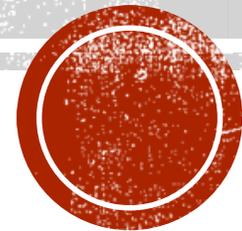


# QUALITY DOCUMENTATION

Training for Behavioral Health Therapists



# OUTLINE

- What does quality mean in documentation?
- Who is monitoring quality and sets the standard?
- Why does quality matter?
- Evidence Based Treatment
- CARF
- Examples of How To Make Quality Measurable
- Review



# WHAT IS QUALITY DOCUMENTATION??

- The definition of “quality” changes depending upon the audience/funder.
- Here is an example of the “bare minimum” and NOT considered quality documentation.
  - Met with client who has anxiety symptoms that impact every day and helped client identify triggers.
- Here’s what quality documentation would look like.
  - Met with client who’s anxiety symptoms of fixating, ruminating, frequent irritability and distraction most of the day every day are influencing client’s ability to leave the house, interact with others, and perform household tasks. Assisted client through the use of cognitive behavioral therapy to identify their core belief about themselves and how the triggers of someone making them feel “unworthy” are fueling anxiety symptoms. Worked with client on how to identify these triggers in a situation this week and reframing their core belief.
- If you were the company that was trying to control costs and was responsible for having to pay for “medically necessary” behavioral health care, which one would satisfy you?





# MORE ON QUALITY

- Quality is NEVER doing the “bare minimum”.
- Today, some, insurances might pass your documentation as a billable service now, but accountability standards are ever increasing. They are demanding proof of “bank for the buck!”
- With the change to managed care, MCOs are looking much closer at documentation and are expecting more.



# WHO IS MONITORING FOR QUALITY

- House of New Hope marches to numerous “drummers”, all requiring varying standards of “quality”.
- The audience for if documentation meets quality standards is influenced by many. Here are a few examples:
  - House of New Hope QI Department does quarterly reviews.
  - Commission on Accreditation for Rehabilitation Facilities (CARF) comes every 1-3 years (depending on how we do when they come).
  - ODMHAS comes if there is a complaint or concern brought forward. Otherwise they defer to CARF.
  - Medicaid does periodic reviews and comes if there is a complaint or violation.
  - Managed Medicaid plans have not started reviewing yet, but have indicated they will set a standard for quality documentation by 2018.



# WHY SHOULD IT MATTER TO YOU?



- There are a lot of regulations and rules, so why should you even take the time to understand all of them, let alone make sure your documentation matches the expectations?
- First, we hope you have the desire to do a good job.
- Second, our contract with you spells out minimum documentation expectations.
- Third, funders are demanding outcomes to justify expenses.
- Fourth, various entities will come in and monitor and we could have serious negative consequences if we do not maintain a high quality, such as loss of license and loss of funds/having to pay back. The decision to pay for a service is almost entirely based in the quality of your documentation.
- However, the best reason to care about quality documentation is that it supports the great work you're already doing for each client!
- **QUALITY = ACCOUNTABILITY + TRANSPARENCY**



# EVIDENCED BASED TREATMENT



- What is an Evidenced Based Treatment? It is a treatment that has been thoroughly researched with strict protocols for implementation.
- Many Clinicians utilize an EBP with clients. If you do choose to use one, your documentation must show proof of meeting fidelity requirements.
- “Fidelity” refers to proof that your implementation is exactly like that approved by the EBP.
- Aside from your supervision notes with your supervisor will also need to reflect verification that you are correctly implementing your EBP. Some EBPS require that you be evaluation on a periodic basis, take a certain number of trainings, or be observed by someone that represents that EBP.
- All of this must be documented.



# ALTERNATIVES TO EBP

- Quality documentation is *ALL* about the way you word things in your notes. If you are using an EBP, refer to it as such, you must speak to your fidelity to your model.
- If you use words that describe your EBP without calling it the official name, here is an example of what it could look like “used cognitive strategies to assist client in developing triggers” you are not naming a specific EBP so fidelity documentation isn’t necessary.



# CARF: OUR LARGEST AUDIENCE

- The largest audience for your documentation aside from House of New Hope is CARF. We work very hard to get the highest level of accreditation. For the last 3 cycles we have achieved a 3 year accreditation, which is the highest standard achieved!
- We want to keep up this level of quality. This means that we all need to focus on ensuring high quality standard of service and documentation.
- As you may have heard it said: “if it isn’t documented, it didn’t happen!”
- So here are some tips and tricks on how to makes sure you meet the expectations.





# TIPS AND TRICKS

- Always provide fidelity verification of your EBP if naming one
- Always provide more detail than the question asks on the documentation. For example, when asked if they have ever been a victim of abuse or neglect, think beyond sexual or physical. What about domestic violence, witnessing abuse or neglect, witnessing domestic violence. Ask the follow-up question and document it!
- Be sure to talk about symptoms; specifically, length, duration, and impact.
- Be sure to talk about specific strategies you are employing.
- Be sure to always talk about physical symptoms that may be influencing their progress and any recommendations you have to have them seek medical advice.
- Don't forget to talk about medications and if they are following up with their doctor, especially for "hot" diagnoses like ADHD.
- Always make direct reference to the ISP and the current diagnosis you are addressing in the session.



# MORE TIPS AND TRICKS

- Don't forget to talk about treatment alternatives they may be using (such as yoga)
- Finally, make sure everything that can be measured is **MEASURABLE!**



# HOW TO MAKE IT MEASURABLE

- When you write an ISP for a client, you need to remember to make specific, measurable goals.
- A goal that says “will reduce anxiety symptoms” is back to the “bare minimum”. It doesn’t meet the standard of quality.
- A better way to write it is “anxiety symptoms of ruminating, irritability, fixating, and worrying consistently will reduce from a daily basis to no more than 3 times a week”. This goal is much more specific and is measurable. This way when your ISP is reviewed, you are able to then speak to specifics, not general changes.
- Remember, when you make goals measurable, be sure to measure it regularly and report your findings.
- Insurance companies will not pay for no progress eventually.



# REVIEW

- Always look again at your documentation and ask yourself:
  - Is it specific
  - Is it detailed
  - It it high quality
  - Did I accurately represent what EBP I used and show fidelity
  - Did I go beyond the question on the paper
  - Is it measurable
- When in doubt, always ask your supervisor if this documentation would meet HONH and CARF's standards.

