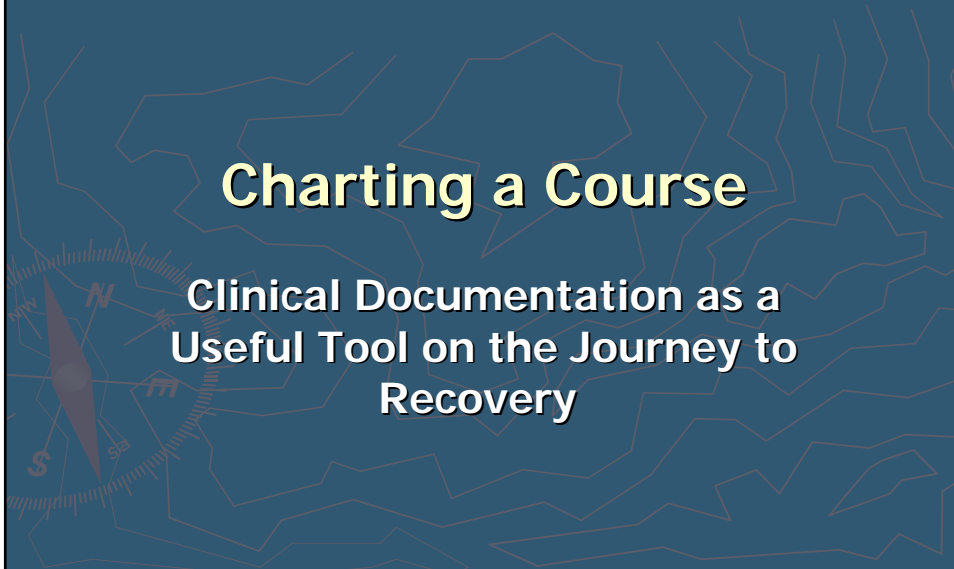


# The 2nd Annual Collaborative Behavioral Health Provider Training



## Charting a Course

Clinical Documentation as a Useful Tool on the Journey to Recovery



## Session Overview

- ▶ Review of Clinical Process and Key Considerations for:
  - Assessment
  - Service Planning
  - Progress Notes
- ▶ Navigation of Systems
- ▶ Solution-Focused Dialog

