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"Collaborative Documentation Gets You Off the Compliance Treadmill"

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MTM Services

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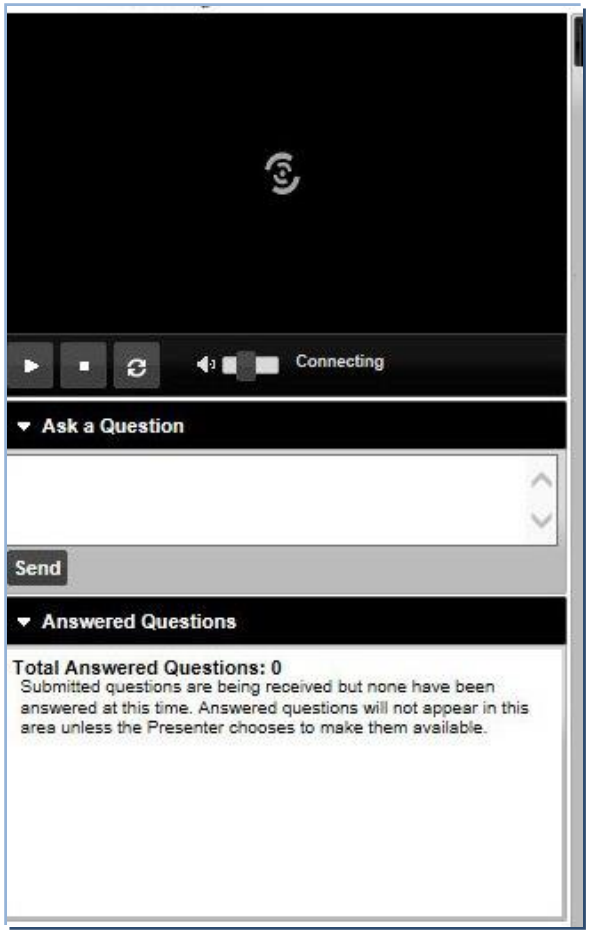
Asking Questions



Submit your questions using the “Ask a Question” box to the left of your screen and send it to the organizer.

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Audit Environment and Risk Recovery Audit Contractors

ACTION: Final rule. Medicaid Program; Recovery Audit Contractors (RAC)

57808 Federal Register/Vol. 76, No. 180/Friday, September 16, 2011/Rules & Regulations
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
42 CFR Part 455 [CMS–6034–F]
RIN 0938–AQ19
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

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How much money are Medicaid RACs expected to recover?

In the final RAC rule CMS estimated that Medicaid RACs would recover the following amounts:

- **ESTIMATED SAVINGS IN MILLIONS - FY 2012-2016**

Year	2012	2013	2014	2015	2016	2012-2016
Federal	$60	$190	$280	$330	$360	$1220
State	$50	$140	$200	$250	$270	$910
TOT	$110	$330	$480	$580	$630	$2130

Note: Medicare RAC audits collected $2.4 billion in 2012 and expectation is that Medicaid RAC audits will follow similar trend!

- **See more at: http://www.medicaid-rac.com/medicaid-faq/#sthash.iFzckRDe.dpuf**

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Medicaid RAC contractors only get paid if they recover dollars for Medicaid

RACs only collect fees on overpayments that are recovered and underpayments that are corrected (12%). In addition, RAC contractors must return any recoveries that are reversed after a provider appeal. This means that auditors are incentivized to pursue only those claims they can prove are inaccurate.

- See more at: http://www.medicaid-rac.com/medicaid-faq/#sthash.iFzckRDe.dpuf

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NM - Public Consulting Group (PCG) Audit Report Summary

Audit Findings

Each of the 15 providers audited through this process failed to meet compliance standards.

$36 million in overpayments have been identified, amounting to more than 14% of the dollars paid to these providers.

The most egregious claims that were audited were found to have a more than 25% error rate while the case files impacting individual health and safety were found to have a 57% error rate.

