Thriving in the New DMC Managed Care Environment
SYNERGY BETWEEN BUSINESS OPERATIONS, CLINICAL PRACTICE & FINANCE

Service Documentation Goals:
Noting Key Activities and Adhering to Timelines

By: Jan Tice
Documentation Goals: Organizing and communicating to ensure comprehensive and quality care

Objectives

- Distinguish between a **Program Driven** and an **Individualized** care plan
- Understand the process of and elements required for developing a patient centered care plan that engages the patient and meets stakeholders needs
- Describe the requirements and best practices for documenting services rendered
- Identify how to document an authorization for continuing services
Admission to Treatment
INTAKE/ASSESSMENT and Reviews

Who
- Physician
- Counselor
- LPHA

I just have a few questions and a little paperwork to do. . .

When
At intake

What
- Assessment (ASAM)
- Diagnosis and medical necessity determination
- Physical Exam
- Treatment plan
- Case Notes
- Discharge

How
- Face-to-face
- Information entered into an EHR

Establish Eligibility
Admission to Treatment
INTAKE – ASSESSMENT (The ASAM)

ASSESSMENT - Part of the intake process involves assessing the patient using a full ASAM assessment. This will be used as a part of determining medical necessity and to confirm level of care placement. Title 22 requires the completion and review of a Personal, Medical, and Substance use history.

Who  Completed by Counselor or LPHA; reviewed by Physician or LPHA
What  Full Continuum ASAM (Adult/Young Adult); Full ASAM Youth (Youth 12-17)
How  The assessment is completed in a face-to-face session between Counselor or LPHA with beneficiary
When  You have 7 days from admission to treatment date for Adults, 7-14 days for youth*. As soon as possible is advised.

The Assessment should identify the patient’s strengths, needs, and preferences; any specifiers for the diagnosis; and, impairments which support medical necessity.

* “THE PULSE”: Highlights and Updates
Changes to Youth intake period: SAPC Provider Meeting held on November 2, 2017.
http://publichealth.lacounty.gov/sapc/NetworkProviders/pm/110217/ProviderMeeting110217The%20Pulse.pdf
Complete all Six Dimensions of Multidimensional Assessment

1. **Acute Intoxication and/or Withdrawal Potential**
2. **Biomedical Conditions and Complications**
3. **Emotional, Behavioral, or Cognitive Conditions and Complications**
4. **Readiness to Change**
5. **Relapse, Continued Use, or Continued Problems Potential**
6. **Recovery and Living Environment**

Provide “rationale” for risk ratings from information documented in each dimension

- **4** Utmost Severity Imminent Danger
- **3** Serious Issue, high risk or near imminent danger
- **2** Moderate difficulty, with some persistent chronic issues
- **1** Mild difficulty, Chronic issue likely to resolve soon
- **0** Non-issue, or very low-risk issue. chronic issues likely to be mostly or entirely resolved
Admission to Treatment

INTAKE- Evaluation for DIAGNOSIS and MEDICAL NECESSITY

Who  Physician or LPHA

What  Performs an Evaluation of patient for SUD Diagnosis by reviewing assessment information

How  The evaluation must be performed through a review (of the Intake assessment), face-to-face (in person or telehealth) with the counselor who conducted the assessment (Notice #16-044). The ASAM Criteria is applied to determine placement in the appropriate level of care.

When  You have 7 days from the admission to treatment date. As soon as possible is advised.

The basis for the SUD diagnosis must be documented, with specifier(s) and the basis for each specifier (reference to assessment)
For Admission into a DMC SUD Treatment Program a Physical Exam is required in one of the following ways:

a. They have had a Physical Exam within the past 12 months. Obtain copy and place in patient record; 
or
b. Perform a new physical exam (by a physician, PA, or LNP)
   OR, if neither (a) or (b) has been performed,
c. Include the goal of obtaining a physical exam in the Treatment Plan

Perinatal Treatment is limited to pregnant and post partum women; medical documentation of pregnancy and the last day of pregnancy must be in the client record
Poll: Access to care

Our agency received a referral from SASH last Friday afternoon. We scheduled an assessment appointment, but we need to be sure it is conducted:

a) Within 10 working days from the date it was scheduled
b) Within 3 calendar days from the screening/referral
c) Within 10 calendar days from the screening/referral
d) On the date we scheduled it for or put the individual on a wait list
Developing and Implementing a Person-Centered Care Plan
Treatment Planning - Goals

Important to be patient-centered, address Medical Necessity, and always include

1. Physician Exam (if necessary)
2. Goal of obtaining treatment for an identified significant medical illness

**Problem:** Patient has lost several teeth recently and experiences frequent, significant oral pain. Absence of dental care in over 7 years