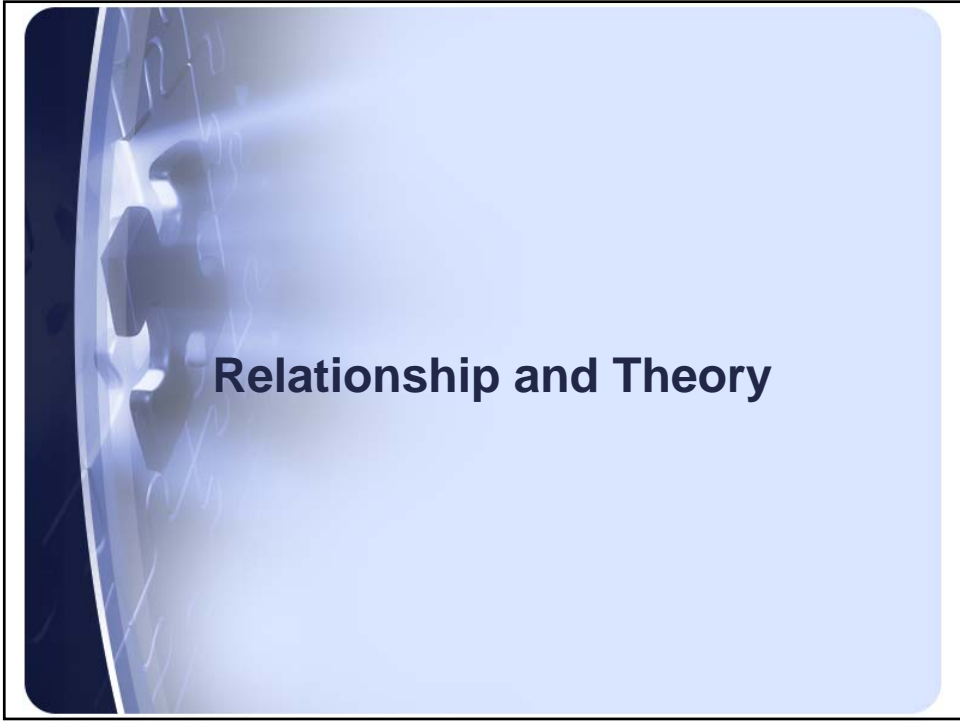




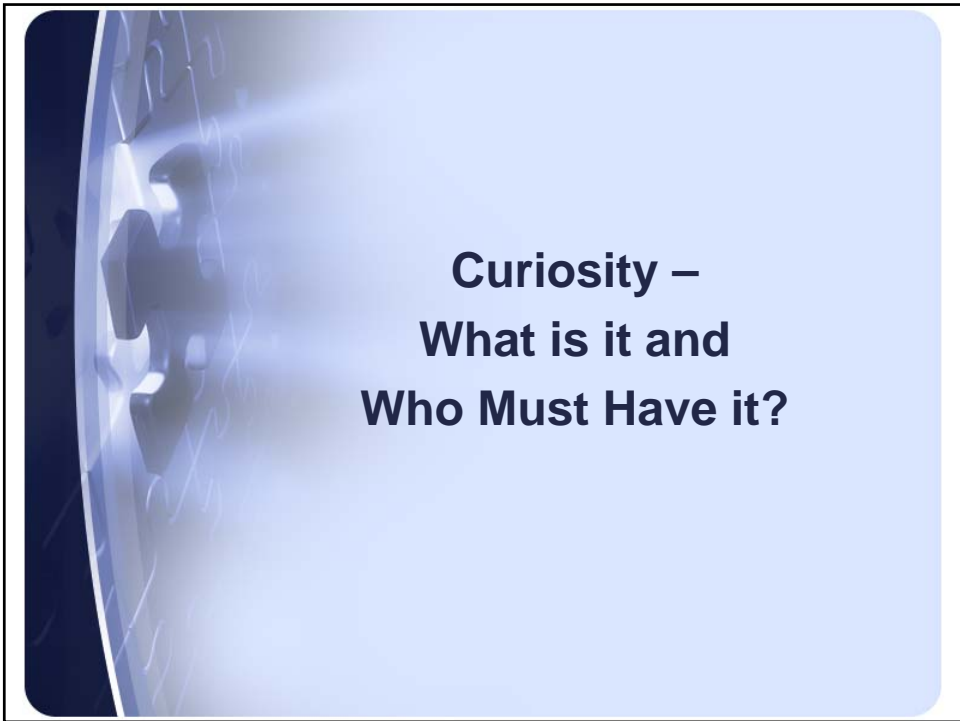
**The Current Direction of  
Therapy**



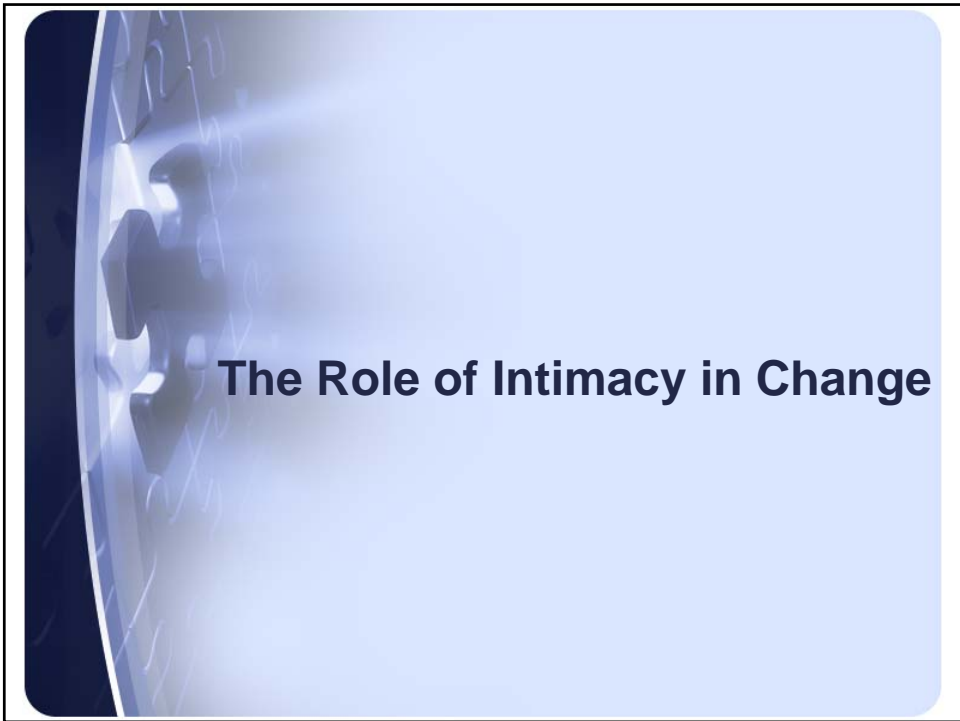
**What is an Assessment?**



**Relationship and Theory**

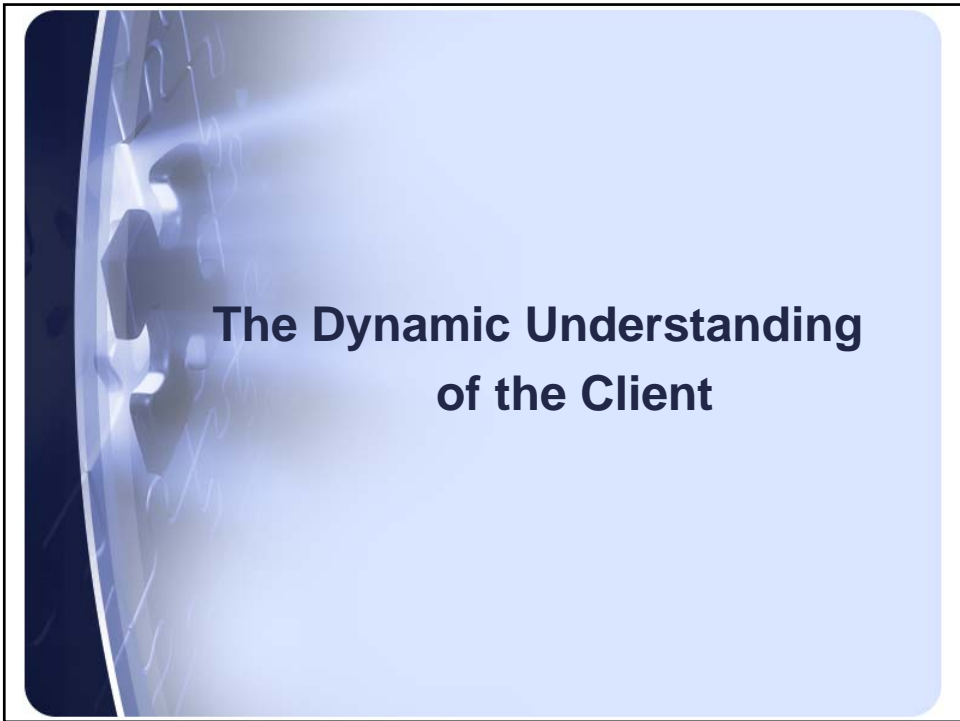


**Curiosity –  
What is it and  
Who Must Have it?**

