

# CORE CLINICAL PROCESSES & DOCUMENTATION FOR MRO IN CONNECTICUT

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## Objectives

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- Identify required components of assessments to establish medical necessity for rehabilitation option services.
- Develop treatment and rehabilitation plans that incorporate client priorities and meet standards for billing Medicaid.
- Outline key procedures to establish and maintain linkages among various programs and/or agencies involved in the delivering MRO services.
- Use documentation templates to ensure their own agencies have documentation structures that meet MRO requirements.
- Outline how to use the CASIG as part of the ACT and Community Support treatment planning processes.
- Develop internal tracking systems to ensure that all documentation and coordination requirements are met.

3	Medicaid, Medical Necessity & Rehabilitation

CMS Proposed Rules for Rehabilitation Services*	
4	
<ul style="list-style-type: none"><li><input type="checkbox"/> All Rehab Services Incorporated: Physical as well as Psychiatric</li><li><input type="checkbox"/> Clear Emphasis on Restoration/Improvement of Function</li><li><input type="checkbox"/> Requires Person-Centered Planning in Psychiatric Rehab</li><li><input type="checkbox"/> Requires Progress; maintenance of effort not sufficient</li></ul>	

## CMS Defines Rehabilitation

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- “Medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.”
- “. . . the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health.”
  - CMS Proposed Regulations

## Medical Necessity: CT Definition

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- “Medically necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring.

## Key Concepts for Medical Necessity in Rehab

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- No service or intervention, by itself, is medically necessary
- Requires a chain of evidence that includes:
  - ▣ Eligible client & condition
  - ▣ Assessment that documents impact of illness/condition on functioning AND that functioning can be improved/restored
  - ▣ Order for services
  - ▣ Treatment/rehabilitation plan that outlines covered interventions to meet outcomes with expected duration, frequency, intensity
  - ▣ Service delivery in alignment with plan
  - ▣ Documentation of service delivery
- Funder “rules” are followed (who, what, when, how, etc.)

## Rehabilitation for Clinicians

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- “Medical necessity” based on functional criteria, not just diagnosis.
- Focus is on teaching not providing – cueing, reminding, training, overcoming barriers
- Must specifically reference a covered service (so “residential rehab”, not housing; “Community Support Team” not “case management”)
- Clearly rehabilitative, not medical/clinical
  - ▣ Organized approach to development of new or redevelopment of old competencies
  - ▣ Implies that a baseline has been established (can be through assessment)
  - ▣ Not clinically focused although clinical services may play an integral or supportive role in treatment (referenced separately)
  - ▣ Symptom reduction is not the focus – symptom and disability self-management are
  - ▣ Must focus on restoration/improvement of functioning
- Will *replace* TCM for vast majority of clients

## Another Look

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Clinical	Rehab
Use tools and techniques to guide, facilitate and provide opportunity for change	Use tools and techniques to address functional impairment and restore level of function
Focus primarily on internalization to motivate behavioral changes	Focus on skill acquisition and mastery, adapting environment, and accessing resources
Not always transparent and usually the balance of power is with the professional provider	Almost always transparent and is dependent on partnering to yield successful results
May involve skills: DBT, anger management, etc.	Almost always involves skills of one sort or another.

## What does that mean for Clinicians?

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- REHABILITATION
  - focuses on issues caused or impacted by disability and directly related to psychiatric illness
  - Not just beneficial – necessary
  - Eventually as defined in State Medicaid Plan; currently defined in DMHAS Service Definitions available on DMHAS website

## Demonstrating Medical Necessity

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- ❑ Assessment documents psychiatric condition and impact on functioning – in other words says that condition is something that rehab can help.
- ❑ “Order for Services” links assessment to client goals and key *rehab* outcomes.
- ❑ Rehab Plan addresses areas identified on assessment & summarized on order, and includes steps to restore functioning
- ❑ Rehab Plan prescribes services in amount & duration reasonably expected to foster change (or prevent relapse)
- ❑ Interventions directly relate to Rehab Plan
- ❑ Notes demonstrate progress (or prevention of relapse)

## Medical Necessity cannot be defined without Matching the following:

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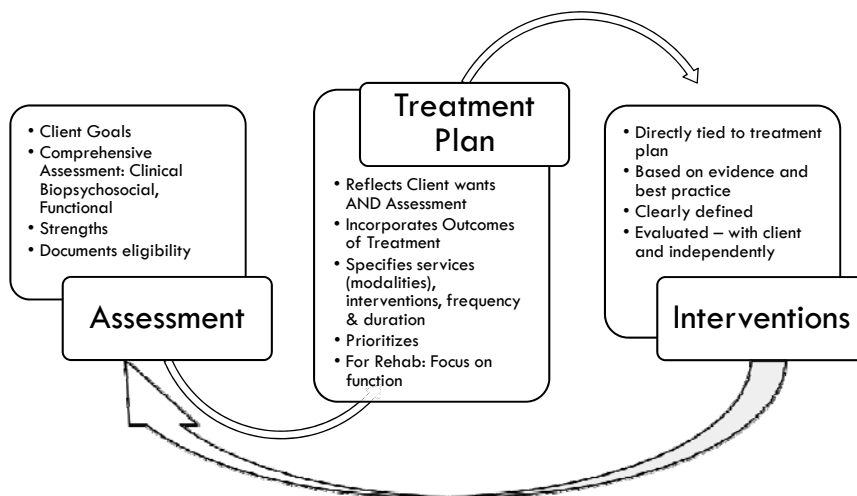
- ❑ A defined client need which is clinically assessed
- ❑ A defined service individualized and structured and delivered specific to the client’s need
- ❑ Reflective of best practice and known outcome

### AND FOR REHABILITATION:

- ❑ Assessed functional needs
- ❑ Interventions that will restore/improve functioning

## Connecting the Dots . . .

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## Medical Necessity Discussion

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- When might the following be medically necessary?  
When are they not?
  - Parenting skills
  - House cleaning
  - Weight management
  - Social Skills

15	Rehab-Focused Assessment

<b>CMS Proposed Rules</b>	
16	
	<ul style="list-style-type: none"><li>□ “The rehabilitation plan must be based on a comprehensive assessment of an individual’s rehabilitation needs including diagnoses and presence of a functional impairment in daily living.”</li></ul>



## This Means That the Assessment

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- Must include the standard diagnostic assessment
- Must include an assessment of functioning that ties the diagnostic issues to the functioning issues.
  - A functional deficit alone is not sufficient. It must be tied back to the diagnostic issues.