**Goal:** Get a dental check up and develop a care plan with dentist
THE TREATMENT PLAN is really the creation of a map which:

1. **SUMMARIZES** the important **CHALLENGES** identified in the assessment process and **GOALS** and **OBJECTIVES** for the treatment to be provided

2. **DESCRIBES** services or interventions provided and responsibilities of all parties

3. Clinically **ORGANIZES** treatment— the quality and continuity of care

Treatment plans are **necessary** for ethical and reimbursable practice

They also **MODEL SOLUTION-ORIENTATION** teach **PROBLEM SOLVING SKILLS. . .**
Treatment Plan
Patient-Centered, with all the right stuff...

1. **Statement of problem(s)** clearly linked to issues identified in the assessment (ASAM)
2. **Goals to be reached** that address each problem
3. **Action steps** - Specific activities and interventions
4. **Target dates** to complete action steps/interventions
5. **Description of services** - *type* and *frequency*
6. Assignment of Primary **counselor** - name
7. **DSM diagnosis** (Both DSM-V and ICD-10 codes should be in the clinical record)
8. **Signatures** - counselor, patient, and LPHA (Typed/Printed names)—remember date(s) and signatures.
START WITH A **PROBLEM STATEMENT**

Problem statements **relate to the problems identified in the assessment**. In general, Problem Statements:

- **Accurately describe an important issue** for the client—define the problem in a clear but concise manner.
- **Reflect client’s perception**—may use client’s own words
- Problem statements should be **concerned with impairment(s)** or barriers to recovery (MEDICAL NECESSITY)
- May be broadly stated, however **avoid “one-word” problems** (Dependence) **or addictions jargon** (Denial, etc.)
GOAL STATEMENTS

Goals statements answer the question, “What does the client need to establish/restore healthy functioning?”

It is important that goals:

• **Promote recovery**: Address identified impairments and barriers
• Reflect the individual’s **strengths, abilities, and preferences**, especially **values**, and **culture**

Reaching agreement on the goal(s) is critical—if you are unable to appreciate, and capture the clients’ goals, then the plan is inherently flawed.

For Example: Counselor says: “Maintain sobriety”; the Patient says: “Get my kids back!” . . . how could this reflect collaboration?
Can you identify an “impairment” and possible goal from the responses below (from an ASAM, Dimension 5)?

31. In the last 30 days, how often have you experienced cravings, withdrawal symptoms, or disturbing effects of your use?

**Response:** I can go a couple of hours then I start to get sick and really have to have get something. The buprenorphine is helping, I’m not craving so bad. But, it doesn’t stop all of the thoughts about using

33. Do you feel you will continue to either relapse or continue to use without treatment or additional support? ☒ Yes  ☐ No

**Response:** I think I can do good on the buprenorphine but I was on it before and started thinking I could do it on my own. I’ve got to watch out and not do that again.
Identifying Problem Areas and Goals

Which statement below best describes a problem in Dimension 5 (see previous slide—think medical necessity and patient centered)

a) Problem: Opioid dependency
   Goal: Sobriety

b) Problem: Patient lacks recovery skills
   Goal: Develop recovery skills

c) Problem: Patient’s relapse risk only marginally managed by medically assisted treatment
   Goal: Increase patient’s skill set for managing relapse

d) Problem: Patient reliant on buprenorphine to manage addiction
   Goal: Get off buprenorphine and stay sober
GOALS NEED OBJECTIVES and INTERVENTIONS

OBJECTIVES are THE ACTIONS that help to achieve the Goal.

Objectives define in measurable terms the behaviors that demonstrate, or interventions that support, progress toward the goal.

Objectives are Behavioral interventions which are:
- Simple or straightforward
- Measurable
- Attainable
- Realistic
- Time-framed

In other words, SMART!

It’s really smart if they lead to the Planned outcomes
Timely Treatment Plans - OP/IOT

- Signed by Patient within 30 days of signature by counselor

**Initial Treatment Plan** - Complete within 7 days of admission and signed by Counselor and Patient

- Reviewed and signed by LPHA within 15 days of counselor signature

**Reviews** - Every 30 days (min), document in client record

**Updates** - Every 90 days (minimum or as needed)

- The LPHA must review, approve and sign within 15 calendar days of the signature by the counselor

*Names must be printed or typed and then signed*
Withdrawal Management - Completed at intake, signed by patient and LPHA during treatment episode

Residential

Initial Treatment Plan - Complete within 7 days of admission, signed by Counselor and Patient

✓ Reviewed and signed by LPHA within 15 days of counselor signature

Reviews - Every 15 days (min), document in client record

Updates - Every 30 days (minimum or as needed)

✓ The LPHA must review, approve and sign within 15 calendar days of the signature by the counselor

✓ Signed by Patient within 30 days of signature by counselor
Do you list all of the “problems” identified through the intake/assessment process on the treatment plan?