Provider	Randomly Sampled Claims		Longitudinal Claims		Total Overpayment Amounts
	% Non-Compliance	Extrapolation - Lower Bound	% Claims Failed	$Value Claims Failed	
Provider A	29.3%	$ 2,046,690.0	64.8%	$ 179,903	$2,226,593
Provider B	35.3%	$ 2,757,585.0	84.6%	$ 210,548	$2,968,133
Provider C	13.3%	$ 772,016.0	27.8%	$ 78,854	$850,870
Provider D	14.9%	$ 565,309.0	35.5%	$ 291,436	$856,745
Provider E	21.8%	$ 3,629,976.0	70.7%	$ 103,063	$3,733,039
Provider F	6.0%	$ 57,614.0	97.4%	$ 22,736	$80,350
Provider G	55.3%	$ 3,138,735.0	38.2%	$ 55,521	$3,194,256
Provider H	27.3%	$ 4,327,784.0	59.6%	$ 161,843	$4,489,627
Provider I	3.3%	$ 7,856.0	41.1%	$ 14,018	$21,874
Provider J	36.7%	$ 1,304,140.0	34.8%	$ 44,239	$1,348,379
Provider K	15.3%	$ 1,028,069.0	98.6%	$ 437,537	$1,465,606
Provider L	21.1%	$ 9,262,711.0	60.2%	$ 335,833	$9,598,544
Provider M	17.3%	$ 612,663.0	20.0%	$ 43,137	$655,800
Provider N	40.0%	$ 4,128,958.0	49.7%	$ 64,907	$4,193,865
Provider O	18.0%	$ 228,309.0	97.1%	$ 68,661	$296,970
Grand Total	**23.7%**	**$33,868,415**	**57.1%**	**$2,112,234**	**$35,980,649**

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NM - Public Consulting Group (PCG) Audit Report Summary

- Assessments (psychosocial/psychiatric evaluations) were not up to date (within last 12 months) to determine if the consumer continued to meet the need of the rendered service.
  - Incomplete critical information such as Five Axis diagnosis.
  - Substance abuse history was absent for most consumers with a dual-diagnosis of mental health and substance abuse.
- Treatment plans were not up-to-date and individualized per consumer. Updated treatment plans are necessary to determine any changes to goals/objectives in addition to progress or lack of progress by the consumer. Without continuously updated treatment plans, it is impossible to determine if the treatment interventions still meet the behavioral health needs of the consumer.
  - Goals/Objectives were not measurable and did not document achievable target dates based on the consumer's needs.
  - Service specific clinical interventions used to reach goals/objectives were absent.

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NM - Public Consulting Group (PCG) Audit Report Summary

Longitudinal File Review Findings

- Safety/Risk Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
- Treatment plans were not up-to-date and individualized per consumer.
  - Plans contained the same goals/objectives for more than 12 months.
  - Potential overutilization of services without documented justification of the service related to extensive length of stay.
- Consumer Documentation *(Progress Notes)*
  - Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
  - Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
  - Billed units did not match the units documented on the progress notes.

Did the NM Audits Teach us Anything New?

Did the NM Audits Teach us Anything New?

No!

Did the NM Audits Teach us Anything New?

No!

They taught us the same things again!!

Did the NM Audits Teach us Anything New?

What We Know

1. **Our sense of security based on state, county, and local payor audits is often illusory.**
2. **Trying to manage compliance <u>strictly</u> through documentation formats, checklists, and documentation rules has never worked. They are helpful but not the solution.**
3. **Documentation is completed by <u>clinicians</u>! Separating documentation from the clinical process removes it from their sphere of interest. Compliance efforts will be mechanical – not substantive or sustainable!**

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Ubiquitous Documentation Challenges

I see one or more of the following in 80% or more of charts I review annually:

Assessments:

- No specific support for diagnoses
- Assessments identify diagnoses but not individualized treatment targets (needs)
- Assessments are not updated to reflect changes in assessed target needs

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Ubiquitous Documentation Challenges

I see one or more of the following in 80% or more of charts I review annually:

Treatment Plans:

- **Goals not linked to Individually Assessed Target Needs**
- **Life/Recovery Goals confused with Behavioral Health Goals**
- **Objectives are not "Measurable or Observable Outcomes".**
- **Failure to indicate "Specific Interventions/Methods" intended to help achieve Gs and Os in Tx. Plans**

Ubiquitous Documentation Challenges

I see one or more of the following in 80% or more of charts I review annually:

Progress Notes:

- **No Linkage to Specific Goals and Objectives**
- **No clear statement of the Intervention(s) provided**
- **No statement of Progress related to Tx Plan Objectives**
- **No recommendations/plans for next steps**

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Common Organizational Challenges