## Assessment: Who Does What?

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	Core Provider	Specialty Provider	ACT Provider
Diagnostic Assessment	X		
Initial LOCUS	X		
Repeat LOCUS		X	X
Order for Rehab	X		
Re-Ordering Rehab	X		X
CASIG		X	X

## Recovery-Oriented Assessment Philosophy

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- **Initiates helping relationships**
  - ▣ Ongoing process
- **Domain based**
- **Identifies strengths**
  - ▣ abilities and past accomplishments
  - ▣ interests and aspirations
  - ▣ resources and assets
  - ▣ unique individual attributes
- **Specifies stage of recovery/change**
- **Ties Diagnosis to Life Functioning**

## Assessing Function

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- Outlines how the client's illness is interfering with their functioning and their ability to achieve their "best possible functional level."
- As part of that, outlines functional deficits and functional strengths.
- Ties the functioning level to the illness AND to the client's recovery goals.
  - ▣ IF YOU CAN'T DO THIS, then rehab services are not appropriate for this client.

## Functional Assessment Tools & Levels

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- Like clinical assessment, functional assessment is ongoing. But pay attention to specific uses:
  - To determine program/payor eligibility
  - To recommend Level of Care
    - CT will use LOCUS for this
  - To aid treatment & rehabilitation planning
    - Many tools, including CASIG (CT will use CASIG)
  - To assist in planning intervention sequences
    - Borrow from OT and MRDD

## LOCUS

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- The LOCUS should be administered at initial assessment to help guide level of care (ACT versus Community Support).
- The LOCUS should then be administered every 90 days for clients in ACT and once a year for clients in Community Support. The follow-up LOCUS can be administered by ACT team or the Licensed Staff supervising Community Support. (More often if indicated)
- DMHAS will eventually require submission of scores.

## LOCUS Scores\*

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- For ACT or Group Homes or Higher
  - LOCUS scores of 20 or above (Level 4 or above)
- For Community Support
  - LOCUS scores of 14 – 19 (Level 2 or 3)
  - LOCUS Level 4 if no ACT team in community OR client is actively engaged in some community services that would contraindicate ACT
- Community Referral/Self-Help
  - LOCUS scores of 10-13, Level 1
- \*Remember that scores are only ONE indicator for level of care.

## A good rehabilitation assessment answers:

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- Why the consumer seeks services
- What are the presenting and historical issues, problems, strengths, and needs
- How is the illness/condition effecting their functioning? Effecting their ability to achieve their recovery goals?
- Stages of change/recovery
- What worked and what did not if the consumer has received services in the past
- What are the current issues placing the client most at risk
- How should these and other needs be prioritized and addressed
- What skills and resources the client has; What skills and resources the client needs to meet their goals
- What interventions are needed, when, how quickly, in what services and settings, and with what provider(s).

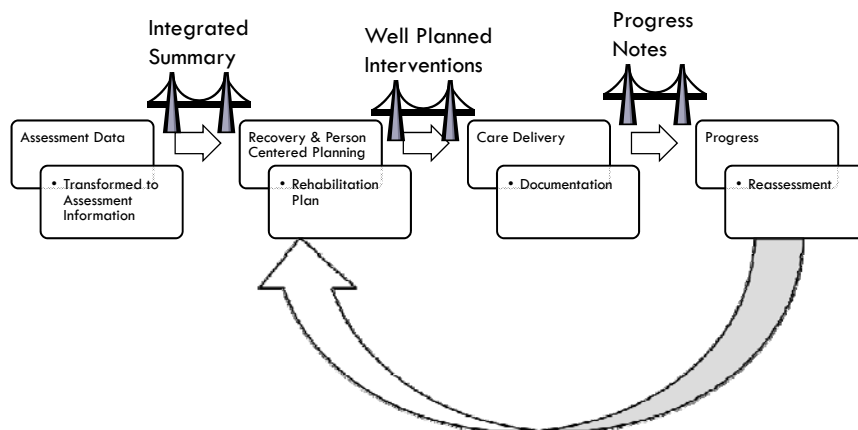
## Readiness to Change & Possible Interventions

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- **Precontemplation – Pre Engagement**
  - ▣ outreach, practical help, crisis intervention, peer support, WRAP
- **Contemplation & Preparation – Engagement or Persuasion**
  - ▣ provide education, set goals, build awareness
- **Action – Active Treatment & Rehabilitation**
  - ▣ counseling, medications, skills training, family and self-help groups
- **Maintenance – Recovery- Relapse Prevention**
  - ▣ WRAP, relapse prevention plan, skills training, expand recovery to other areas of life

## The Essential Bridges

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## Integrated Summary Bridge



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- Informative findings based on assessment data and the subsequent recommendations
- Perception of the individual on his/her SNAP (strengths, needs, abilities and preferences)
- Perception of the provider on individual's SNARF (strengths, needs, abilities, risk and functional status)
- Provider insight into contribution and impact of individual's psychodynamic, cognitive, familial, environmental and personality traits on current status, service goals and treatment outcomes

(more)

## Integrated Summary Bridge (continued)

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- **Provider & individual's understanding of how illness/condition impacts function**
- Provider and individual's speculation and understanding of previous treatment outcomes
- Groundwork for recovery vision and future goals
- Prioritization of needs for service planning
- Individual's readiness and motivation for change



## What's missing?

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- Janet, 58 years old, diagnosed with major depression, recurrent, with psychotic features, has spent the last 20 years institutionalized either in the hospital or a nursing home. She is moving into an apartment this month. She has a complicated medical regimen because of high blood pressure, obesity, and cardiac insufficiency. She presents as clean but is disheveled and has on multiple layers of clothes on a hot summer day. Refer her to Rehab.

