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DOCUMENTING CARE: PROGRESS NOTES

California Mental Health Services Authority (CalMHSA)

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CALMHSA INTRODUCTIONS

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WE ARE HERE

TRANSFORMATION WEBINARS: FOR COUNTY LEADERSHIP & QI STAFF

Welcome to CalAIM: Then vs. Now	04/27/22
Shifting our Focus: Compliance vs. Quality	05/04/22
Communication Plans: Change Messaging	05/11/22
Initiating Treatment: No Wrong Door/Treatment Prior to Diagnosis	05/18/22
Standardizing Documentation: Universal Assessment	05/25/22
Identifying Treatment Focus: Problem List	06/01/22
Documenting Care: Progress Notes	06/08/22
No Money, No Mission: Billable vs. Non-Billable Services	06/15/22
Outcomes That Matter: Quality Measurement	06/22/22
You've Got This: CalAIM – A Summary	06/29/22

TRAINING OBJECTIVES

Participants will walk away with:

- An understanding of what is now required of progress notes for Specialty Mental Health Services (SMHS), DMC and DMC-ODS
- Clarity regarding progress note timeliness guideline
- An understanding of common areas of confusion related to progress notes

PROGRESS NOTES

Applies to SMHS as well as DMC & DMC-ODS

STREAMLINE, SIMPLIFY & REDUCE UNNECESSARY COMPLEXITY

UNDERSTANDING THE IMPACT

KEEPING IT SIMPLE

"SMALL" CHANGES --> BIG IMPACT

- Staff can complete 6-10 or more services per day for therapy/rehab sessions, quick case management calls, collateral check ins, etc.
  - In many EHRs, each note takes 15-20 minutes to complete, though staff may or may not bill for all of this time
  - Reducing clicks, narrative boxes and progress note elements = reduced note writing time

If we can cut the time in half:

8 notes x 20 minutes/note = 160 minutes of note writing (nearly 3 hours!)

Becomes

8 notes x 10 minutes/notes = 80 minutes (less than 1 ½ hours of note writing!)

But What is Actually Different?

Keep in mind:

- The full impact of CalAIM documentation reform will not be fully realized until payment reform occurs in July 2023

- In the meantime, documentation can be leaner with less jargon with more emphasis on what was done and what the next steps will be

3 KEY FUNCTIONS OF A PROGRESS NOTE

3 KEY FUNCTIONS OF A PROGRESS NOTE (CONTINUED)

CARE PLANNING

- Used as a basis for planning treatment among practitioners and across programs.
- Should be understandable when read independent of other progress notes.
- Should provide an accurate picture of the treatment provided, and plan for future care.

COMMUNICATION

- Used to communicate with other care providers.
- Provide a quick exchange of information to coordinate care, reduce duplication of services, and improve outcomes.
- Should reflect what is up next and what is needed.

REIMBURSEMENT

- Used as verification of billed services for reimbursement.
- Are a legal record to describe treatment provided.
- Must include sufficient documentation of the intervention to justify payment.

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WHO ARE PROGRESS NOTES FOR?

WHO ARE PROGRESS NOTES FOR

CLIENT

- The people we serve have the right to access their medical records. Technology will continue to create greater opportunity for real time client access to charts.
- When individuals have access to their health information, it empowers them to be more in control of decisions regarding their health and well-being

CARE TEAM

- Help others involved in the client's care know what's going on with treatment and what's needed
- Provide a clear and concise description of services and needs to help inform care planning and treatment of other practitioners

YOURSELF

- Help formulate a record of your thought process in care
- Show the rationale for what you are doing

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CALAIM VISION: LEAN PROGRESS NOTES

Problem	New Policy	Impact
• Long progress notes due to fear of audit findings • Need to "establish medical necessity" in every note leads to over-writing by staff • Notes so long that they are not read by others and key information is lost	• Fewer progress note requirements • It is most crucial to record the service and interventions provided and a plan for next steps	• Less time spent on documentation means more time spent with individuals who need services • Fewer audit disallowances

PROGRESS NOTE REQUIREMENTS (CONTINUED)

SMHS, DMC & DMC-ODS

- The type of service rendered (for example, Individual Therapy, Collateral, Plan Development, etc.)
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date that the service was provided to the beneficiary
- Duration of the service, including travel and documentation time
- Location of the beneficiary at the time of receiving the service
- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate

"BEHIND THE SCENES" PROGRESS NOTE REQUIREMENTS

In other words: Things typically managed automatically in your electronic health record

- A typed or legibly printed name, signature of the service provider and date of signature
- ICD 10 code (this is not required on each progress note written by a provider; this means that the claim that is submitted to the state must include the ICD-10 code—this should not be a change from the current process)
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code

GROUP PROGRESS NOTES

SMHS, DMC & DMC-ODS

- When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider
- Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider
- While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements listed above shall also be met

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PROGRESS NOTE TIMELINESS

SMHS, DMC & DMC-ODS

- Providers must complete progress notes within ***3 business days*** of providing a service
- Notes for crisis services must be completed within ***24 hours***
- If a progress notes is entered after the required timeframe, it is good practice to document the reason a note is delayed
- Based on program / facility type, stricter note completion timelines may be required by state regulation (e.g., STRTPs)

WHAT SHOULD NOT BE INCLUDED

- A lengthy narrative that does not add clinical value
- A copy and paste of the last progress note (even if some elements remain the "same" as the last visit)
- Jargon: special words or expressions that are used by a particular profession or group and are difficult for others to understand
- Specific note formats such as BIRP, SOAP, SIRP, etc. are not required

HELPFUL TIP

Ask Yourself:

- **What service did I provide?**
  - What specific service activities / interventions did I provide?

- **How did the service address the client's needs?**
  - What symptoms, diagnosis(es), risk factors, and/or social determinants of health did we focus on?

- **What is the plan?**
  - What action steps will be taken by me and/or the client?
  - Is care coordination needed?
  - Do I need to make any updates to the problem list?

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PERSON-CENTERED LANGUAGE

A person is not their illness

- Person-centered language emphasizes the person first rather than the illness
- People are so much more than their substance use disorder, mental illness, or disability
- Using person-centered language is about respecting the dignity, worth, unique qualities, and strengths of every individual
- A person's identity and self-image are closely linked to the words used to describe them

Providers' words can be harmful or healing, so we need to pay attention

Hyams, K, Prater, N., Rohovit, J., Meyer-Kalos, P.S. (2018). Person-centered language. Clinical Tip No. 8 (April, 2018): Center for Practice Transformation, University of Minnesota.

Words are powerful.

Words can unintentionally lead to biases and further stigmatize individuals, which can become accepted as part of an agency's culture over time.

Use them to empower.

PROGRESS NOTE MYTHS

DEEP DIVE

PROGRESS NOTES

WHAT YOU'VE HEARD:

"If progress notes are completed after 3 days, then we need to write the notes off"

REAL DEAL

Progress note timeliness is not related to audit recoupments.

DEEP DIVE - CONTINUED

PROGRESS NOTES

WHAT YOU'VE HEARD:

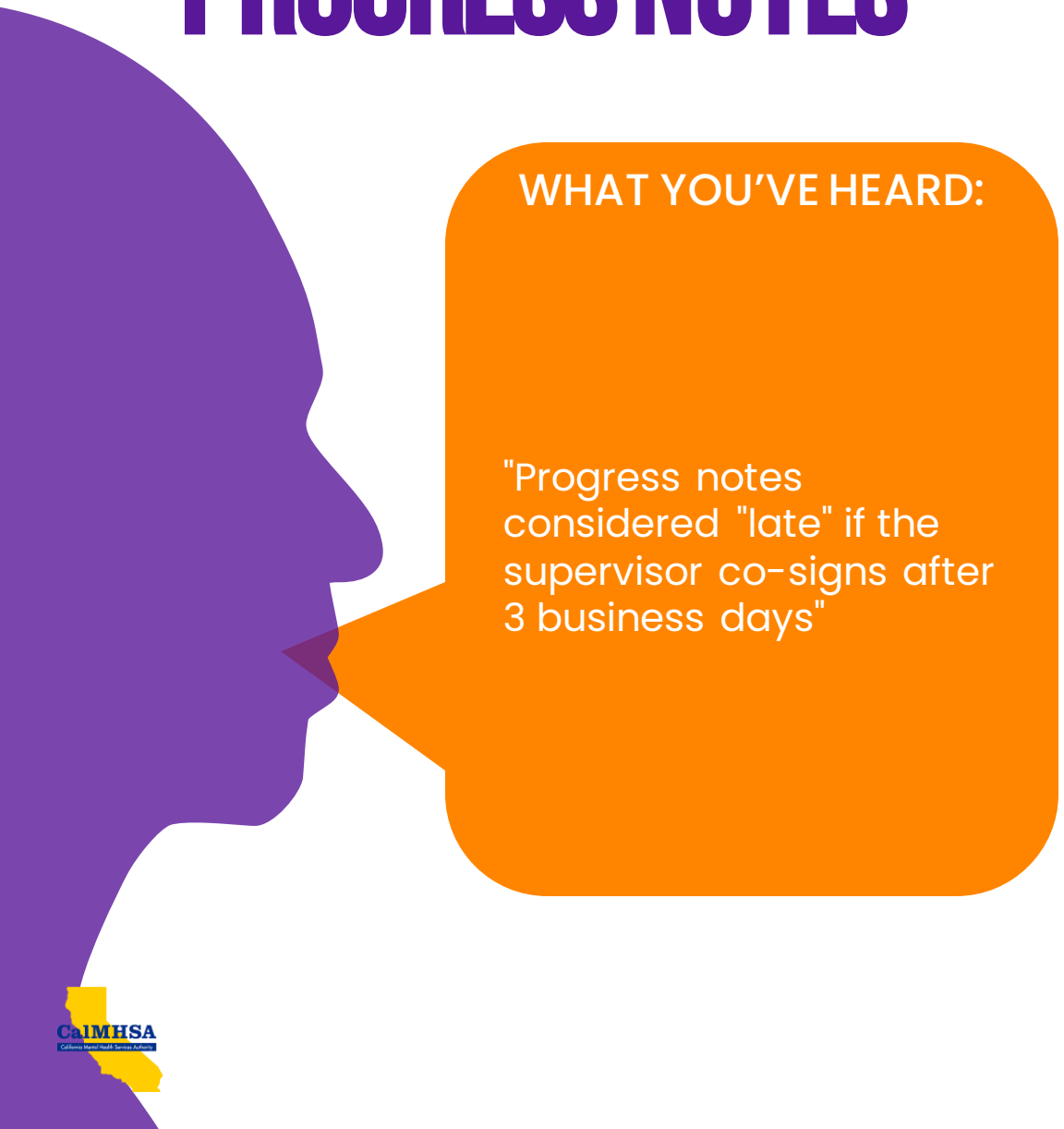
"We are allowed to come up with our own timeliness guidelines for progress notes"

REAL DEAL

Progress note timeliness are now officially set by the DHCS. Counties are strongly advised against setting timeliness requirements that are more stringent than the set timeliness requirements. Counties cannot set timeliness requirements that are less stringent than the DHCS timeliness guidelines.

DEEP DIVE - CONTINUED

PROGRESS NOTES



WHAT YOU'VE HEARD:

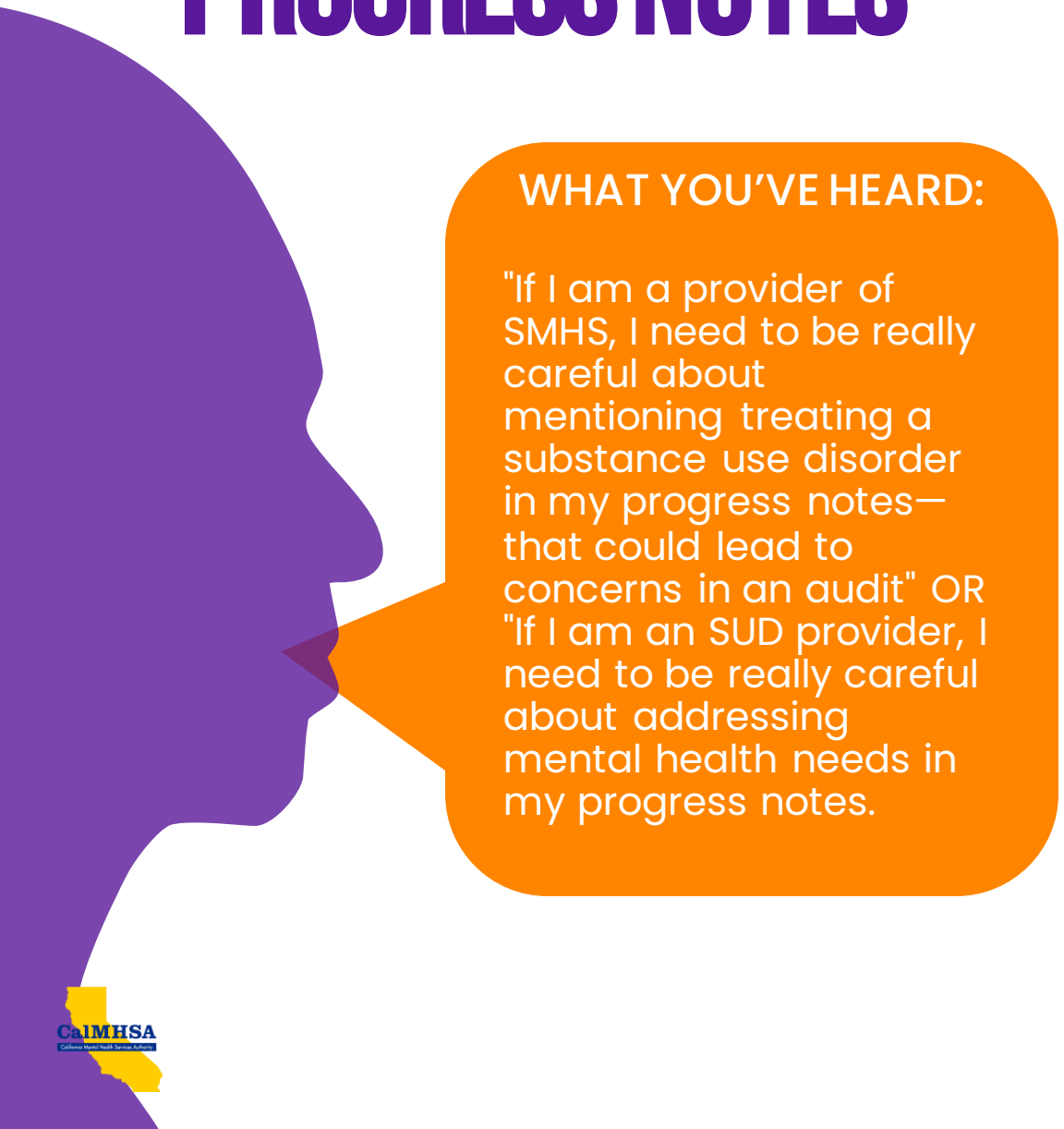
"Progress notes considered "late" if the supervisor co-signs after 3 business days"

REAL DEAL

Progress note timeliness is tied to the author of the note who is working within their scope of practice to provide the service. That said, co-signers should co-sign notes as soon as possible.

DEEP DIVE - CONTINUED

PROGRESS NOTES



WHAT YOU'VE HEARD:

"If I am a provider of SMHS, I need to be really careful about mentioning treating a substance use disorder in my progress notes—that could lead to concerns in an audit" OR "If I am an SUD provider, I need to be really careful about addressing mental health needs in my progress notes.