1. **Documentation viewed as "necessary evil" (for audits and billing support) as opposed to important to clinical process, care coordination, and risk management.**
2. **No clear understanding/operational definition or audit focus related to Documentation Linkage (Golden Thread)**
3. **No operational definition of "Assessed Target Needs"**
4. **No agreed upon definition of Tx Plan Goals and Objectives that are in line with Federal Definitions**
5. **Allow use of "Drop Down" Goals and Objectives that are not individualized**

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Common Organizational Challenges

6. **Attitude – "Clinicians will never get it right.. So OK is good enough". (Audit Fatigue)**
7. **Deploying EHRs that are good at billing and reporting but do not support the clinical process.**
8. **Telling staff that they have to document certain elements because "Medicaid, JCAHO, CARF, etc. etc. say we have to" (Scapegoating – failure to lead – sends the wrong message)**
9. **Justifying billing for "interventions" provided during transportation of clients (serious medical necessity / fraud challenge)**
10. **Documentation Timeliness Standards greater than "Same Day"**

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Common Organizational/Local Regulatory Challenges

1. **Over-reacting by requiring that all progress notes must "Stand Alone" in terms of supporting medical necessity**

Require relisting of the following in every progress note:

- ✓ Complaints
- ✓ Symptoms
- ✓ Precipitating factors
- ✓ Cognitive capacity
- ✓ Strengths
- ✓ Etc.

This model

- ✓ Exceeds Federal Requirements
- ✓ Results in redundancy and excessive documentation time (15+ minutes)
- ✓ Ignores the "Golden Thread:"model of medical necessity support.
- ✓ Increases the risk of veering from the treatment plan and "meandering with the client"

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Simple Question

Ask 10 clinician client pairs who have been working together for at least 6 months what the clients' specific current Goals and Objectives are.

I estimate that 20% or fewer will know!

Do you know what specific outcomes you are working on when you work with your primary care physician?

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How Collaborative Documentation Can Help!

- Collaborative Documentation integrates documentation into the clinical process
- Documentation becomes useful to the interests and values of clinicians
- Documentation becomes timely (real time) by default and so provides value for risk management, care coordination, and compliance.
- Because documentation is done with the consumer there is a focus on treatment plans (not just in office linkage to treatment plans)

How Collaborative Documentation Can Help!

- In order to document progress with the consumer the treatment plan needs to make sense and have objectives (measurable or observable outcomes) that the consumer can relate to. Treatment Plans improve!
- Client participation in Treatment Plan Development and Services becomes real and not just a signature or check box.
- Interventions will naturally be stated in terms of the actual description of interventions provided (common sense terminology) and phrases like “helped client process past abuse” or “provided empathic listening” will disappear.

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Collaborative Documentation – What is it?

- **Completing all or most documentation with individuals being served at the time of service**
- **Efficient – creates clinical capacity**
- **Allows persons served to:**
  - ✓ Know what is in their chart
  - ✓ Clarify information
  - ✓ Include their perspective
  - ✓ Become more engaged and involved in their services

Collaborative vs. Concurrent Documentation

- **Collaborative and Concurrent**
  - ✓ Intake/Assessment
  - ✓ Treatment Plans
- **Collaborative – Generally at End of Session**
  - ✓ Progress Notes

Intake / Assessment

Process:

- One section at a time
- Alternate between listening and summarizing
- Let individual / family see the computer screen and point to it periodically

Tips:

- Try to have non-clinical staff gather non clinical information
- Complete all information gathering sections collaboratively
- Based on presentation may determine that some sections should be completed post session (e.g. Mental Status)

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Treatment Plans

Process:

- Start with “identified target needs” from the assessment
- Ask “What do you want the outcome to be as we address this need” = Goal
- Decide “What do we want to result from our work over the next few months & how will we know if we’re successful”? = Objective(s) (Measurable or Observable Outcomes)
- Review and document “What will we do together to move toward your Goal/ Objective(s) = Interventions and Services

Treatment Plans

Tips:

- Develop plan with client throughout planning session
- Tie Goal(s) Objective(s) to identified Assessed Needs
- Be sure “objectives”:
  - ✓ Are measurable or observable
  - ✓ Meaningful to the individual
  - ✓ Achievable in relatively short time
  - ✓ Can be measured objectively by individual and clinician
  - ✓ These are changes in competencies, skills, symptoms, functioning, behaviors, etc.