## Better Integrated Summary

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- Janet is happy to be out of nursing home, eager to make friends and live more independently, but anxious because she has not been responsible for taking care of herself for a long time. This is her highest hope for help from Rehab. She is not yet connecting her needs with her illness, attributing them primarily to lack of services that the nursing home staff provided her. Her depression and sometimes tenuous reality testing make it difficult for her to learn complex skills and grasp complex concepts without extensive support and repetition. Rehab services can assist Janet by providing structure and support. Highest priority skill development areas include maintaining at least a minimal energy level through illness self-management, maintaining her physical health, developing basic food preparation and living space management skills, and developing recovery goals for her life outside of an institution.

## Common Assessment Mistakes

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- Not person centered
- Not used as a process to engage client
- Linear format does not support recovery process
- Conflicting information that is not rechecked for accuracy and clarification
- Data not turned into information
- Not tying function to illness
- No assessment summary to condense information to salient points and support planning and rehabilitation

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## The “Order” for Rehab

AKA: “Master Treatment Plan”, “Prescription”



## The “Order”

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- The Core Provider Agency “orders” the rehabilitation service initially and every 90-days thereafter.
- The Core Provider Agency is certifying through this order that the client meets medical necessity, and requires rehabilitation to restore or improve functioning that has been impacted by the illness/condition.
- For clients on an ACT team, the ACT team does the subsequent “orders” as part of their treatment plan updates.
- Requires an LPHA signature from the Core Provider or ACT Team.

## Formats for the “Order”

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	Separate “Order”	Included in Integrated Plan
Core Agency Also Provides Rehab	X	X
Core Agency and Separate Rehab Provider	X	
ACT Team (re-orders as part of tx plan revision)		X

## Which Parts of the “Order” Update may be (billed as) Community Support?

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- From Community Support definition:
  - “Support to facilitate recovery (including support and assistance with defining what recovery means to the individual in order to assist the individual with recovery-based goal setting and attainment).”
  - “Participation in the development and implementation of an individual’s treatment plan which supports recovery. ”
- Thus: meeting with client to evaluate their current recovery goals, strengths, needs, abilities and preferences and whether or not rehab services are still indicated to help them restore/improve their functioning.

## Client Choice of Providers

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- If the Order/Assessment Indicates Community Support as a recommendation, client has choice of providers.
- Core provider, through assessment team, has “affirmative responsibility” to inform client of the available providers and offer them a choice.
  - Should document the offering and the client’s response.
  - Will require maintaining lists of Community Support providers in area, along with contact information,
- Core provider should maintain contact until client is “attached” (not just connected) to provider of their choice.

## What if there is a community psychiatrist?

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- Clients have choice of their providers.
- The Core Provider does not have to be the psychiatric/medical provider
- The Core Provider does have to “order” rehab services.

## What might that look like?

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1. MD sends assessment info to Core Provider. Core Provider reviews it; meets with client to discover recovery goals, conduct LOCUS, and determine if rehab is appropriate. If so, “orders” rehab.
2. Core Provider conducts clinical assessment and meets with client to discover recovery goals, conduct LOCUS, and determine if rehab is appropriate. If so, “orders” rehab.
3. For 90-day reviews; Core Provider meets with client to evaluate their current recovery goals, strengths, needs, abilities & preferences; and whether or not rehab services are still indicated to help them restore/improve their functioning.

39	<b>The Rehabilitation Plan</b>
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<b>Planning: Who Does What?</b>			
40			
	<b>Core Provider</b>	<b>Specialty Provider</b>	<b>ACT Provider</b>
Order & Re-order for Service	X		X
Clinical Treatment Plan	X		
Rehabilitation Plan		X (based on goals from order)	
ACT Plan			X

## Scenarios for any Given Client

41			
	Core Provider Also is CS Provider	Core Provider only	CS Provider Only
Integrated Order, Clinical Plan, and Rehabilitation Plan	X		
Separate Order and Integrated Clinical/Rehab Plans	X		
Separate Order, Clinical Plan, Rehab Plan	X	X	
Separate Rehab Plan based on Order Goals			X

## CMS Proposed Rules on Rehabilitation Plan

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<ol style="list-style-type: none"> <li>1. Based on comprehensive assessment</li> <li>2. Qualified practitioner, input from client &amp;/or family</li> <li>3. Follow guidance from client</li> <li>4. Rehab &amp; recovery goals</li> <li>5. Specify disorder being addressed</li> <li>6. Identify medical &amp; remedial services</li> <li>7. Identify methods to be used</li> <li>8. Specify anticipated outcomes</li> <li>9. Frequency, amount &amp; duration</li> </ol>	<ol style="list-style-type: none"> <li>10. Signatures</li> <li>11. Anticipated providers</li> <li>12. Timeline for re-evaluation</li> <li>13. Be re-evaluated with individual;</li> <li>14. Evaluate goals &amp; services</li> <li>15. Document individual participated in development</li> <li>16. Document that services are rehabilitative</li> <li>17. Include history and coordination needs</li> </ol>	

## CASIG

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- The CASIG is both a tool to guide treatment planning AND a functional assessment.
- Once a client is in a rehab service, the team (either Community Support or ACT) uses the CASIG over a 6-month period to guide conversations with the client to establish priorities, goals, objectives, outcomes for the rehabilitation plan.
- The CASIG should be re-administered at least every 6 months.
- DMHAS will eventually collect data from the CASIG; for now, begin using it as a rehabilitation planning tool with clients.