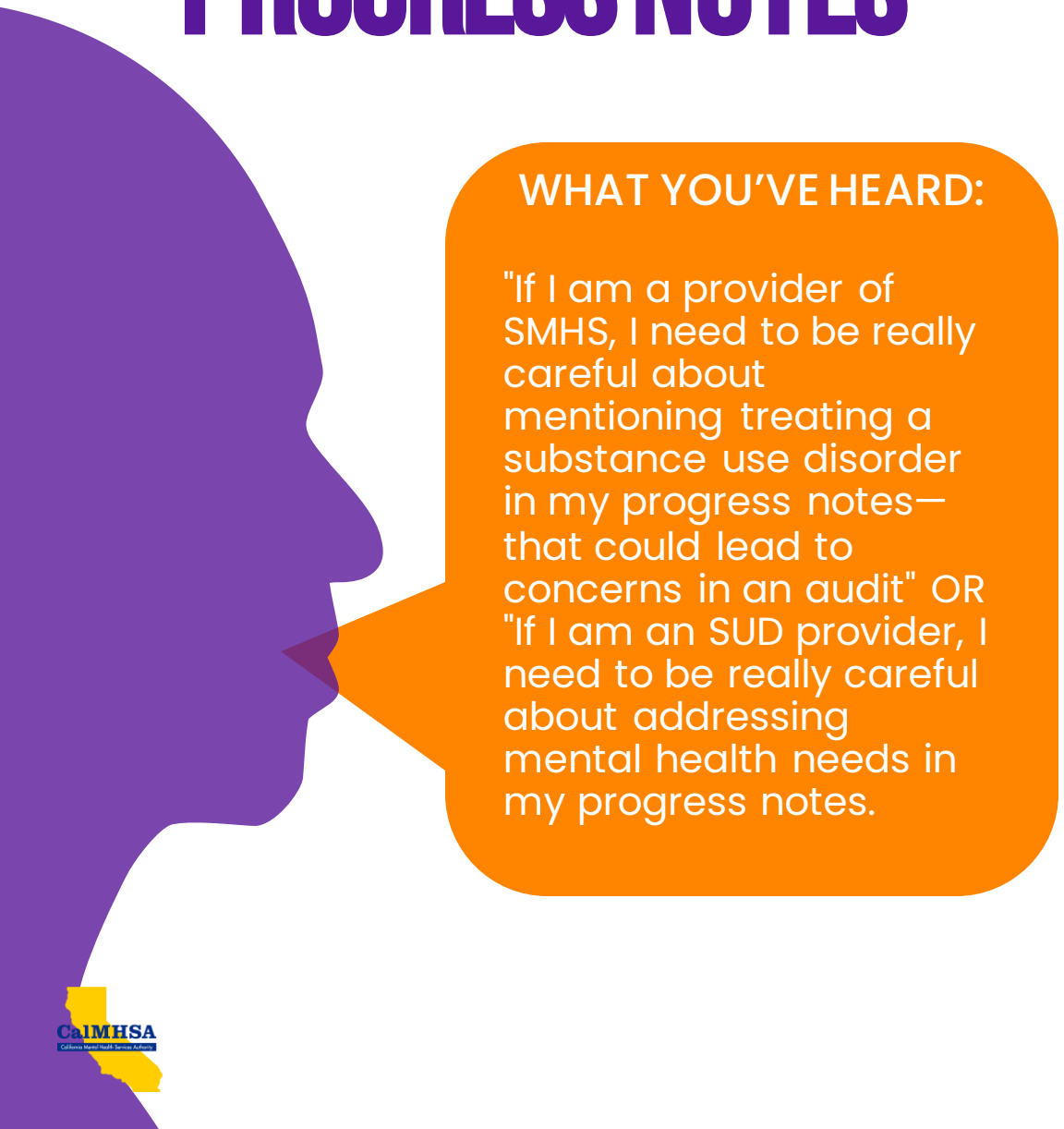
REAL DEAL

Co-Occurring Treatment allows SMHS providers to address SUD needs within progress notes/clinical documentation and allows SUD providers to address MH needs within progress notes/clinical documentation.

Co-Occurring Treatment does not require staff to work out of scope and if more comprehensive support is required, providers should assist the client with receiving more in depth services in the appropriate type of setting (MH or SUD).

