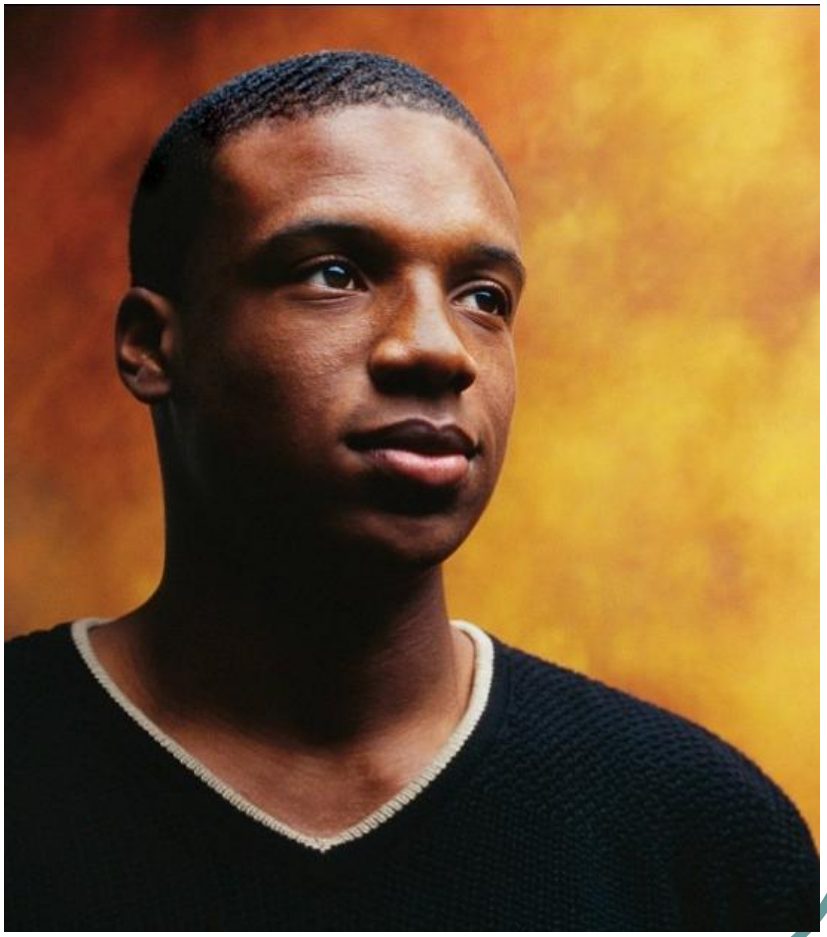
- To observe and document evidence of medical necessity within the individual's scope of practice.
- Non-licensed professionals often see behavior and know of issues the consumer is experiencing which other professional staff may be unaware of.
- Documentation of symptoms, functional impairments and results of interventions are key to providing evidence of medical necessity.

# Exercise

Identifying Peer Provider Interventions that Connect to Functional Impairments

# Identifying strengths

Meet Jayson.  Review his psychosocial assessment and underline all the strengths you find.



# County Differences

Every county develops documentation standards according to their understanding/interpretation of the regulations.

Always refer to the program's established policies and procedures.

# Progress Note Basics

- Always include:
  - Name of client
  - Date of service
  - Location
  - Time involved
  - Signature, including discipline
  - Date of signature
  - Co-sign signature