Treatment Plans

Paradigm for Development of Objectives

1. **Related to Goal Identify current <u>baseline(s)</u> for:**
   - ✓ *Symptom(s):* (e.g. using tools like PHQ9, describing nature and frequency, etc.) or
   - ✓ *Functioning Level:* (e.g. using tools like DLA20, or description) or
   - ✓ *Behaviors:* (e.g. destructive, aggressive, self destructive, etc. using description and frequency) or
   - ✓ *Competencies:* (e.g. lack of ability to identify triggers, lack of knowledge or competency in applying coping skills, etc.)

Treatment Plans

Paradigm for Development of Objectives

2. **Identify a reasonable <u>change from baseline</u> that you expect interventions to attain in 3 or 6 months**
   - ✓ *Symptom(s):* (e.g. change in PHQ9 score to.., change in nature and frequency, etc.)
   - ✓ *Functioning Level:* (e.g. change in DLA20 overall or specific scale scores, or description)
   - ✓ *Behaviors:* (e.g. Change in description and/or frequency)
   - ✓ *Competencies:* (e.g. ability to identify several triggers, and ability to articulate/ demonstrate coping skills, etc.)

Progress Notes

Process:

- Start with the “Plan” section of previous note if possible to review client follow through with expectations and recommendations.
- Then ignore computer and focus on client
- Interact normally with individual saying “I may jot down some notes on a pad during our session so we won’t forget to include them in our note later”
- During last few minutes (5-7) of session enter session note allowing individual to view, clarify, etc.

Progress Notes

Process:

- Some clinicians do parts of note at intervals during the session. Not a black and white issue.
- Depends on the individual (e.g. children with ADHD, adults with cognitive deficits or agitation may benefit from brief breaks and change in focus)
- Be flexible and do what works for you and the individual/family.

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Progress Notes

Tips:

- Allow individual/family to see note
- “Agree to Disagree”!
- Think of CD as written “Wrap-up” – not paperwork!
- Leverage documentation to enhance the clinical process
- Use a formatted note or sequence so note can be written succinctly while addressing required areas.

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Progress Notes

Sample formatted note sequence:

- New, salient information presented (interim update)
- Goal(s)/ Objective(s) addressed today
- Significant changes in mental status
- Interventions (“What did we do that was helpful”)
- Response of individual today
- Progress toward Goal(s)/ Objective(s)
- Plan (homework, recommendations, symptom/behavior monitoring)

Progress Notes

Older progress note formats (e.g. DAP, SOAP, etc.) can be used with collaborative documentation but organizations need to map requires elements into the format areas.

These formats do not prompt for any required elements except the Plan for continued work

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Why Do It?

- Creates Clinical Capacity (Efficiency)
- Improves Engagement and Focus on Outcomes
- Improves Accuracy of Documentation
- Improves Timeliness of Documentation
- Support Compliance Naturally
- Supports Care Coordination and Risk Management
- Supports Transparency
- Supports Person Centered / Driven Services
- Improves Quality of Work Life

Implementation

Mastering CD is not the biggest challenge!

Getting Staff Over the Hump!

- Most difficult phase
- Once staff experience the process and it becomes a habit – they don't turn back.
- Need to "suspend disbelief"
- Generally takes 4-6 weeks

Need to address:

- Healthy Skepticism
- Resistance to Change

Healthy Skepticism

- **Most common reaction**
- **Expected and Welcome!**
- **Staff don't want to adopt a process that may jeopardize clinical quality**
- **Acknowledge and respect skepticism and address concerns**

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Addressing Healthy Skepticism

- **Train**

- **Present <u>Clinical</u> Benefits**
  - ✓ Highly positive response by individuals/families
  - ✓ Improved recall and plan adherence
  - ✓ Improved engagement - reduction in no shows/ cancellations
  - ✓ More time available to see clients and meet needs of community

- **Involve respected skeptical (but objective) clinicians in CD pilot**

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Positive Responses by Individuals/ Families

1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session?	Percentages Total	Total %
1 Very Unhelpful	895	5%
2 Not helpful	244	1%
3 Neither helpful nor not helpful	1662	9%
4 Helpful	5458	30%
5 Very Helpful	9251	51%
NA No Answer/No Opinion	466	3%
Total/Approval %:	17,976	93%