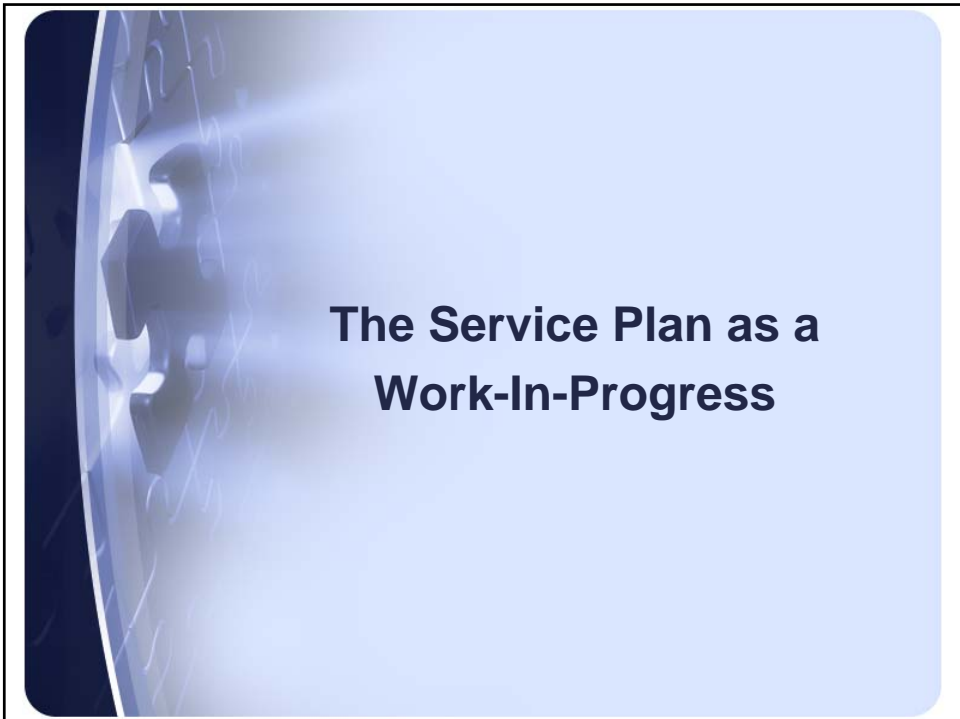


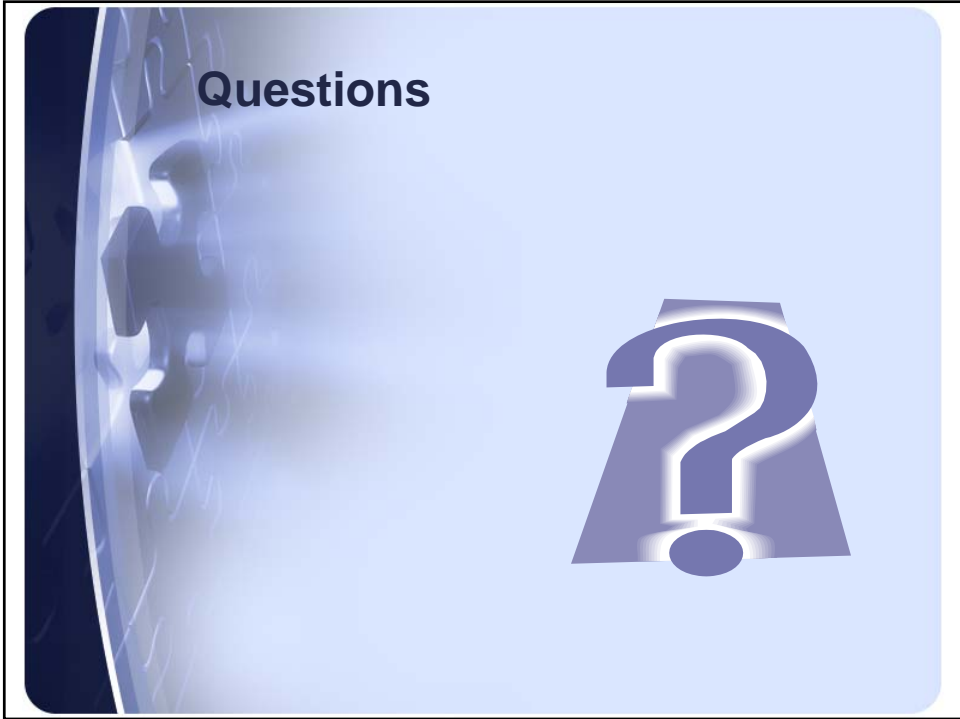


**Assessment as Therapy-  
and Vice Versa**



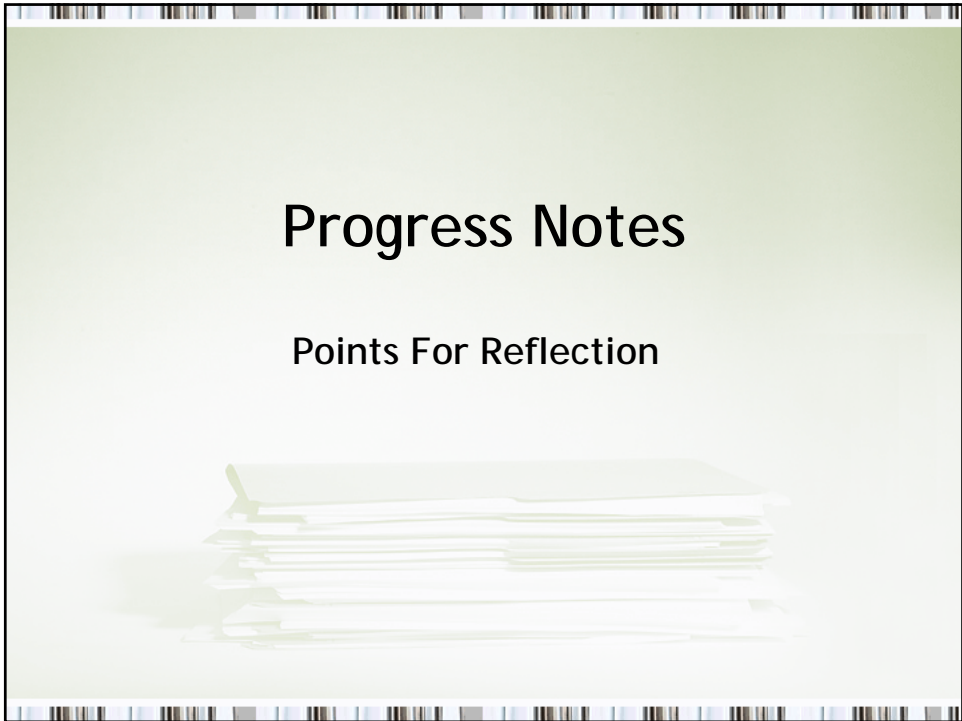
**The Dynamic Understanding  
of the Client**











What is the purpose of documentation?

- It is a record of the client's

healing and  
recovery.



The record is an overall  
*reflection of the therapist/client  
relationship.*

- You can get a sense of how the *therapist views* the client.



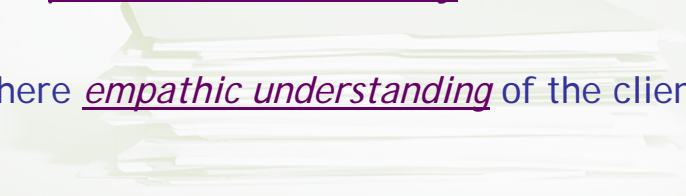
- Our client records reflect the purpose *inherent* in a therapeutic relationship...



- Is it a healing process?



- Is it a process of true recovery?
- Is there empathic understanding of the client?



## Something else to consider...

- Put yourself in the client's shoes.
- Is this the type of progress note that you would want written in your chart if you were the one receiving services?
- You are creating a record of an individual's life.
- The notes need to be stated in a sensitive, thoughtful, professional way.