## CASIG How Tos

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- Not a “one-sitting” tool
- The CASIG is a systematic record of the client’s assessment of his her strengths, interests, and goals.
- Administered as a semi-structured interview.
- Can be administered by multiple team members.
- Start with the areas already “flagged” as higher priority by the Integrative Summary and the client’s recovery goals.

## SOCI

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- The CASIG has a second part that records knowledgeable persons' assessment of a client's functioning.
- Especially helpful to use when staff and client perceptions are different.
- All items are objective and exactly parallel items on the CASIG.
- Provide material for conversations with clients about differences in perceptions.

## CASIG/SOCI Domains

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- |   |   |
|---|---|
| <input type="checkbox"/> Housing/Living Goals | <input type="checkbox"/> Financial/Vocational Goals   |
| <input type="checkbox"/> Relationship Goals   | <input type="checkbox"/> Spiritual/Religious Goals    |
| <input type="checkbox"/> Health Goals         | <input type="checkbox"/> Money Management             |
| <input type="checkbox"/> Lifestyle Supports   | <input type="checkbox"/> Vocational                   |
| <input type="checkbox"/> Health Management    | <input type="checkbox"/> Friends                      |
| <input type="checkbox"/> Nutrition            | <input type="checkbox"/> Leisure                      |
| <input type="checkbox"/> Transportation       | <input type="checkbox"/> Care of Personal Possessions |
| <input type="checkbox"/> Personal Hygiene     | <input type="checkbox"/> Rights                       |
| <input type="checkbox"/> Medication Practices | <input type="checkbox"/> Quality of Life              |
| <input type="checkbox"/> Side Effects         | <input type="checkbox"/> Symptoms                     |
| <input type="checkbox"/> Cognitive            | <input type="checkbox"/> Community Behaviors          |
| <input type="checkbox"/> Quality of Treatment |   |

## CASIG “Decision Rules”

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1. If a change in a condition and/or behavior is needed for the life and safety of the client and others, **INCLUDE IN PLAN/PROVIDE SERVICE.**
2. If client does not have the skills to function as needed to reach the goal, **OFFER SKILL TRAINING**
3. If the environment doesn't allow or doesn't support the skills, **OFFER TO WORK WITH THE CLIENT TO MODIFY THE ENVIRONMENT**
4. If the client wants to use or learn to use the skills, **OFFER TRAINING OR PRACTICE.**

## Plan Development

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- Acquired skill / Art form**
  - not often taught in professional training
  - often viewed as administrative burden and paper exercise
- Opportunity for creative thinking**
- Integrates clinical data**
  - derived from integrated summary and prioritization
  - information transformed to understanding
  - guides recovery



## The Key to Good Plans: Goals & Objectives

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- Goals: Start with the Client's Recovery Goals or Client's Goals for Services.
  - These should be stated in client's own words
  - Can be short, intermediate, or long-range
  - May or may not change over time
    - May just become more refined

## Rehabilitation Outcomes (Goals)

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- Intermediate to Long-Term
  - May not change over multiple treatment plan revisions
- Point to function that must be attained to assist client in meeting his/her recovery goals
- Often helpful for these to be broad statements
  - Allows for flexibility in covered interventions/objectives
  - Helps to keep client and staff pointed toward "vision of recovery" and not get lost in details of day-to-day activities
- Should be attainable and written in plain English
- Serve as ultimate outcomes of rehabilitation.

## Good Goals Say Where Client is Going

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- Examples of unhelpful goals:
  - Goals that describe the process of the intervention, not the outcome of the intervention.
    - See doctor once/month
    - See therapist
    - See community support specialist
    - Go to therapy
  - Goals that say what staff will do
    - Monitor client's meds
    - Take client to doctor

## Better Goals

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- ACTIVE Goals & Objectives
  - “Consumer will take meds regularly using tools and self-prompts.”
  - “Consumer will demonstrate ability to take meds on a regular and consistent basis.”
  - “Consumer will cooperate with medication schedule administered by residential staff.”

## Good goals say what client will be able to do

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- Keep doctor appointments on his own
- Keep a list of money he has spent
- Practice three different ways to start a conversation with potential employers and customers
- Describe what her hopes and dreams are
- Practice anxiety reducing techniques when she wants a drink

## Good goals and objectives have the client as the subject

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- Goals, Outcomes & Objectives say what the client (or support system/family) will be able to do
- Interventions say what the staff will do

## Examples of Recovery Goals & Rehabilitation Goals/Outcomes

I don't want to get sicker.	I will focus on staying well and getting better by managing my medication and symptoms.
I want my own apartment where no-one can tell me what to do.	I will achieve skills to live independently in community.
I want a girlfriend and lots of buddies to do things with.	I will develop a network of friends and social contacts for socialization and support.

## Outcomes to Objectives

Rehab Outcomes	Objectives
I will focus on staying well and getting better by managing my medication and symptoms.	<input type="checkbox"/> Identify different medications and their uses <input type="checkbox"/> Identify at least one side effect of each medication
I will achieve skills to live independently in community.	<input type="checkbox"/> Bathe 3x/week with minimal prompting <input type="checkbox"/> Close door when using bathroom in public places
I will develop a network of friends and social contacts for socialization and support	<input type="checkbox"/> Make eye contact and say "hello" to one person a day <input type="checkbox"/> Respond in groups when asked questions

## Objective Template

At the end of this plan, the consumer will be able to:

\_\_\_\_\_

NOTE that the objective does *not* say what the staff is doing.

