QUALITY NOTES AND DOCUMENTATION

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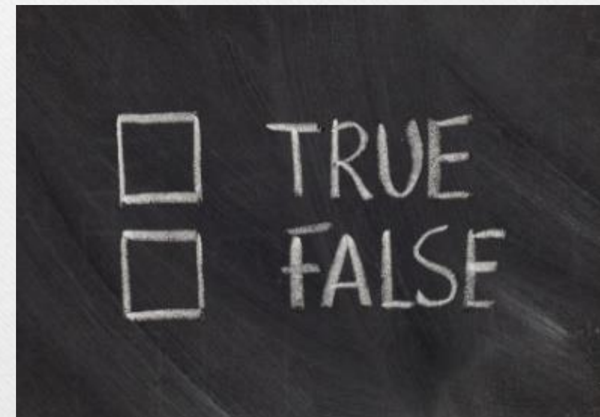
If it isn't documented, it didn't happen.

Why is Documentation so Important?

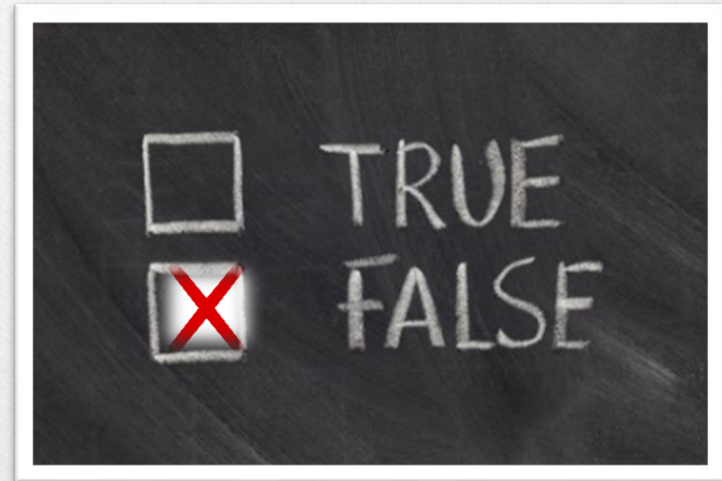
True or False?

The **primary** reason that proper documentation standards should be followed is so that your agency can bill for Core Services provided to a Member.



TRUE or FALSE?

The primary reason to follow proper documentation standards is so that all case participants can accurately communicate about the Member's progress and Plan of Care.



This is why we document…

1. Outcomes - Member progress & to ensure quality services
2. Reminders - for yourself and for your Members
3. Coverage - other staff can be in the know when needed
4. History - crisis patterns and in/effective interventions
5. Protection - compliance, legality, billing & reimbursement

Real Example

- "Care manager discussed with parole officer that an appointment was scheduled for member for 12/10/2018 by this care manager as member had not yet rescheduled the appointment with the clinical provider which had been cancelled by the program."

Real Example

- "Member called this writer. A face-to-face appointment to complete the comprehensive harassment was made for 5/2/18 at 11:30am at their residence."

Real Example

- Member name is Nichelle
- "This writer attempted to meet with Nichel on the unit today. Michelle would not speak to this writer but would only not her head or shake her head no. This writer trying to engage with Nichle and offer assistance with discharge planning, but Nishelle shook her head no when this writer offered help. This writer asked Nishel if she wanted to remain in care coordination services and Nick shell sugar head no and said she did not want to services."

Real Example

- 284-minute face to face visit
- "Member reports member has attempted to ensure he will be able to maintain member's pain medication regimen. Member informed writer that member plans to send writer a list of routes member has taken to try and keep member's pain medication regimen"

Facts, just the facts! Documentation should be….

- ✓ Complete and Thorough
- ✓ Relevant/Member Centered
- ✓ Objective
- ✓ Timely

CRHC Policy on Documentation:

C4. Care Coordination: Care Note Documentation

Complete and Thorough Documentation

- Complete sentences
- People, places, things identified (not abbreviations)
  - Policy C4: Care Note Documentation Section B4
  - Policy C4: Care Note Documentation Section B7
- End with an Action Statement
  - Policy C4: Care Note Documentation Section C2
- Support Core Service Delivery

Complete and Thorough Real Example

- "CM transported client to his appointment at the CDPC clinic. CM transported client home after his appointment.”