DEEP DIVE - CONTINUED

PROGRESS NOTES



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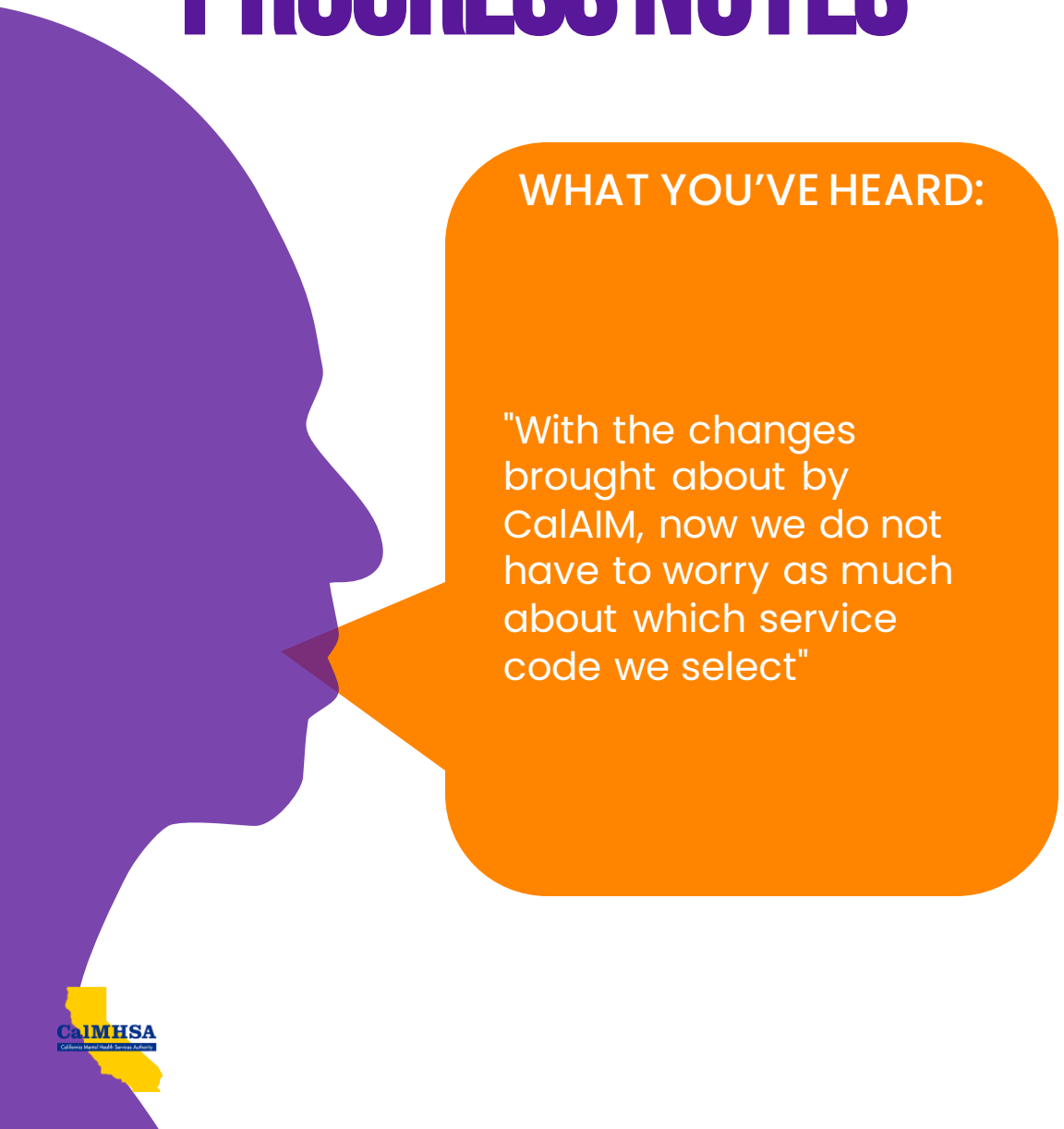

WHAT YOU'VE HEARD:

"With the changes brought about by CalAIM, now we do not have to worry as much about which service code we select"

REAL DEAL

It is still important to ensure that the services you document in the narrative of your progress notes speak to the service code that you have selected.

REVIEW OF MOST CURRENT CALMHSA OFFERINGS

Recent Additions

- No Wrong Door P&P and attestation
- Revised slides for transformation webinar #1 and addition of change log for webinar slides
- SUD LPHA Documentation Guide (Revised 6/3/22)
- Web-based documentation trainings via CalMHSA Learning Management System (LMS):
  - CalAIM Overview
  - Access to Services
  - Assessment
  - Diagnosis/Problem List
  - Progress Notes

Upcoming Items

- Remaining Transformation Webinars
- Additional MH and SUD Documentation Guides
- Staff communication materials
- Documentation Requirements P&P and related attestations
- Additional web-based documentation trainings:
  - Care Coordination
  - Discharge Planning

To Access these Resources Please Visit: California Mental Health Services Authority | CalAIM Support for Counties (calmhsa.org)

Feedback? Questions?

Calaim@calmhsa.org

Please click the NEW Survey Monkey link in the chat to complete our post-training evaluation

THANK YOU!

Thank You!