# Mistakes Happen

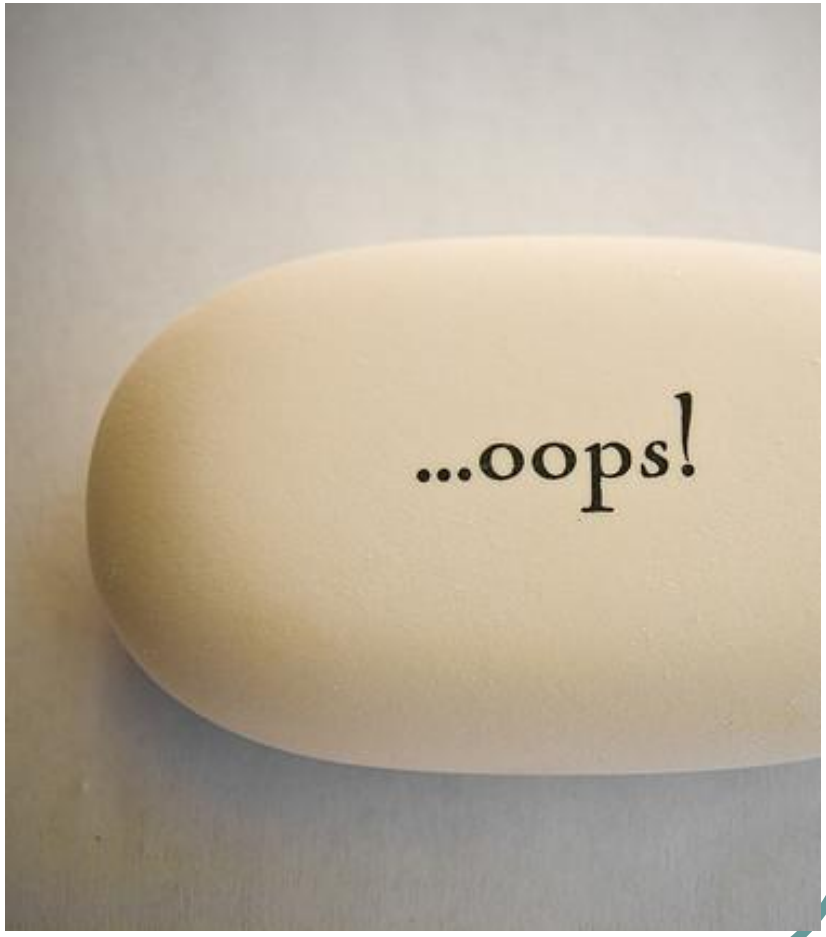
**Paper**

- Every progress note must be legible
- When you make a mistake, cross out with ONE LINE, write “error”, and write your initials.

  NEVER USE  WHITE-OUT

**EHR**

- Adhere to agency's **process** is for making a change to the health **record**.



# Progress Note Basics


If it isn't documented, it didn’t happen

# Progress Note Basics

- Notes must accurately reflect the activity, location and time for each service
- Time includes
  - Time spent in travel to deliver the service
  - Providing the service
  - Documenting the service
- Big time = big note (or at least one that clearly identifies how the time was spent)

# Progress Note Basics

If a client misses an appointment, the time is not billable.  However, be sure to document and follow up.

Notes must adequately describe the interventions delivered during the time frame.

# Progress Note Basics

Notes must reflect services based on the current assessment and client plan.

Not all services are billable – and may still be exactly the right service to provide.

# Progress Note Basics

Notes must not include other consumer's names

# Progress Note Basics

- Include documentation of coordination and collaboration, e.g., referrals.
- Include date of follow-up care, appointments or discharge summary.