Complete and Thorough Real Good Example

- "The writer transported member to her PCP apt. During the transport [member] talked about wanting to try some massage therapy to help release some tension in her body and to relax her mentally. [Member] stated that her goal is to be free of all her medication. She stated that she would like to try holistic medicine. This writer encouraged [member] to discuss this with her primary care provider at their apt. During the apt [PCP] advised that the member discuss goals of being off medications with her BH provider and recommended that she not stop her antidepressants without first having that discussion. Member was frustrated by this but this writer encouraged the member to wait and reminded the member that she had an apt with [Doctor] her BH provider next week. - On the ride back, [Member] reported that she has not seen or heard from the stalker and feels safer in her apt. She no longer wants to seek new housing."

Complete and Thorough
Real Example

- "This writer was unable to make contact with the member."

Complete and Thorough Real Good Example

- "Care coordinator went to Member's house and knocked on the door. The Member did not answer. There were two post it notes from the landlord on the door. One was from 9/23/18 and the other was 9/29/18. The landlord left his phone number and asked the Member to call him. Care coordinator called Member's emergency contact and asked if she had heard from the Member. She said she has not spoke to him in months and has no idea how to contact him or find him. - Care coordinator emailed the Member's parole officer [Officer]. [Officer] said there is a warrant out for his arrest, and he has stopped reporting to parole. They do not know his location."

Relevant/Member Centered Documentation

- Details are important but not all details are relevant.
- Consider whether what you are documenting is relevant to the Member's care.
- Notes are the Member's story, not yours.

Relevant/Member Centered Real Example

- "Care manager plan was updated at this visit."

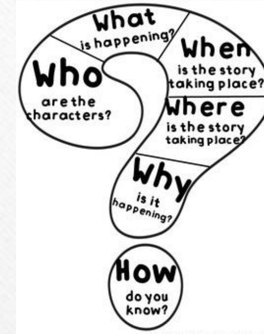
Relevant/Member Centered Real Example

- "Care manager plan was updated at this visit, however, writer attempted to enter it into care manager over 10 times and it would not input, there was always an error. Writer will input the plan today, however, it was completed 1/22/19."

Relevant/Member Centered Real Good Example

"[CC] met with Member face to face at Albany Medical Center Inpatient Behavioral Health Unit (E2). CC and Member completed intake and comprehensive assessment. Consent was obtained to add Albany Medical Center, Medical Answering Services LLC (MAS), Fidelis Care, [brother and emergency contact], and Capital District Psychiatric Center (CDPC) to the DOH5055. Member is currently inpatient at Albany Medical Center due to a suicide attempt. Member reported they would utilize MAS for transportation once out of the hospital. Member has been referred to CDPC and may be transferred there from Albany Medical Center hospital. Member's main concerns are mental health and his housing. Member has multiple suicide attempts and reported during the assessments that the most important thing to him is finding a way to commit suicide successfully. Member stated that he would be dead before he was homeless. Member fears going back to his home as this is where his suicidal attempts have taken place. Member reported that he has no income after losing employment. Member reported that if he is discharged from the hospital, he will need assistance with obtaining SNAP benefits, applying for social security, being connected to a food pantry, scheduling transportation with MAS, finding a PCP and a pharmacy, finding housing, and obtaining a therapist and psychiatrist."

Objective Documentation



- Stick to the facts and write professionally
- Who, What, Where, When, Why and How
  - Policy C4: Care Note Documentation Section C1
- Would you say this to the Member, MCO or a Judge?
- Summarize email exchanges
  - "As reported by [name, title]…"
  - Policy C4: Care Note Documentation Section B5

Email Example:

Notes

New Note | New Task

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telephone at [redacted] and destroy the original transmission and its attachments without reading them or saving them to disk. Thank you

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Objective: Real Examples

Non-Objective text seen in real notes:

- “Member is scatter brained”
- “Member dyed her hair purple which did nothing for her overall appearance.”