2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?	Total	Total %
1 Very Uninvolved	471	3%
2 Not involved	181	1%
3 About the same	2378	14%
4 Involved	4851	28%
5 Very Involved	8673	51%
NA No Answer/No Opinion	482	3%
Total/Approval %:	17,036	96%

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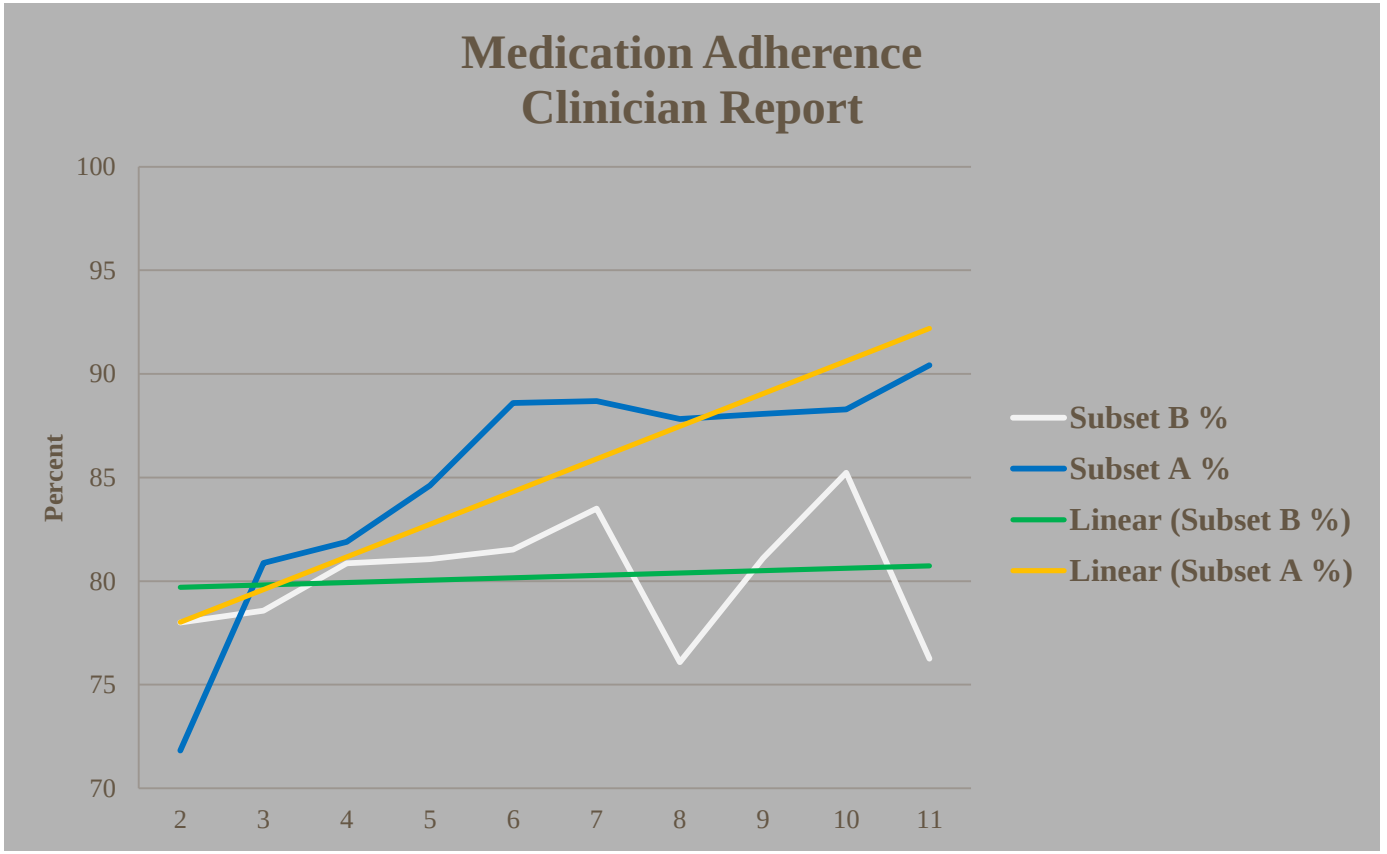
Positive Responses by Individuals/ Families

3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?	Total	Total %
1 Very Poorly	85	1%
2 Poorly	44	0%
3 Average	746	4%
4 Good	4150	25%
5 Very Good	11558	68%
NA No Answer/No Opinion	347	2%
Total/Approval %:	16,930	99%