## Frequency, Duration, Intensity

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- Based on what you know about the client's SNAP and your SNARF –
  - With the client estimate how much time, how often will need to be spent to help the client achieve the objective in 90 days
  - Combine with risk assessment – higher risk usually means more frequent
  - Must be sufficient to make progress and have an effect
  - Trial and error often.
- Tie to LOCUS – higher the LOCUS score, the higher the frequency and intensity

## Review of Treatment/Rehab Plan

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- **Reassess plan at clinically appropriate intervals (at least every 90 days)**
  - Determine effectiveness based on progress
    - Use monthly progress notes – you have already done the work!
  - Re-evaluate appropriateness and currency
  - Cannot do it without input of client
- **Plan revisions**
  - Revisit the client goal(s)
  - Re-examine needs
  - Change and update rehab goals(outcomes) and objectives
  - Look for new interventions and modalities
  - Adjust the time frames and target dates
- **Plan should change – whether it is working or not!**

## Common Mistakes: Treatment Plan

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- Not person centered and not recovery oriented
- No person first language
- No client outcome or goal which drives the process
- Not strength based but focused on problems
- Generic strengths which are non-specific to goals, objectives and interventions
- Goals are diagnostic driven
- Generic goals and objectives which are not individualized to client
- Goals and objectives use clinical language and terms which are generic and meaningless to client

## More Common Mistakes

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- Objectives do not seem to be clearly related to goal attainment
- Objectives are not measurable or behavioral
- interventions and objectives are confused
- Interventions do not include specific modalities and not time framed
- Too many goals and objectives
- Interventions do not reflect client preferences and past treatment (if it did not work last time why will it this time?)
- No link between treatment plan and assessment
- Not focused on restoring function

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## Documentation

## Documentation: Two Kinds of Rehabilitation Notes

- Encounter (Billing) Notes
  - ▣ Real-time notes of interventions related to the Rehabilitation Plan
  - ▣ Completed by the person who performs the intervention. Client can participate/contribute.
- Monthly Progress Notes
  - ▣ Summary of progress toward Rehabilitation Plan Goals and Objectives
  - ▣ Completed and signed by Licensed Clinical Staff (CST clinical supervisor), in conjunction with other staff and client
  - ▣ Serves as documentation of progress *and* of supervision.

## Encounter Notes

- Minimum requirements
  - ✓ Date
  - ✓ Actual Time (Length)
  - ✓ Location
  - ✓ Individuals present
  - ✓ Goal/objective addressed
  - ✓ Type of service
  - ✓ General description of what was done
  - ✓ Client's response
  - ✓ Signature & Credential of providing person



## 4 Core Questions for Encounter Notes

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- What goal (from Service Plan) were you working on?
- What was the intervention?
- How did the consumer respond?
- What are the next steps?

## Encounter Notes

- Rounding convention for tracking time (8-22 minutes = 1 unit)
- If able to review and write with consumer, then documentation time counts as rehabilitation service
- If group interaction, an individualized note must be in each person's chart.
- Separate forms, rather than continuous record, make encounter notes easier for community-based services.
- To use for all services, not just "billable" ones, add a check box for payor and/or nonbillable. (See example)

### Two Notes for John

Outcome: John will be able to plan and implement a healthy menu for himself within his budget.  
 Objective: John will be able to use a planning guide to identify and select "healthy meal" items.

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□ Picked up John to go to the grocery store. We picked up food for several meals and discussed need to budget. John does not like fruit. Discussed importance of eating balanced meals including fruit. John was uncomfortable in store and wanted to leave. Told him I would be by again on Thursday.

□ Coached John on selection of meals for the week using the checklist we had developed on Monday. John was able to pick appropriate foods in 4 of 6 categories. Reviewed alternatives to fruit including extra vegetables. John began to get anxious in store. Encouraged and modeled use of deep breathing and visual imaging of fishing with cousin. John attempted to practice these skills. Scheduled again for Thursday. John plans to use the checklist next week when he shops with his neighbor.

### Two More Notes for John

Outcome: John will self-manage his medication effectively so that he can work toward his own business.  
 Objective: John will identify side effects of medication which could result in his stopping his medication.

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□ Asked John to identify medication name, purpose and dosage instructions. John stated his medication makes him feel tired and hungry and he is gaining weight and cannot fit into his clothes. Discussed why it is important to keep taking his medication to remain outside hospital.

□ John said his medication makes him feel tired and hungry and he is gaining weight and cannot fit into his clothes. Together, we reviewed the "Solutions for Wellness" section about avoiding weight gain through food selection, exercise, and alternative activities. Coached John on sugar-free food selection. Modeled easy exercises that John can do at home, even while watching TV. John practiced stretching and floor exercises, and agreed to try two exercises each of the next three days. We will use the "healthy food selections" list we developed last week when we go to the grocery store on Friday, with an emphasis on foods that will help John avoid weight gain.

## And Two More Notes for John

Outcome: John will have an expanded network of friends and supports.  
 Objective: John will make eye contact while greeting strangers appropriately.

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Took John to McDonalds to practice making friends and socializing. Ordered John's meal and reminded him to say thank you and make eye contact with the person taking his order. John was polite and greeted two food servers.

Reviewed "Making Friends" module with John and role played greeting wait staff at local fast food restaurants/ Asked John to assess his comfort level when speaking to know and unknown staff. John agreed to practice smiling and making eye contact with known staff. He was able to greet two staff at McDonald's appropriately and without discomfort. He agreed to practice greeting the cashier when he goes grocery shopping on Thursday.

## Progress Notes

- Once per month **and** as needed
- Reflect the treatment plan including consumer reaction and choice
- Summarize interventions and response; Outline progress (if any) toward goals and objectives
- Recommend modifications to rehabilitation plan as necessary
- Signed by Licensed Clinician on ACT team or supervising CST
- Excellent opportunity to reinforce progress and review goals and objectives with client.
- If significant issues are occurring that aren't on the plan – revise the plan!
- Face-to-face review time with client is counted as rehabilitation service.