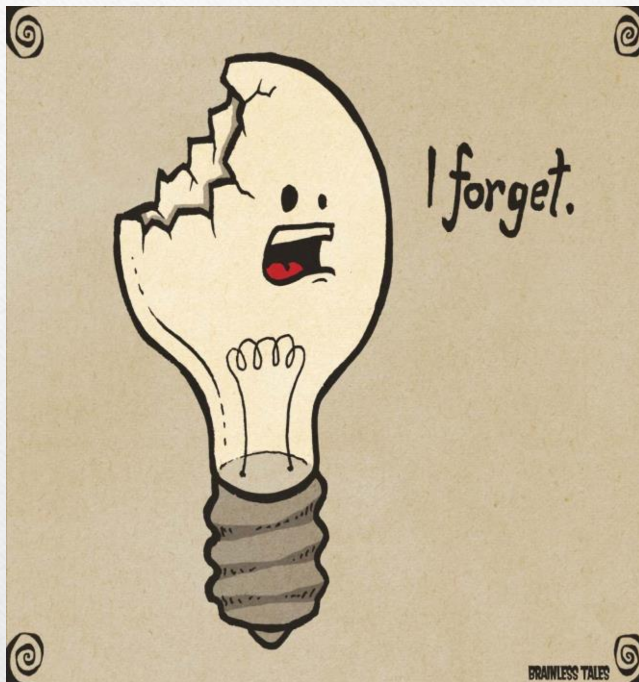
Objective: Real Good Example

- "…..In the exam room was [Member], an aid, and CM. CM attempted to speak to [Member] calmly; however [Member] was already furious and outraged. [Member] stated that if they didn't finish her tooth today that she was going to slit her wrists; [Member] then began punching herself in the head. CM requested that [Member] stop. CM asked if she had taken her medication this morning to relieve the panic like symptoms; [Member] responded "fuck no, I stopped taking my meds, I don't need them." CM asked if she has seen [Therapist] (her therapist) she responded with "no, I was supposed to see her today but cancelled because of my dentist appointment." [Member] then began yelling because she was still waiting for the dentist to come in; at this time she stated again that she was going to kill her self and that she has plans for the dentist too. CM advised [Member] that that she shouldn't say those things. [Member] then stated that she feels that the staff are plotting against her because she heard them state that they were calling 911. CM did not acknowledge as it would set [Member] off even more. [Member] then stated that if she sees a cop she is going to fight them; CM advised that she should not do that and asked her to calm down…."

Objective Documentation: Strength-based words to use

- Advised
- Assessed
- Assisted
- Clarified
- Counseled
- Discussed
- Directed
- Educated
- Encouraged
- Focused
- Identified
- Recommended
- Reflected
- Summarized
- Supported
- Urged

Timely Documentation



- **Ideal:** Concurrent Documentation or Same Day Documentation
- **Policy:** Within two business days
  - Policy C4: Care Note Documentation Section D2
- **Good time management.**

Bonus Tip: Scope of Practice

- Be sure that your recommendations fall within your scope of practice and support member health as recommended by providers.
- Collaborate and Coordinate with Providers!

Real Example

"This writer discussed with [Member] his recent blood sugar readings. [Member] stated that his nurse that comes to his house every week told him that he only needs to test his blood sugar twice a week. This writer asked [Member] what his blood sugar readings were recently and [Member] stated that they were under 200, which was lower than usual. This writer encouraged [Member] to still test his blood sugar daily, as it is important to have consistent readings. This writer told [Member] that if he tests it every day and one day it is higher than another, he would be able to possibly determine what he ate the previous day that caused his blood sugar to spike. [Member] understood."

Documenting your work is just as important as doing the work.

Core Service: Comprehensive Care Management

Comprehensive Care Management	
NYS DOH Definition	• Assessment and Plan Development (includes crisis intervention plan). • Consult with providers on Member's needs. • Monitor Member adherence to or variance from treatment guidelines. • Conduct outreach and engagement activities to assess ongoing needs to promote wellness.
Related Tasks	• Conduct Assessments, Re-assessments and Screening Tools. • Develop Plan of Care. • Obtain information from other providers to inform plan or contacts with the Member. • Obtain information from Member in terms of adherence and concerns.

Real Good Example

- “This writer and member completed the comprehensive assessment together. The member stated he had a history or concern with being a flight risk and homicidal history. He stated that he sometimes feels like he just wants to get up and leave or run away. He also stated that he has never killed anyone in the past, but he thinks about harming others sometimes. The member reported that he has trouble taking his medication because he forgets to take them sometimes. He said that he has anxiety about going to pick up his medication from the pharmacy and will wait a few days before actually going to pick them up.”

Core Service: Care Coordination and Health Promotion

Care Coordination and Health Promotion	
NYS DOH Definition	• Coordinate with provider; sharing of information pertinent to treatment and prevention. • Link Member to needed services to support plan of care. • Advocate for services & assist with scheduling of needed services. • Coordinate with treating providers. • Monitor, support or accompany member to scheduled medical appointments. • Provide Health Education specific to chronic conditions • Crisis intervention.
Related Tasks	• Conduct case conferences or case reviews with providers. • Provider referrals, transportation scheduling, appointment reminders. • Coordinate with treating providers to ensure changes in treatment are addressed. • Discuss and share literature on disease management.

Real Good Example

- "CC met with member's BH provider [Provider] regarding member's ongoing ER use. [Provider] reports that member has been no-showing to apts for the last month and is at risk for being discharged from their program. The [Provider] suggested that the member could benefit from PROS. This writer will discuss this plan with the member when they meet next week."