4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?	Total	Total %
1 No	939	6%
2 Unsure	1867	11%
3 Yes	12571	77%
NA No Answer/No Opinion	904	6%
	0	0%
	0	0%
Total/Approval %:	16,280	94%

10 Center Access and Engagement Project National Council for Behavioral Healthcare

Monthly clinician/prescriber report of Medication Adherence



Addressing Healthy Skepticism

- **Discuss Current Behavioral Health Context Needs**

  - ✓ EHR Meaningful Use Objectives, Increased Care Coordination and Risk Management require virtually real time documentation accessibility.
  - ✓ Movement toward increased Documentation Transparency (Assume individuals will see their records at some point)
  - ✓ With improved coordination and integration of services (e.g. physical health) do individuals really understand the kind of information that is being shared. Is informed consent really informed?

Staff Resistance

- Feeling overwhelmed
- Fears about lack of competency
- Don’t believe documentation should be shared
- Not the way they were trained
- Will try it only when all obstacles are removed
- Focus on exceptions rather that norm

Addressing Staff Resistance

First - Assume It's Healthy Skepticism

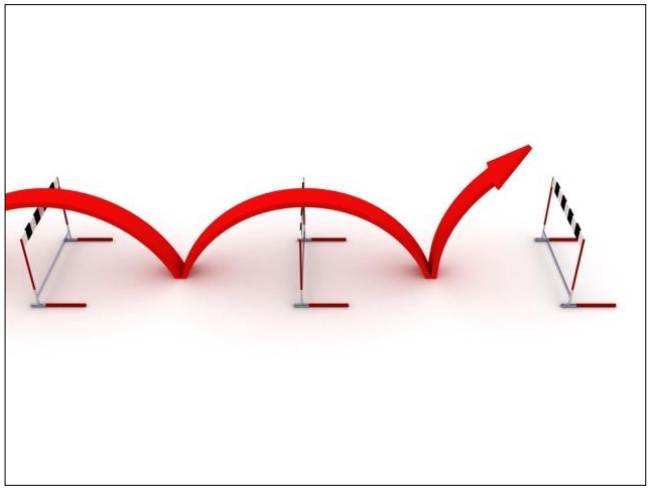
- Train
- Present Clinical Benefits and Current Context Needs
- Respected peer Pilot Staff role models can help break down resistance by sharing experience with others and demonstrating it can be done!
- Set expectations and provide supervision and support
- Acknowledge that gaining competence will take time
- Hold accountable for meeting documentation timeliness (e.g. same day) and productivity standards.

Most Common Obstacles

- **Technology**
  - ✓ EHR flow, slow and/or overly complex
  - ✓ Technology–Connectivity not availability in the field
- **Documentation Content**
  - ✓ Excessive-beyond requirements
  - ✓ Duplication
- **Office Setup**

Addressing Obstacles

- **Start where you can and do as much as you can!**
  - ✓ e.g. where technology is present; with individuals you are most comfortable with
- **Streamline documentation!**
  - ✓ Remove unnecessary elements
  - ✓ Remove duplication
  - ✓ Have non-clinical staff gather non-clinical information
- **Office Setup**
  - ✓ Review - make as CD Friendly as possible



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Addressing Obstacles

- Use Pilot to identify unique organizational obstacles and ways to address them
- Use pilot staff to motivate and help others
- Organizational commitment to support process is critical!
- Don’t wait to address all obstacles before starting CD
- Do what you can and use clinical judgment

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Most Common Questions

- “What if an individual says they don’t want to do collaborative documentation”?
- “What if the individual does not agree with something I need to enter in a note”?
- “What if I don’t want the individual to see something I am writing in their note”?

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Most Common Questions

- "What if an individual asks me not to enter something in the chart"?
- "Can you do Collaborative Documentation with Groups"?
- "How do you introduce Collaborative Documentation to individuals and families"?

Introducing Collaborative Documentation

- **Attitude is Important! – Present as an invitation!**

- **Develop Scripts: (example)**
  - ✓ "I usually write in your chart about our work together after our sessions. We now believe that it is important for you to know what is in your chart and to help insure that is accurate. By writing in your chart together we can also be sure that we are on the same page about your treatment and progress.

    So from now on we'll spend just a few minutes at the end of our sessions to record in your chart".

Questions?