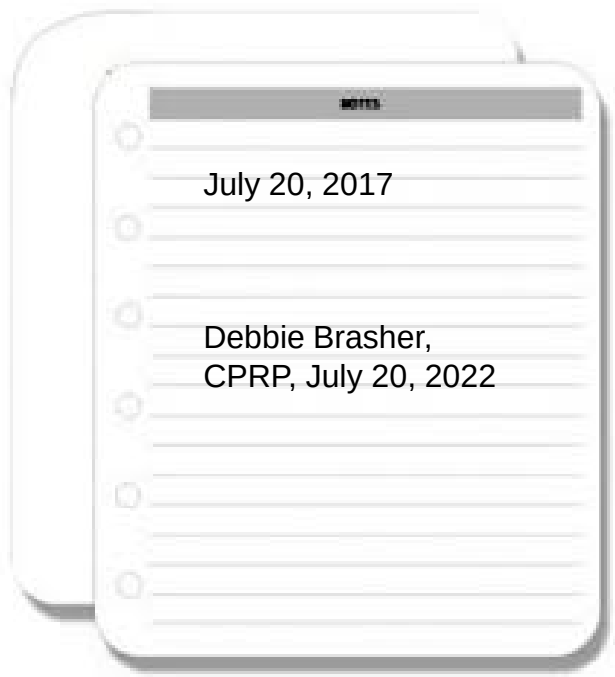
# Progress Note Basics

Write as if the client is looking over your shoulder

- Use respectful, person-first and recovery-oriented language

# Progress Note Basics

- No Placeholders!!
- It can be hard to get your notes done in a timely manner – but do not create a blank note to go back to later.



# Timelines

- Best practice is to write the note as soon as possible after delivering a service.
- Check your county guidelines: Some notes need to be written within one business day of the service provision

# Some Billing Categories to Know

*Always stay within your Scope of Practice*

Licensed professionals can use billing codes for therapy, medication services, assessment and diagnosing as their license permits

# Some Billing Categories to Know

Non-licensed professionals may use these billing categories:

- Rehabilitation (skills training for increasing recovery)
- Group Rehabilitation (skills training in a group setting)
- Case Management/Brokerage (services provided on behalf of a client, such as referrals)

# Peer Support Services

**Peer Support Services** are defined as:

Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

# Peer Support Services Components

## Educational Skill Building Groups

Providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. Groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

# Peer Support Services Components

## Engagement

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Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.

# Peer Support Services Components

## Therapeutic Activity

A structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

# Service Codes

The Peer Support Service components should be claimed under the identified codes as follows:

- **Self-Help/Peer Services (H0038)**
  - Engagement
  - Therapeutic Activity

- **Behavioral Health Prevention Education Service (H0025)**
  - Educational Skill Building Groups

# Welcome to BIRP

- Behavior:  non-judgmental and strengths-based description of the client and his/her behavior.  How is the client doing today?
- Interventions:  What are you there for?  What did you do? What goal or objective are you working on?
- Response:  What happened?  How did the client feel about the intervention/meeting with you?
- Plan:  What will you do next?