Is “As Needed” for frequency of group services adequate or does it need to be more specific?

Must frequency of collateral services be listed?

Do you have to document anything if the patient refuses to sign the treatment plan?
Progress notes serve three major functions:

1. They document all services rendered during the course of treatment.
2. They provide a record of all significant, individualized Clinical Treatment data.
3. They indicate the degree of goal attainment (progress in treatment) made by the client.

Information in the progress notes are primarily used to evaluate progress or lack of progress in treatment.

- Source for reviewing and adjusting treatment plans.

SAPC requires that progress notes for both group and individual sessions follow one of 4 formats.
S.O.A.P. Method of Documentation

Subjective - client’s observations or thoughts, client statement

Objective – counselor’s observations during session

Assessment - counselor’s understanding of problems and test results

Plan – goals, objectives, and interventions reflecting identified needs
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<tr>
<th>GIRP</th>
<th>SIRP</th>
<th>BIRP</th>
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<tbody>
<tr>
<td><strong>Goal:</strong> Patient’s current focus and/or short-term goal, based on the assessment and treatment plan.</td>
<td><strong>Situation:</strong> Patient’s presenting situation at the beginning of intervention</td>
<td><strong>Behavior:</strong> Patient statements that capture the theme of the session and provider observations of the patient. Quotes or paraphrase.</td>
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<td><strong>Intervention:</strong> Methods used to address the patient’s goal, provider’s observations, and treatment goals and objectives.</td>
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<td><strong>Plan:</strong> The treatment plan moving forward, based on the clinical information acquired and the assessment</td>
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For each individual or group session, the counselor who conducted that session shall record a progress note for each participant. Must be a legible, individual narrative summary and include the following information:

- **Topic of Session**
- **Description of progress toward goals**
- **Date, Start, and End Time** of each Service
- Document location of service and if in community, how confidentiality was ensured
- **Typed/Printed Name of LPHA or Counselor, signature, and date note written** – **MUST BE WITHIN 7 DAYS OF THE SESSION**
The counselor shall record one progress note (at a minimum) per calendar week for each participant. Must be a legible, individual narrative summary and include the following information:

- **Topic of each Session**
- **Description of progress toward goals**
- **Date, Start, and End Time of each Service**
- **Record of participant’s attendance**
- **Document location of service and if in community, how confidentiality was ensured**

Typed/Printed Name of LPHA or Counselor, signature, and date note written – MUST BE WITHIN the following calendar week.
Let’s talk about writing chart notes. ..... 

How do we consistently chart PROGRESS TOWARD TREATMENT PLAN GOALS AND OBJECTIVES?
ASAM Reassessments- Initial and continuing assessments based on the ASAM Criteria ensure that a standardized clinical structure is used to make appropriate SUD level of care determinations.

Assessments need to be appropriately documented, reviewed, and updated on a regular basis, including at every care transition.

- **Adequate Progress** - If the provider determines that adequate progress toward goals has been made, plans to build upon these achievements including transitions to other services and recovery-focused strategies needs to be made.

- **Poor Progress** - Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed upon goals is not being made within a reasonable time.
Continuing Services Justification - Documentation

To extend treatment past the 6-month limit the counselor must review the progress and eligibility of the beneficiary and make a recommendation for the client to continue or not continue receiving services.

What must be Documented before Continuing Services can be authorized: A Review of:
- Beneficiary’s personal, medical, SUD history
- Most recent physical exam
- Progress notes and TP Goals
- Counselor’s recommendation
- Beneficiary’s prognosis

Review by Who:
- LPHA (DMC-ODS)

When: After 5th month; before 6th month

The patient must be discharged; there is no medical necessity
Discharge/Transfer Planning

**Narrative summary of the treatment episode.** Describe services received and the patient’s response by ASAM Dimensions

- Indicate patient’s *prognosis*: “Good”, “Fair”, or “Poor”, and provide an explanation.
- Describe *relapse triggers*; the *patient’s plan* to avoid relapse when confronted with each trigger; and, support system
- List all patient’s medications. Include dosage and response.
- Indicate the *reason for the discharge/referral* or level of care transferred to if appropriate.
- Describe *recommendations* for follow up.
TOGETHER
WE CAN DO IT!

KEEP 'EM FIRING!