## Thoughts about the process of treatment....



- It is not static.
- Healing is not a linear process.
- It is fluid.
- Human beings are full of surprises.
- Treatment is not like tuning up a car.

## With that said... You can move

- You can **move with the client's directionality** even if it deviates from the established treatment plan.
- It is **ok for this movement to be apparent** in your progress notes.
- If there is a deviation from the plan, you can note the changes in 2 ways:
  1. in your progress note or
  2. you have the option of completing a service plan development, low complexity.



- You can conduct an additional service plan development, low complexity procedure when it is clinically necessary. You have the option to do more than one per review period.

## Clinically speaking...

- Progress notes provide a window into the clinician of record's clinical judgment, and critical thinking as it relates to the care and treatment of the client.
- It reflection of you and your professionalism.
- Do your notes reflect Integrity?

(Definition -Quality of possessing and steadfastly adhering to moral principles or professional standards.)



## Something to think about...



- Reporting of client information needs to be factual.
- Exercise caution in your note writing.
- Be diplomatic and choose the right words.

Diplomatic: skilled in dealing with sensitive matters.

- *This is a record which will follow the client.*

## The progress note is...

- a legal record.



33

## *Legal Considerations ...*

The patient's health record is created every time documentation occurs.



## Legal Considerations and Liability

- In the case of litigation, good documentation is essential for you and/or the client.
- Without documentary records, a court would have no concrete evidence of the care provided.
- Defense of malpractice litigation would be difficult or next to impossible.

## *Increases liability*

- Incomplete documentation *or*
- Complete documentation that reveals substandard professional practice

increases liability.



## Documentation ...

- A record of the data collected.
- Progress notes help the clinician to maintain continuity of care from visit to visit.
  - (Definition of continuity: Unchanging quality - being consistent throughout.)



## Reasons for progress notes

- It helps the clinician to remember key elements of the session for future reference.

38

## Reasons for progress notes:

- It is the vehicle for communicating with other practitioners - now and in the future.
  - Now: with others on the treatment team.
  - Future: with other professionals who may request the record.

39

## Reasons for progress notes:

- Progress notes provide the required evidence for reimbursement.

40

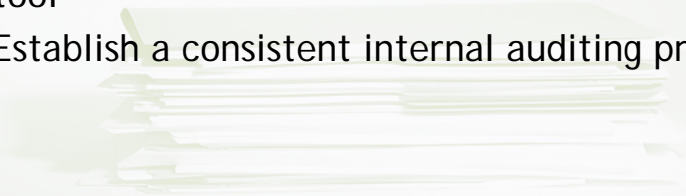
## Why should I document?

When taking responsibility for a client's needs, all practitioners are professionally obliged to maintain a record of care.

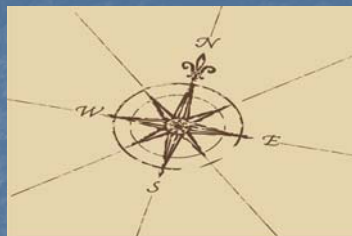


## Tips for Successful Documentation for Medicaid Auditing Purposes

- Know the rules and policy
- Follow the current rules (make sure your copy is up to date)
- Make sure the employees know the rules
- Use the rules and policy to develop an audit tool
- Establish a consistent internal auditing process



## Questions



## Navigation Points

OHCA and ODMHSAS

# Medical Necessity

Clinical Documentation  
Requirements  
(OHCA)

versus

Prior Authorization Documentation  
Requirements (APS)

**Requirement Differences Between  
OHCA and ODMHSAS**

Questions



Let's Talk

Solution - Focused Dialog

# Clinical Documentation - Balancing Clinical Process and Funding Requirements

## How Can We Help?

- Questions
- Training Needs
- Potential Solutions for Systems Barriers

## THANK YOU!!

- For Coming
- For Your Participation
- For All You Do to Provide the Best Care to the People You Serve