## Two Kinds of Notes

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### Encounter Note

- Date of service
- Signature of Provider
- Date of Signature
- Description of mental health rehab intervention
- Description of client's response to intervention

### Progress Note

- Dates of Included Services
- Signature of writer and signature of licensed supervisor if not the writer
- List of each goal and objective
- Progress towards goals and objectives

## Make Sure You Show Progress

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- Not so Good: "John continues to make progress."
- Better: "John is now able to initiate deep breathing and visual imaging of fishing with cousin 50% of the time without prompting when he becomes anxious at the grocery store."
- Better: "John is correctly using his meal planning guide to select healthy foods with very little assistance. He asks me to check his work and I seldom find errors."

## Common Rehab Note Mistakes

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- Not related to treatment plan
- No intervention
- Does not indicated next steps or plan for next session
- Too much or too little information
- Only documents symptoms/functioning (monitoring)
- Use of clinical language, jargon or terms which are not descriptive or unique to client (psychiatrically stable, depressed, anxious, manic, etc.)
- Judgmental or subjective descriptions
- No continuity from session to session
- Repetition from session to session
- No evaluation if intervention is working or should be modified or changed
- If client presents in crisis no link to treatment goals and objectives

## Group Notes

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- Intervention can be same for everyone in group\*
  - Name of group is NOT intervention
  - Individualize intervention for anyone where group is a setting for practice of other skills (see next)
  - Intervention can refer to a specific curriculum.
- Client's Response to Intervention *and* Next Steps must be individualized for each participant

## Individualizing Group Notes

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- “Juanita attended cooking group”
  - Juanita holds a job as a cook at Burger King.
  - Juanita does not have independent living skills on her treatment plan.
  - She does have anger management and social interaction skills on her treatment plan.
- Make sure that you write what Juanita practiced in this group – not interrupting, waiting her turn, and being supportive to others. The actual group was a context, not the event.

## Use Templates

76

- Develop templates for all core documentation elements
  - Templates should reflect requirements and prompt staff to do what is needed.
  - Templates should mandate connections among elements
- Begin Example Logs:
  - good and bad.
  - Bad to good

## Concurrent Documentation

77

- Best practice involves concurrent documentation – documenting with client
- Because this is rehab, content is especially transparent.
- Client can contribute and have copies
- Client can keep own records to bring to sessions to assist with documenting progress, planning next steps.
- Will require some skill development with your staff and monitoring of implementation.

## Link Notes to the Service you Delivered

78

- Anyone should be able to tell what service you delivered by the narrative of the note.
- Take care to distinguish
  - Targeted Case Management
  - Rehabilitation (Residential rehab, Community Support & ACT)
  - Counseling
  - Social Club
  - Peer Support (not one of the other services)

## More Connections

79

- The narrative of the documentation should tell you what service is being delivered.
- Interventions in narrative should match up with those described in service definitions.
- Documentation should clearly spell out that this is rehabilitation.
- Assessments and treatment plans should explicitly point to the covered services.
- Supervisor's job to ensure staff know which service to do when, and how to write it.

## What service is this?

80

- ““Met client at home. Client quiet but would answer questions. Discussed her symptoms of depression and encouraged her to use coping skills. Discussed her meds and getting confused about what amount she is to take and when. Called doctor's office about refill because client would run out of meds early.”



## What service is this?

81

- “Client did not want to leave apartment as his brother was coming over. Client and writer played a game of Chess. Client has had no luck finding a job. He won't see his kids till Thanksgiving. Client was asked to put a shirt on before the brother arrived; he did without complaint. Client was pleasant.”

82

Supervision

## CST Supervision

83

- Services are delivered under the supervision of a licensed professional (see definitions at end) who may be the team leader or a member of the team.
- Each team shall have a team leader who provides ongoing supervision. The team leader must have the following qualifications:
  - A licensed or licensed-eligible mental health professional (see definitions at end);
  - A person with a Master's degree in a behavioral health area and two years of mental health experience;
  - A person with a Master's degree in a behavioral health area and certification for USPPRA; OR
  - A person with a Master's degree in a behavioral health area and a CADC.
- Clinical supervision shall occur at least monthly as evidenced by the supervisor's signature on a monthly progress note documenting the individual's progress toward meeting treatment plan goals and objectives.

## Core Internal Controls for Documentation

84

- A note for every encounter
- A Note for every billed event
- Time from service delivery to billing
- Time from service delivery to documentation done & filed
- Rehabilitation plans current
- Orders Current
- Progress Notes
- Program requirements (Track ratios)

## Sample supervisory checklist

85

- |   |
|---|
| 1. <b>Treatment Plan Due Dates in Next Month (Any overdue?)</b> |
| 2. Orders Needed in Next Month (Any Overdue?)                   |
| 3. Services delivered last week; notes completed last week      |
| 4. CASIGs due/in progress                                       |
| 5. Service schedule for coming week based on treatment plans    |

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## Coordination of Care

## Core & Specialty Provider

87

- Key Issues:
  - Orders
  - Communicating Progress
  - Coordination of Effort, Information
  - No Duplication, No Lost in Cracks
- This is practice time – start developing, testing, revising systems now.

## Key Tools

88

- Joint Calendars for Tracking Order Due Dates, Appointments
- Designated Contact People
  - For Core Providers, may require some shift in organization
  - Team Leader for ACT/CST are obvious choices for specialty providers
  - Regular “meetings”
- Monthly Progress Notes

## Data Set for Each Client

89

- Core Provider:
  - Contact Person
  - Physician
  - Diagnostic/Clinical Assessment
  - Order forms
  - Other Services Client involved in
- Specialty
  - Contact Person
  - Rehabilitation Plan
  - Monthly Progress Notes

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## Samples

## Joe - Profile

91

- Joe, 62-yr old male, schizophrenia-chronic undifferentiated, poly substance abuse; homeless, currently in transitional housing following d/c from state hospital – 12 week stay, hospitalized 3X in past 24 months; currently on probation for DIP and public nuisance; unkempt, dirty clothes and hair; denies visual hallucinations but describes some minor voices-not command; denies suicide and homicide ideations or thoughts; physical health issues include dental, hearing and visual needs as well as heart problems in past, + family history for heart disease and stroke; has some family support from sister; limited financial resources and poor money management skills, graduated from high school and some job history in janitorial services and animal shelters; interested in having house and pets; wants friends; and has history of sobriety after involvement in 12-step programs.