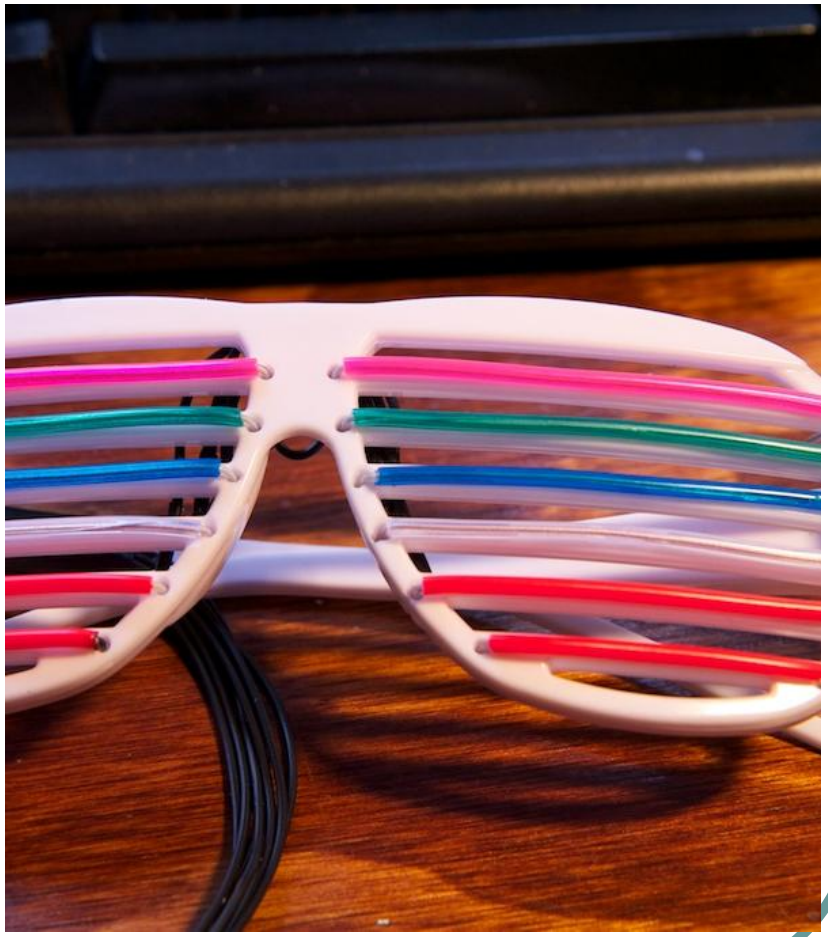
# Behavior/Client Description

| | | |
|---|---|---|
| Physical appearance | Thought process | Affect/Mood |
| Behavior | Speech | Attitude |

# Behavior/Client Description

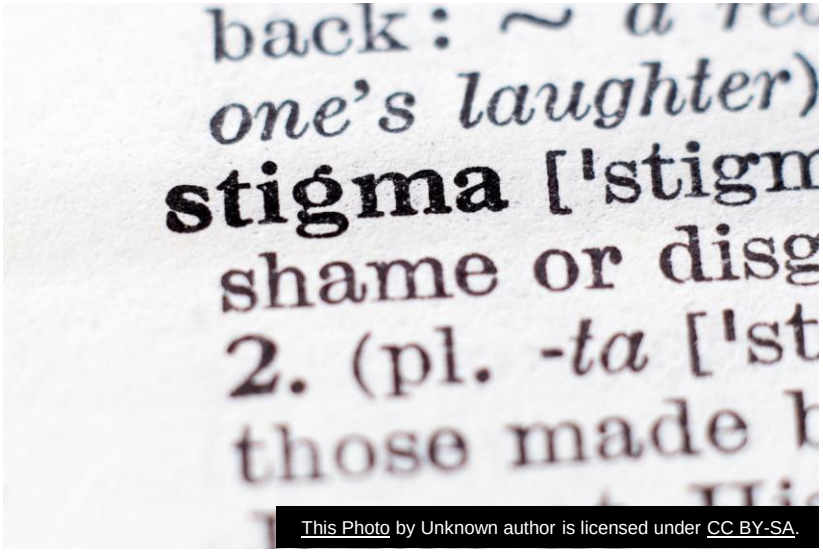
First identify the behavior and **describe** what you see.

- This description is where you might be documenting symptoms and behaviors that connect to the person's diagnosis and functional impairments – using non-clinical language.



# Behavior/Client Description

Be aware of stereotyping, stigmatizing and bias that may lead to misinterpretation of client's symptoms and behaviors.



# Behavior/Client Description

- Bias can be either positive or negative
- Be aware of a tendency to either over-identify with clients like yourself or reject/be wary of clients who are different

# Interventions

- Documentation of the action taken in the service of the client's goals and objectives.
- What service are you providing?
- Services must work to reduce or eliminate barriers to the individual's goal. They address the symptoms, behaviors and functional impairments experienced by the individual.

# Goal-Oriented

Every visit is in the service of furthering the consumer's stated goals and objectives.

Identify what part of the service plan is being targeted.

# Interventions: Progress Note Action Words

- Supported
- Assisted
- Referred
- Practiced Skill Development
- Confronted
- Demonstrated
- Problem-solved
- Engaged

# Response

It’s important to not only describe the process, but also to identify what the client decided to do.

- If problem-solving, which response did the consumer choose?
- If discussing, where did the conversation end up?

# The Plan

A good progress note includes a statement of what's next:

- Date of next meeting
- Referral information
- Commitment to an action step

# Group Notes

Include all the BIRP elements AND

- Summary of group's purpose and goals
- The specific participation of the client and how it relates to the client's goal
- Total number of client's served in the group
- Total service time (includes the amount of time it takes to write progress notes for all clients in the group)

# Exercise

Audit Mock Progress Notes