Core Service: Comprehensive Transitional Care

Comprehensive Transition Care	
NYS DOH Definition	• Follow up with Hospital/ER upon notification of Member admission or discharge. • Support discharge planning from inpatient setting to ensure safe transition. • Notify/consult with involved and appropriate providers. • Follow up post discharge with member and family to ensure needs are met.
Related Tasks	• Consult with hospital staff or navigators on event. • Participate in facility discharge planning meetings. • Review discharge paperwork with Member to ensure Member understands discharge instructions. • Ensure Member has needed medications and follow-up appointments scheduled. • Follow-up with Member post-discharge to ensure Member is following plan (ideally prevent re-admission).

Real Good Example

- "CC picked up [Member] from Samaritan Hospital Geropsych unit and assisted him with getting home to his apartment. CC took [Member] food shopping as he had not been home in a couple of weeks. CC and [Member] met with the discharge nurse to go over [Member's] upcoming appointments and review his medications. [Member] said that he had spoken with [provider] from the Mental Health Empowerment Project and planned on attending an AA meeting with him in the next couple of days. CC called and spoke with [Member] later in the day and he reported that he had set up transportation for his appointment with [Provider] at Samaritan Hospital Outpatient Mental Health clinic tomorrow at 10:30am, as well as transportation to get to his PCP's office for his 2pm appointment with [Provider 2]. CC reminded [Member] of his appointment on Monday with [Provider] at Samaritan Hospital Outpatient Mental Health clinic at 5:15pm and his appointment with [Provider 3] at SHOP for his medication injection on 1/9/19 at 10am. CC provided positive reinforcement for [Member] setting up his own transportation for his appointments and offered to assist [Member] with transportation if needed. CC asked [Member] to call him later in the week to see how he was doing."

Core Service: Member and Family Support Services

Member and Family Support Services	
NYS DOH Definition	• Engage family/supports in Plan of Care. • Review Plan of Care with Member to ensure Plan reflects preferences of the Member • Refer family/supports to support groups, entitlement programs, social services, etc. as needed to help promote health literacy and self-management of care.
Related Tasks	• Review individualized Plan of Care. • Consult with family / supports on the Plan of Care and Member progress. • Refer Member and family / supports to self-help, peer supports or other programs. • Complete Advance Directives paperwork.

Real Good Example

- "This writer met with [Member] to discuss advance directive options. Member's significant other [Name] was present. Member had requested meeting to take place with [Name] as this member has had anxiety about discussing advance directives without his significant other present. This writer explained the living will and health care proxy and gave the member and his SO handouts. Member stated he wanted time to think over the paperwork with his SO but thanked this writer for the information. This writer will follow up with the member next month regarding his choice or any additional needs."

Core Service: Referral to Community and Social Support

Referral to Community and Social Supports	
NYS DOH Definition	• Assist Member and family / supports in maintaining benefits and eligibility for needed resources and services. • Identify community supports / services and actively manage status of referrals / services. • Linkage with disease-specific supports to promote health education (smoking cessation, diabetes management, etc.)
Related Tasks	• Assist in maintaining active benefits (Medicaid). • Identify community based supports and services and link Member and family / supports to programs. • Coordinate with above-referenced providers to ensure engagement in services.

Real Good Example

- “The member stated he would like to go back to school and eventually get a job. He stated he currently has his GED but would like to take business classes, become a personal trainer or obtain his CASAC. The member stated that he doesn't know how to achieve these goals but is worried about his criminal background and being able to find a job. This writer talked to the member about linking him the Northeast Career Planning who can assist him in achieving these goals. He also reported that being able to manage his mental health symptoms would be challenging for him to be able achieve these goals.”

Documentation to Supporting Billing

CRHC Policy E1 Section B8

Although rare, it is possible to bill for a Core Service without directly interacting with the Member. Such examples may include the following.

- Case conferencing with collaterals for the purpose of coordinating care, evaluating goals or obtaining feedback or input regarding the Plan of Care (Care Coordination and Health Promotion)
- Interactions with other individuals who are part of the care team for the purpose of coordinating care, discussing Member needs, or consulting about Member goals (Care Coordination and Health Promotion)
- Following up on referrals to and engagement with community, behavioral health or medical service providers (Referral to Community and Social Support)
- Advocating for services on behalf of the Member (Care Coordination and Health Promotion)

Do not bill for this…..

CRHC Policy E1 Section B10

- Mailing a letter
- Emailing or texting without receiving a response
- Receiving information via letter, fax, email, etc.
- Leaving a voicemail
- "Check-ins"
- Providing transportation only
- Anything that does not support Core Service delivery

Remember….