## Joe's recovery vision

92

- “I want to live in the country, have a red truck, a dog named Buddy, go to the movies with my sister, be with my friends and have bacon and eggs on Sunday night. ”
- “I do not want to go back to the hospital or be in jail or drink anymore. I do not want to scare my great nieces or lose my job because I am hearing or seeing things. I want to get rid of the biting voices.”

## Joe's Goals

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- Live in own home
- Get and keep a job
- Develop and keep friends
- Get and care for a dog
- Make decisions independently
- Be symptom free from hearing biting voices
- Maintain sobriety from use of alcohol

## Joe's strengths

94

- Motivated to work towards dreams and goals
- Has previous work experience and job skills
- Has history of sobriety from alcohol (18 years)
- Has developed and maintained relationships with sister and friends in 12 step groups
- Has skills in caring for and training animals
- Can describe importance of developing money management and self care skills
- Can prioritize needs and is willing to look at possibilities for additional skills training
- While unwilling to commit to continuing to use medication to help with self management of symptoms, can list benefits as well as anticipated side effects of current medications

## Joe – Partial Integrated Summary

95

- Joe is motivated to live independently, make choices, support himself financially and to develop a network of family and friends. Joe wants to find support for continued sobriety from ETOH and self management of his delusions and hallucinations which he has experienced for 40+ years off and on due to his MH disorder. Joe is not certain that his continued use of pot contributes to his MH symptoms and is unwilling at this time to address that issue. Joe does not feel his personal appearance or housekeeping skills are major issues but does recognize that his personal hygiene and housekeeping may be important in meeting and keeping friends, maintaining his housing and securing a job. Joe states he needs to manage his financial resources better and knows finding and maintaining a job is key to financial self sufficiency and living in his own home. Joe states he has had difficulty securing and keeping a job in the past because he becomes impulsive and frightened when he starts "hearing voices and seeing things." Joe recognizes the voices and hallucinations are the result of his MH disorder but he is not committed to taking medication on an ongoing basis to control these due to the side effects he sometimes experiences. He is willing to consider the possibility of meds if it gets him his own home. Priorities for services include medication evaluation and education , skills development in financial and money management, self care and housekeeping, self management of symptoms hallucinations, delusions, impulsivity and sobriety from ETOH.

## Carlotta's profile

96

- Carlotta is 32 yr female w/depression, bi-polar, anxiety disorders, panic attacks and Hx of self injury (cutting) and several suicide gestures and attempts resulting in numerous hospitalizations over past 10 years. Recently diagnosed with insulin dependent diabetes, she is 60+ lbs overweight and has potential kidney and cardiac involvement. She has been inconsistent in taking any medication because she "forgets." Carlotta recently reported that she was molested starting at age 8 by uncle and began cutting her arms, stomach and legs at age 12; a practice she continued until 2 years ago. Carlotta is twice divorced, has 3 children by her 1<sup>st</sup> husband who are not in her custody but living with her ex-husband. She has visitation but says she is often "too depressed" and "overwhelmed " to visit them although she does phone on a regular basis. Carlotta is estranged from her family (due to the abuse allegations) but does have some contact with her mother and younger brother. She says she does not have friends but would like to have someone to do things with. She completed high school and was in several management training programs in fast food industry. She most recently was shift manager at a local "Trudy's Chicken" but she was fired 6 months ago for missing too much work. Carlotta has spoken to the general manager and he is supportive of her returning at some time in the future. Carlotta has lost her apartment due to failure to pay rent. She is currently receiving public assistance and is in public housing which is temporary. Carlotta continues to isolate, does not keep scheduled appointments with her therapist, does not follow through on attending her panic disorders group and says she feels overwhelmed and scared and anxious all the time. She denies any suicidal thoughts or plan. She says she wants things to be different but does not know where to start.



## Carlotta's recovery vision

97

- "I really do not have any goals - I just want to feel better"
- "I would like to get my job back and move out of this place."
- "I would like to see my kids more and not be so impatient and mad with them when I do see them."
- "I would like to lose some weight."
- "I like to reunite with my family and I would like a friend to go shopping with and to talk to."
- "I cannot remember to take my medications and I know I should so that would be a good goal."

## Carlotta's Partial Integrated Summary

98

- Carlotta's depression and physical issues make it difficult for her to articulate long-term goals and find motivation to achieve them. Small incremental changes and skill building in areas of self management of symptoms, self-care, parenting, socialization, building and re-establishing supportive relationships will be helpful to Carlotta in realizing current goals and establishing new goals for herself. Carlotta's history of sexual abuse, subsequent pattern of self injury (cutting), isolation from her family and losses (marriage, housing and job) have contributed to her feelings of loneliness and shame and have resulted in difficulty coping with life situations. At times, she finds it too difficult to bathe, dress and care for her apartment- although she says she has always been "messy." Despite this, Carlotta has refrained from self injury for 2 years, expresses the desire to be a better parent, develop friendships, seeks to return to work, improve her health, feel better and improve her financial situation resulting in a new home where her children can visit in comfort and safety. Carlotta believes past treatment was not successful because it placed too many demands on her and she did not feel supported. She agrees focusing on small steps and seeking and finding support among new and old friends will be helpful in reaching her goals.

## Carlotta's Goals & Sample Interventions

99

"I would like to get my job back and move out of this place."	Establish and follow daily routine of getting up and getting dressed by set time (Carlotta)
"I would like to see my kids more and not be so impatient and mad with them when I do see them"	Plan 1 hour stress free play activity with children ; practice through role play with CSW (CS)
"I would like to lose some weight"	Develop healthy eating meal plan for next week to use as shopping list and meal preparation activities (Carlotta/CS? Help as needed)
"I like to reunite with my family at sometime and I would like a friend to go shopping with and to talk to"	Contact friend from work by phone and talk for 5-10 minutes (Carlotta)
"I cannot remember to take my medications and I know I should so that would be a good goal"	Place daily morning medication in plastic bag and attach by rubber band to coffee cup (Carlotta)

## Resources

100

- CASIG/SOCI
  - Order from [www.psychrehab.com](http://www.psychrehab.com) -- \$25)
- Order for Rehab Template
- Rehabilitation Plan Template
- Encounter Note Template
- Monthly Progress Note Template
- Excerpts from APS – on DMHAS website
- More templates and checklists on DMHAS website

# Integrated Summary Narrative

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- Who is this person?
- Why is s/he presenting for services?
- What are his/her risk factors?
- What is/her understanding of issues and problems?
- What are his/her desires for the future?
- What is his/her previous treatment experiences?
- What did/did not work in the past?
- What does/doesn't s/he want in service planning and delivery?
- How will s/he know what is/is not working?
- What are the priorities and risks?

# Integrated Summary Compilation

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- Problem and needs summary
- Life concerns summary
- Stage of readiness and motivation summary
- Source of issues, problems and needs summary
- Potential influencing factors and functional assessment summary
- Previous care delivery and outcomes summary
- Goals summary

# ORDER FOR MHRS SERVICES

**Client Name** \_\_\_\_\_ **ID Number** \_\_\_\_\_  
**Core Provider** \_\_\_\_\_ **Core Provider Contact** \_\_\_\_\_  
**Start Date** \_\_\_\_\_ **End Date** \_\_\_\_\_

Attach Integrated Summary From Assessment.

Client's Prioritized Recovery Goals	Corresponding Rehabilitation Goals/Outcomes

**Rehab Service Ordered:**

- Community Support Team
- Assertive Community Treatment
- Residential Rehabilitation in a MH Group Home

ADDITIONAL INFORMATION:

Primary Diagnoses:	
<b>Axis I</b>	
<b>Axis II</b>	
<b>Axis III</b>	
<b>Axis IV</b>	
<b>Axis V</b>	

Signed: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Name & Credentials: \_\_\_\_\_ Phone \_\_\_\_\_











# Rehabilitation Plan Template

PLAN START DATE: \_\_\_\_\_

PLAN END DATE \_\_\_\_\_

Client Name (First/MI/Last):	Page _____ of _____
------------------------------	---------------------

Other Agencies Involved		
Agency/Provider Name	Contact Name, Title, Phone	Services Provided

Projected Plan Review Date: \_\_\_\_\_

Discharge/Transition Goals

Discharge/Transition Criteria:

Client Statement and Signature	Date
Licensed Clinician Signature & Date	Print Name, Title
Primary Rehab Work Signature & Date	Print Name, Title

### ENCOUNTER NOTE 1

<b>Client Name (First MI Last):</b>	<b>Client #</b>
-------------------------------------	-----------------

<b>Check type activity</b>	<input type="checkbox"/> ACT <input type="checkbox"/> Community Support <input type="checkbox"/> DHMAS <input type="checkbox"/> Residential Rehab <input type="checkbox"/> Other: (Specify)
----------------------------	--

<input type="checkbox"/> Individual <input type="checkbox"/> Group	Location: <input type="checkbox"/> Off-Site <input type="checkbox"/> On-Site
--	--

<b>Goal(s):</b>	<b>Objective:</b>
-----------------	-------------------

Significant observations:

<b>Interventions Provided</b> <small>(Please continue on back if necessary)</small>	
--	--

<b>Client Response to Interventions; Plan:</b> <small>(Please continue on back if necessary)</small>	
--	--

Signature and Credentials of Staff	Date of Signature	Date of Service	Start Time	Stop Time
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### ENCOUNTER NOTE 2

<b>Client Name (First MI Last):</b>	<b>Client #</b>
-------------------------------------	-----------------

<b>Check type activity</b>	<input type="checkbox"/> ACT <input type="checkbox"/> Community Support <input type="checkbox"/> DHMAS <input type="checkbox"/> Residential Rehab <input type="checkbox"/> Other: (Specify)
----------------------------	--

<input type="checkbox"/> Individual <input type="checkbox"/> Group	Location: <input type="checkbox"/> Off-Site <input type="checkbox"/> On-Site
--	--

<b>Goal(s):</b>	<b>Objective:</b>
-----------------	-------------------

Significant observations:

<b>Interventions Provided</b> <small>(Please continue on back if necessary)</small>	
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<b>Client Response to Interventions; Plan:</b> <small>(Please continue on back if necessary)</small>	
--	--

Signature and Credentials of Staff	Date of Signature	Date of Service	Start Time	Stop Time
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## Monthly Rehabilitation Progress Note

Client Name (First      MI      Last):	Month/Year
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SERVICE:  ACT     Community Support     Residential Rehab

<b>General Level of Client Functioning during the month:</b> <small>(Observed or Reported)</small>	(May include mood, affect, behavior, cognitive functioning, etc.)
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**Stressors/Extraordinary Events During Past Month:**  None Reported     Requires Modification of RP see below

<b>Progress Toward Goals and Objectives:</b> <small>(Address each goal and objective; describe progress, evidence of progress from perspective of both provider and client.)</small>	GOAL/ OBJ	

<b>Suggestions for changes or modifications of Rehabilitation Plan</b>	
--	--

Signature of Primary Rehabilitation Specialist/Credential	Date:
Signature of Licensed Clinician/Credential	Date:
Signature of Client :	Date: