

Version

1

NYSCRI STANDARDIZED DOCUMENTATION INITIATIVE
2010 Training Manual



NYSCRI
Training Manual

NEW YORK STATE
Standardized Clinical Records
Initiative

Developed by the NYSCRI Standardized Documentation Team
Compliance Review by the NYSCRI Compliance Review Team
Long Island, New York

**For information, resources, and updates related to this initiative visit the NYSCRI
Download Website at:**

http://www.mtmservices.org/NYSCRI_2010/2010-Forms.html

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INTRODUCTION :

The Long Island Coalition of Behavioral Health Providers (The Coalition) represents 30 mental health providers in the two-county Long Island Region. The Coalition, along with the New York State Office of Mental Health, engaged M.T.M. Services (MTM) to provide onsite and offsite consultation and training support for the New York State Clinical Record Initiative (NYSCRI).

The NYSCRI has involved Coalition members and other stakeholders at the regional and state levels to help ensure that the NYSCRI integrates required clinical record data elements for all applicable funders, accrediting bodies, and federal/state documentation requirements. The decision was made to also include representatives from NYS OASAS and chemical dependency providers in the Long Island Region in order to develop an integrated set of documents for mental health and chemical dependency providers.

The primary focus of the initiative has been to develop a standardized set of data elements and a documentation flow that supports efficiency, compliance, and person driven, outcome oriented services. The NYSCRI data elements and form sets support paper, e-form, and Electronic Health Record (EHR) formats. It is intended that these standardized form process and data elements will be expanded for use throughout New York State.

The statewide NYSCRI Standardized Documentation Initiative was developed as a proactive response to Goal Six of the *2003 New Freedom Commission Report* and to the Executive Order to develop e-health initiatives to support a migration to Electronic Health Records (EHR) for all individuals served. The critical first step to developing statewide capacity to electronically document mental health and chemical dependency services is to develop a standardized clinical documentation flow process that includes standardized data elements for each type of form/process.

Historically, NYS provider agencies/programs have independently developed and used a wide variety of clinical and medical documentation processes. As a result, there are a significant number of different genres/styles of assessments, service plans, and progress notes in current use.

The costs associated with developing a standardized electronic record based on these multiple approaches would be significant for each provider/program individually. As standards and regulations change, the burden is currently on individual providers to ensure that their form processes continue to be compliant and to negotiate with individual EHR vendors to support required changes. The ultimate goal of the NYSCRI initiative through the development of a standardized set of clinical documentation processes and data elements is to create a single set of statewide data elements and form processes that can be used by providers and EHR vendors and that can be updated at the statewide level to accommodate changes in regulatory and payer requirements and accrediting body standards.

The NYSCRI standardized documentation model also supports a more person-centered and person-driven assessment, service planning, and service delivery approach. In addition, the model provides specific support for the demonstration of Medical Necessity for services billed to Medicaid, Medicare, and private insurance/third party payers.

The standardized documentation process will provide a new **systems learning** capacity for continuously improving the quality of documentation statewide. Experience in other states using a standardized documentation model has also demonstrated support for more objective audit/review outcomes.

About The NYSCRI Training Manual

This manual provides an overview of this initiative, the NYSCRI forms and instructions for their use, and supporting material to enable providers to:

- Use the NYSCRI forms to effectively and efficiently document the individual treatment process for each individual served
- Be in compliance with payer requirements, state and federal regulations, and accrediting body standards
- Apply good clinical practices in support of quality, recovery/resiliency-based mental health and chemical dependency services.

The term *individual or individual served* is used throughout this manual as well as in the NYSCRI form set based on feedback from the Consumers, Families, and Advocates Advisory Committee (CFAAC). While this is the term used it is recognized that different preferences exist surrounding the use of terms referring to the individual served.

How the NYSCRI Training Manual is Organized

Each section of this NYSCRI Manual provides information that will hopefully equip your team with key qualitative and compliance concepts used in the development of the forms. Also, the manual will focus on how to utilize the data fields and clinical flow of each form. A summary of each section of the manual follows:

Section 1: General Information

This section contains background information about the NYSCRI effort, the Standardized Documentation and Compliance Review Teams, the forms development process, and the benefits of the NYSCRI standardized documentation processes. Also, this section provides specific information regarding Medical Necessity, payer, signature, and compliance requirements as well as a discussion of a person-centered Recovery/Resiliency approach to services.

Section 2: Using the NYSCRI Assessment Documentation Processes/Forms.

This section provides a sample of each Assessment form type, guidelines for the use of each form, and instructions for completion of the forms including definitions for each data field.

Section 3: Using the NYSCRI Individualized Action Plan (IAP) Documentation Processes/Forms.

This section provides a sample of each Individual Action Plan form type, guidelines for the use of each form, and instructions for completion of the forms including definitions for each data field.

Section 4: Using the NYSCRI Progress Note Documentation Processes/Forms.

This section provides a sample of each Progress Note form type, guidelines for the use of each form, and instructions for completion of the forms including definitions for each data field.

The ultimate purpose of the NYSCRI statewide forms initiative is to provide all community programs the opportunity to experience system learning and effective use of forms based on the ability of all direct care staff statewide to approach complex documentation requirements from the same perspective. Thank you for your support of the statewide documentation process.

WHAT IS THE NYSCRI INITIATIVE?

What is the NYSCRI Initiative? It is an initiative to develop statewide, standardized, integrated clinical and medical services forms and processes that provide enhanced compliance and quality for mental health and chemical dependency service delivery throughout New York. All documentation processes were designed to accommodate and comply with the following documentation requirements:

1. **State Payers:** NYS OMH; NYS OASAS; NYS DOH
2. **National Accreditation:** TJC; COA; CARF
3. **Federal Payers:** Medicaid and Medicare
4. **Medicaid/Medicare Documentation Support Focus:** Medical Necessity; Individual Served Participation; and Individual Served Benefit

What is the NYSCRI Statement of Purpose?

The purpose is to design, develop, and implement a standardized documentation process that includes identification of the required clinical processes and the specific data elements within each process. Further, the new process needs to adequately support the delivery of quality recovery focused services that are compliant with the requirements of all applicable funders and national accreditation bodies included in the scope of work. The secondary outcome of the NYSCRI will be to use the identified standard data elements to enhance the timely and cost efficient development of standardized EHR systems.

What is the Scope of Work for the NYSCRI Initiative?

The identified scope of work for the NYSCRI initiative includes documentation requirements for services identified below:

1. MH Clinics (Child and Adult)
2. OASAS Clinics (Child and Adult)
 - a. OP Rehab
 - b. Methadone Clinic
3. Partial Hospital
4. PROS
5. ACT
6. Case Management (Adult and Child)
7. CDT
8. IPRT



9. MH Residential
 - a. Congregate Care and Licensed Apartment Treatment
 - b. Supported Housing
 - c. Teaching Family Homes
10. OASAS Residential (Adult and Child)
 - a. Intensive Residential
 - b. Community Residence
 - c. Supportive Living
11. Children:
 - a. Family Based Treatment
 - b. HCBS Waiver for Children
 - c. Children Day Treatment

Within the context of the above services, the NYSCRI will support the development and implementation of the following scope of work:

1. Develop the data elements necessary in each clinical form type to support a statewide, integrated, standardized documentation form set based on Ohio's SOQIC initiative and the Massachusetts MSDP initiative refocused to New York State requirements. The developed form set will support paper processes, electronic forms, and/or EHR specifications
2. Develop a data element dictionary and cross walk for all data elements in each form type
3. Provide compliance review to ensure the created form processes meet applicable state, federal and national accreditation requirements/standards
4. Develop a statewide documentation training manual based on the model used in Ohio's SOQIC initiative and the Massachusetts NYSCRI initiative refocused to New York requirements
5. Provide training to support the documentation model and data elements developed to facilitate an understanding of how to use the new processes to support:
 - a. Medical Necessity linkage requirements
 - b. Recovery/Rehabilitation service delivery focus
 - c. Move to more fidelity between "what we do versus what we write"

What does the NYSCRI mean for you?

- A consolidation of rules/requirements and a lessening of duplicative language and paperwork
- Standardized statewide forms for all mental health and chemical dependency providers
- Forms that support financial and clinical compliance and reduce opportunity for rejection from auditors and payers
- Forms that are compliant with TJC, CARF, and COA accreditation standards
- Structured forms designed to record less narrative and reduce completion time

Why the statewide forms development initiative?

- Lack of similarity in forms among agencies and within agencies. (Lack of standardization, which has resulted in provider agencies using hundreds and hundreds of different form formats and data fields.)
- Difficult for auditors to find information required for reimbursement and clinical audits.
- Huge federal fines and legal problems for providers in other states struggling with adequate documentation
- Need to reduce paperwork so providers can dedicate more time to providing service rather than documentation
- Supports movement to statewide electronic medical records in New York which can best be accomplished using one standardized documentation process

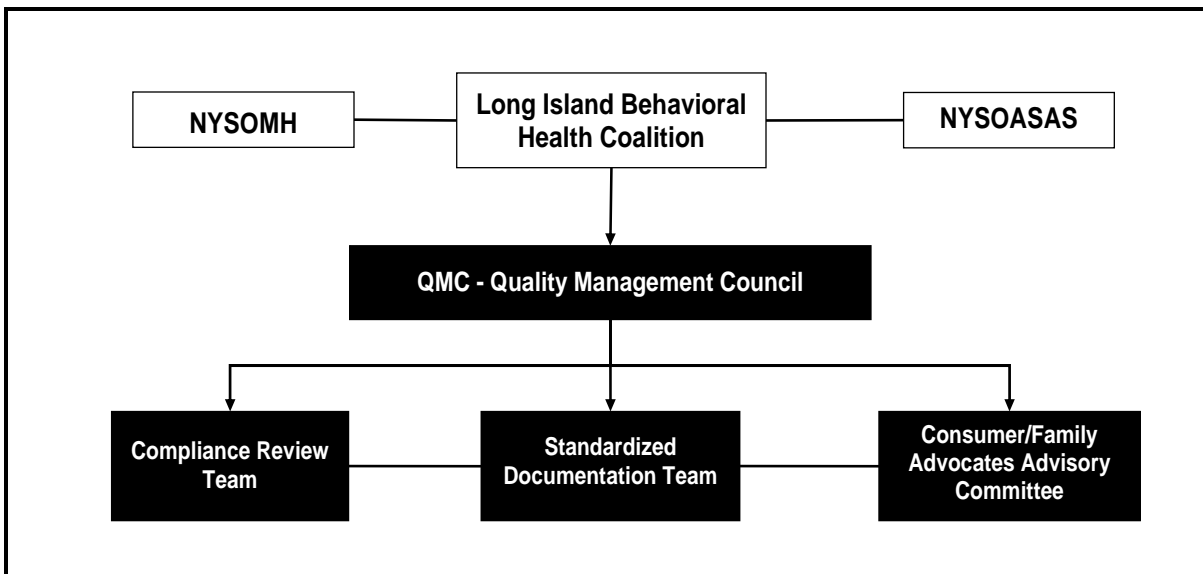
Stakeholders Guiding the NYSCRI Initiative

The following stakeholders have participated in the NYSCRI initiative to help design the standardized documentation processes with a clear focus on the goals of improved quality of care, increased administrative efficiencies, and full legal, regulatory, and accreditation compliance:

- New York State Office of Mental Health (NYS OMH)
- New York State Office of Alcohol and Substance Abuse Services (NYS OASAS)
- Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities Services
- Suffolk County Division of Community Mental Hygiene Services
- Long Island Coalition of Behavioral Health Providers
- Consumer and Family Advocates Representing:
 - Hands Across Long Island, Inc.
 - Mental Health Association of Nassau County, Inc.
 - National Alliance on Mental Illness
 - NAMI of Central Suffolk
 - NAMI Long Island Regional Council
 - FECS - LIFE Program
 - NYS OMH Long Island Field Office

NYSCRI Organizational Model:

The organizational model shown below was developed for the NYSCRI to provide an empowered and effective “top down” and “bottom up” support for the design, development, and implementation of the statewide initiative.



NYSCRI Initiative – Operational Components

Summary

History of Team and Pilot Program Efforts

In March of 2009 the Quality Management Council (QMC), Standardized Documentation Team (SDT), Compliance Review Team (CRT) and the Consumers, Families and Advocates Advisory Committee (CFAAC) of the NYSCRI initiative embarked on a lengthy and challenging journey to investigate and develop standardized clinical documentation forms.

Having completed an inquiry and review of state and federal regulations, accreditation requirements, best practice standards, and generally accepted clinical and medical documentation styles, the teams began their work in April 2009 to develop a standardized documentation forms set.

The SDT used the Ohio and Massachusetts statewide standardized form sets and training manuals as models to direct their efforts. Additionally, the SDT reviewed sample forms/processes being used in New York State by mental health and chemical dependency providers. The CRT created compliance matrices for each group of NYSCRI documentation processes (e.g. Assessments, Individualized Action Plans, Progress Notes, and Transfer/Discharge Summary and Plan). These NYSCRI Compliance Grids will be addressed later in this section of the manual.

The draft Pilot Forms were reviewed by CFAAC members to provide an opportunity for their feedback and recommendations. Recommendations included names of forms/processes, the language used in form processes and manuals, support for a person-centered Individualized Action Plan approach to respond to the identified service needs in the Comprehensive Assessment, and other important recommendations.

During the spring and summer of 2010 the draft NYSCRI forms were piloted by 34 behavioral health agencies on Long Island. The piloting organizations received a full day of “train the trainer” training on the NYSCRI form development process; the concepts behind the form content, structure, and linkage support; the forms and form manuals; as well as on the pilot assessment tools. Local training was then conducted at each organization and feedback was obtained using the “NYSCRI Local Program Pilot Implementation Survey”. This instrument obtained information regarding the quality of the training and supports organizations received, as well as on the success of their local training program. The instrument also helped identify any additional information and/or supports needed to successfully implement the pilot.

The forms were then piloted by clinicians on actual cases for 6 weeks. Feedback and comments regarding the piloted forms were obtained using the following two methods:

1. Direct Care Staff Form “Mark-up” Process

Description:

After using and becoming familiar with the pilot forms, each participating staff member had the opportunity to make detailed suggestions for form improvement by making notations directly on blank forms.

Instruments and Tools:

1. Set of blank pilot forms
2. NYSCRI Pilot Form Markup Instructions and Cover Sheet
3. “Program Type List” to insure correct classification of program type

2. Program Level Pilot Evaluation:

Description:

During the last week of the pilot, local program co-facilitators, with direct input from all participating program staff, completed an evaluation of the pilot including structured and unstructured feedback about each piloted form. Prior to beginning the pilot, all participating staff were given a “Staff Cue Sheet” designed to help focus staff on the kinds of information to track and attend to as they use the pilot forms.

Instruments and Tools:

- NYSCRI “Program Level” Pilot Evaluation Summary
- Staff Cue Sheet

Over 2,000 Pilot comments and recommendations were received. These were analyzed and incorporated into the final NYSCRI form set.

Throughout the project, oversight and guidance was provided by the members of the QMC, including providing stakeholder based leadership in the design of the initiative.

Additionally, the NYSCRI initiative supported the development of forms in pilot study paper format that allows for the standardized documentation concept to be developed and for key data field information to be identified. This will support efforts to create EHR versions of the statewide form/documentation process.

Finally, detailed data specifications development (data mapping) was conducted for each form version and will be made available to electronic medical records vendors to provide electronic record keeping software support.

Team Membership

Below is a list of the members for each team that worked long hours to create a quality based, person-centered, recovery/resiliency focused, and compliant clinical and medical documentation form model for use statewide.

Quality Management Council Membership

The role of the QMC was to provide leadership, vision, and statewide stakeholder involvement in the management, decision making and implementation of the NYSCRI documentation process. Members of the QMC and their stakeholder affiliation are identified below:

| QMC Member | Affiliation |
|----------------------------|---------------------------|
| Alexis Gadsden | Outreach Project |
| Anita Fleishman | Pederson-Krag Center |
| Barbara Bartell | CNGCS |
| Cari Besserman | Phoenix House |
| David Bloomberg | SCDCMHS |
| Denis Demers (Co-Chair) | Catholic Charities |
| Doug Drew | OMH-LIFO |
| Harleen Ruthen | NCDMHCDDDS |
| Herb Cohen | Family Service League |
| Herb Ruben | Peninsula Guidance Center |
| Lisa Lite-Rottmann | OASAS |
| Marge Vezer | SAIL |
| Pat Fogarty | Maryhaven |
| Patricia Hincken | Long Beach Medical Center |
| Philip Mickulas | Family & Children Assoc. |
| Robin Krajewski (Co-Chair) | OMH-LIFO |
| Ron Kaplan | FECS |
| Rosemary Dillon | Central Nassau |
| Steve Greenfield | FREE |
| Tom White | OMH |

Compliance Review Team Membership

The role of the CRT was to develop compliance grids for each clinical documentation process and review all draft forms/processes and supporting training manuals developed by the Standardized Documentation Team prior to the implementation of the Pilot Study and prior to the implementation of the final NYSCRI documentation process. Members of the CRT and their stakeholder affiliations are indicated below:

| CRT Team Member | Affiliation |
|-----------------------------|---------------------------------|
| Carol Bond | OMH LIFO |
| Melena Bowling | Maryhaven |
| Joan Cassara | Pederson-Krag Center |
| Ken Corbin | South Oaks |
| Karen Dolecal | SCDCMHS |
| Judith Doria | Central Nassau Guidance Center |
| Michael Hoffman | OMH LIFO |
| Kristen Lott | FREE |
| Dora Lupo | NCDMHCDDDS |
| Nancy Manigat (Facilitator) | Family & Children’s Association |
| James McQuide (Resource) | NYS OMH |
| Cynthia Nye | Family Service League |
| Diana Reed | OASAS |
| Bob Savitt | North Shore University Hospital |
| Tom Schmidt | SCDCMHS |
| Mary Silberstein | OASAS |
| Frank Tardalo | OASAS |

Standardized Documentation Team Membership

The SDT was responsible for developing each documentation/form process and supporting training manuals, implement the NYSCRI Pilot Study, and collect and review the evaluation feedback from participating pilot programs. The SDT operated using a three sub-group operational model that allowed simultaneous development of all NYSCRI documentation processes. A list of the members within each sub-group and their affiliation information is listed below:

1. Assessment Group

| Name | Affiliation |
|------------------|----------------------------------|
| Gaylene Pandolfo | OMH LIFO |
| Jeff Steigman | Pederson-Krag |
| Leslie Kizner | FEGS |
| Maria Malonowski | Hispanic Counseling Center |
| Omayra Perez | SSCGC |
| Patricia Hartley | Pederson-Krag |
| Scott Burzon | SCDCMHS |
| Sherri Kaplan | Central Nassau Guidance Services |

2. Individualized Action Plan Group

| Name | Affiliation |
|----------------------|--------------------------------------|
| Anu Arnold | FREE |
| Christine Buckley | Mercy Medical Center |
| Christine Santangelo | CNGCS |
| Jim Dolan | NCDMHCDDDS |
| Judy Adams | OASAS Long Island Field Office |
| Elizabeth Weinbaum | Concern for Independent Living, Inc. |
| Loren Campbell | Family & Children’s Assoc |

3. Progress Note Group

| Name | Affiliation |
|------------------|--|
| Pam Rice, Lead | Mental Health Association of Nassau County |
| Susan Steinhardt | Options for Community Living |
| June Newill | Maryhaven Center of Hope |
| Joe Chelales | OASAS |
| Rosemary Sanchez | Pederson-Krag |

Consumers, Families, and Advocates Advisory Committee Membership

The CFAAC reviewed the NYSCRI documentation processes and provided valuable recommendations regarding how to support a Person-Centered Recovery/Resiliency service delivery approach. CFAAC members and their respective stakeholder affiliation are identified below:

| CFAAC Member | Affiliation |
|-----------------|--|
| Barbara Roth | NAMI Long Island Regional Council |
| Douglas Drew | NYS OMH Long Island Field Office |
| Barbara Tedesco | Mental Health Association of Nassau County, Inc. |
| Jesse Smith | Hands Across Long Island, Inc. |
| Donna Classi | Hands Across Long Island, Inc. |
| Lou-Ann Rinde | FEGS - LIFE Program |
| Deb Mayo | NAMI of Central Suffolk |

Consultation Team

Below is a list of the M.T.M. Services consultation team members and their email contact information:

- David Lloyd, NYSCRI Project Manager (mtmserve@aol.com)
- Scott Lloyd, Lead SDT Consultant (mtmscott@aol.com)
- Bill Schmelter, Ph.D., Clinical and Lead CRT Consultant (E-Mail: mtmwilliam@aol.com)

STANDARDIZED DOCUMENTATION BENEFITS

The creation and utilization of statewide standardized documentation data elements and processes can serve to benefit mental health and chemical dependency providers at a variety of levels and in a variety of ways. While deliberation and further evaluation will continue to identify additional long term benefits, other similar initiatives have observed some important benefits of this kind of effort. Some specific benefits identified by the Standardized Documentation Team and the Quality Management Council include those listed below.

A. Clinical Care Benefits

1. ***Enhances Clinical Care Approach:***

Specific attention has been given in the NYSCRI clinical documentation processes to develop “identified needs” (symptoms, behaviors, functional/skills deficits, and support/coordination deficits) that impact the individual’s level of functioning which will help ensure the services ordered meet Medical Necessity requirements.

2. ***Client-Centered Recovery/Resiliency Focus:***

The new standardized forms/processes contain a more client-centered and recovery/resilience focus on individuals’ served needs, strengths, and personal life goals that support the assessment of peer/family support, employment, meaningful activity, power and control, community involvement, education, and access to resource needs and preferences. Integrating the recovery/resiliency needs of those we serve is critically important to engagement and improvement in the clinical care of individuals served while at the same time addressing the need to demonstrate Medical Necessity and address important funding and regulatory requirements.

3. ***Reduction of Redundant Collection of Clinical Information:***

Individuals served, families, and advocate representatives have provided excellent feedback regarding how the standardized processes have reduced redundant information gathering by eliminating multiple assessments and service plan development per individual served, regardless of the number of clinical services he/she receives at the provider agency. The standardized forms/processes have at their core the principle, "Establish a documentation process that will commit to asking the individual a question only once unless there is a justifiable clinical reason to ask the same question twice".

4. ***Enhanced Measurement and Duplication of Positive Outcomes:***

Standardized clinical documentation processes have demonstrated an improvement in the ability to measure clinical outcomes and enhance the ability to duplicate positive outcomes.

5. ***Enhanced Accessibility to Services:***

Streamlining the intake process through reducing/eliminating redundant diagnostic assessment and service planning processes has produced a

reduction in the total time it normally takes to admit individuals into services, which has also had a positive impact on reducing "intake no shows/drop outs".

B. Fiscal Benefits

1. *Staff Retention:*

Proactive adaptation of current service delivery processes to accommodate efficient, low redundancy, standardized documentation models provides the ability for staff to "finish their work" by the end of each day resulting in higher morale.

2. *Enhances Cost Efficiency of Standardized Process:*

With the current funding environment, it is imperative to develop more cost efficient documentation processes. A standardized low/no redundancy documentation process has proven to be more cost effective than historical program/unit based unique models that were replete with redundant recording of information. Additionally, standardized documentation forms/processes have dramatically reduced training costs.

3. *E-Health Conversion of Forms:*

All final forms/processes will be provided to MH/CD providers in a format that will support time and cost effective EHR development.

4. *Enhances System-wide Accountability:*

Standardized documentation has proven that it will enhance system-wide accountability in the following areas:

- a. More accurately determine the cost of services by utilizing standardized documentation and reducing the volume of processes
- b. Provides a more objective comparison of clinical processes/services delivered statewide
- c. Provides individuals served and families the ability to expect the same clinical documentation process regardless of which provider agency in the state they access

C. Enhanced Compliance Benefits

1. *Meets Certification and National Accreditation Compliance Requirements:*

All forms/processes were reviewed in detail by a representative compliance team to ensure compliance with state certification requirements, JCAHO/CARF/COA accreditation standards, and Medicaid/Medicare documentation compliance requirements.

2. *More Objective Reviews/Audits:*

The move to standardized documentation minimizes the subjective nature of audits and site reviews. In addition audit results can be more easily used to improve compliance at other program sites/organizations. In addition, standardization allows for efficient centralized modification of form processes to accommodate audit findings and improve overall compliance.

3. *Provides a Reduced Compliance Risk Environment:*

More objective reviews due to use of standardized forms/processes within MH/CD centers provides a clinical service delivery environment that facilitates a higher level of compliance statewide.

4. Promotes a System Learning Environment:

Standardized documentation improves the ability to provide system wide change opportunities that promote compliance with medical necessity/ documentation linkage requirements, national accreditation standards, and federal/state regulations.

Identified below are the areas of compliance standards that the NYSCRI Compliance Review Team (CRT) used to support a full compliance grid for each form type being developed to help ensure full compliance with all requirements:

| NYS Regulations | | | | Accreditation Standards | | |
|---------------------|---------|----------|-------|----------------------------------|----------------------|----------------|
| OMH | OMH SOC | DOH (CM) | OASAS | TJC | CARF | COA |
| Federal Regulations | | | | Support for Federal Requirements | | |
| Medicaid | | Medicare | | Medical Necessity | Client Participation | Client Benefit |

Hopefully, the above information provides additional reasons to support the statewide standardized documentation initiative. Together... we can make a difference for individuals served, staff, programs, and payers.

Documentation That Supports Quality Treatment

The Value of NYSCRI Standardized Forms and Processes

By: Bill Schmelter, Ph.D., M.T.M. Services and National Council Consultant

The NYSCRI standardized forms and processes were designed to improve the “value” of clinical documentation for individuals served, the staff that provide services, and the organizations that support service provision.

Understanding the intended value of various aspects of the NYSCRI standardized forms and processes is an important step in their optimal implementation for several reasons.

First, an understanding of, “what’s in it for us and the people we serve” is necessary if staff are going to make the effort to fully learn and take advantage of the forms and processes as intended.

Second, understanding the ‘why’ of the forms and processes design can improve the value that results from their implementation. There are many examples of well designed forms and processes that are misused, thus neutralizing their intended value.

Well designed standardized clinical forms and processes can do much more than simply provide a format for recording information. This section discusses the potential *value* of the NYSCRI standardized forms and processes in the following three areas:

1. Improved service quality and compliance
2. Support for ‘person centered, recovery/resiliency oriented services’
3. Improved system learning and responsiveness

1. Improved Service Quality and Compliance

Documentation compliance efforts are often viewed by direct provider staff as independent of or even obstacles to, clinical quality. For example, staff frequently report that documentation requirements interfere with their ability to interact with the individuals they serve. A well designed set of forms and processes should assist and support staff and individuals served as they navigate the recovery process together, not get in their way.

The purpose of compliance standards is to ensure baseline levels of service quality and accountability. Any effort to improve compliance should maintain a focus on how those efforts will improve the quality of care provided. The NYSCRI standardized forms and processes were designed to provide the most current support for compliance, to guide

good practice, and to improve service quality and outcomes in the most efficient manner possible.

All forms in the NYSCRI standardized forms set were cross referenced with applicable standards and regulations to insure compliance. In addition the structure and content of forms were designed to efficiently support core clinical and recovery processes.

The **Comprehensive Assessment** promotes participation by the individual being served and encourages an interactive dialogue. Through a carefully planned sequence of assessment focus areas and prompts, the Assessment supports the efficient collection and analysis of information to:

- Accurately determine and support diagnoses
- Identify individual strengths, preferences, and personal goals
- Identify social, environmental, and other barriers to recovery
- Identify available supports and resources
- Establish baselines for symptoms, domains of functioning, skills, and abilities
- Articulate and prioritize needs and recommended services
- Justify the medical necessity for the types and intensity of services to be provided
- Lay the groundwork for development of a meaningful Individualized Action Plan

The **Comprehensive Assessment Update** is designed to ensure that:

- Relevant new or updated information is incorporated into the Assessment
- Current Assessment data and conclusions directly support the current Individualized Action Plan

The **Individualized Action Plan** is designed to efficiently:

- Ensure active linkage to the findings and recommendations of the current Assessment
- Encourage collaboration between the provider and the individual served
- Encourage the meaningful consideration of strengths, preferences, and personal goals in the development of goals and objectives
- Support the development of meaningful goals
- Support the development of realistic, relevant, and measurable objectives that are changes to the baselines established in the Comprehensive Assessment
- Support the clear articulation of interventions (methods), and service strategies that are expected to help achieve stated objectives and can meaningfully direct staff activities

Progress Notes are designed to efficiently:

- Ensure that interventions/methods remain focused on the goals and objectives developed in the Individualized Action Plan.
- Encourage description of interventions provided, the response/reaction to the interventions by the individual served, and progress toward goals/ objectives.
- Articulate plans for activities recommended prior to the next session as well as the focus for the next session.

- Document pertinent new information that may trigger a Comprehensive Assessment update and potentially require a change in the Individualized Action Plan

All other forms in the NYSCRI Standardized Forms set were similarly designed to support the underlying processes they reflect.

2. Support for Person Centered, Recovery Oriented Services

The NYSCRI standardized forms and processes were designed to help move efforts to provide person centered, recovery/ resiliency oriented services from theory to practice.

Person Centered Approach:

A person centered approach involves a genuine partnership between a provider and the individual being served throughout all aspects of the service process including assessment, action planning, and service interactions. Person centeredness is not just about 'respect' or good 'customer relations'. These should be core elements of any responsible service orientation. Rather, person centeredness is about improving outcomes!

Engaging in the recovery process takes significant and prolonged effort on the part of the recovering individual. Unless individuals believe that providers fully understand their personal goals, strengths, obstacles, and what they hope to gain from services, motivation and engagement will suffer.

Motivation and engagement are enhanced when individuals have real input into the development of goals and objectives that reflect personally desired change and can be easily related to the achievement of personal goals. Finally, ongoing service engagement will only occur if individuals understand how the services they receive are helping them reach the objectives they and their service providers committed to work on.

Person centered services ensure that Assessment and Action Planning are considered more than just paperwork, and that services provided are focused and of value to the individual served. The NYSCRI standardized forms set provides significant support for Person Centered Services.

Recovery Orientation:

Recovery is another concept that has been difficult for many service providers to implement in a practical sense. One nationally accepted definition of recovery is, "A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence."

For obvious reasons the person centered approach discussed above is central to supporting recovery. In addition, a Recovery orientation requires a shift from a primary focus on symptom reduction to a focus on improvement in functioning, resilience, and adaptation.

The NYSCRI standardized forms and processes are designed to support a person centered, recovery oriented approach. It is up to service providers to take advantage of that support.

The Comprehensive Assessment is designed to efficiently prompt exploration of a wide range of issues. The focus is not limited to symptoms and diagnoses, but includes functioning domains, skills, strengths, preferences, available and needed supports, and personal goals. It is important to encourage the individuals being served to offer their perspectives in areas of importance to them and to ensure that they understand the purpose and value of the assessment. This is particularly important when developing identified needs that will form the basis for the Individualized Action Plan.

The Individualized Action Plan is also designed to encourage the active participation of the individual being served and to allow a focus on functioning. This is particularly important in the development of goals and objectives, which should be achievable, realistic and of value to the individual. The opportunity to identify individual strengths and how they can be brought to bear to help achieve goals and objectives is also provided.

Individual Action Plans should not be overly complex. It is difficult for most people (including provider staff) to maintain a focus on more than a few goals and a few objectives at a time. By focusing on a few, relevant objectives, success is easier to achieve and measure thus further building motivation and engagement.

The Progress Note is also designed to support this approach. It is important to maintain “Action Plan Awareness” when providing services. This means that it should be clear to the provider as well as the individual served what the current intervention session has to do with the achievement of a particular objective(s) in their Action Plan. It is all too common to find progress notes that document conversations about current ‘mini crises’ or other ‘topics of the day’ with no obvious connection to the Action Plan. As providers, we have a responsibility to help maintain Action Plan Awareness and provide interventions that help the individual achieve the agreed upon objectives or, based on changing conditions, modify the Action Plan in collaboration with the individual served.

For many of the people we serve, past experience with services has left them with low expectations. In their experience, Assessment and Action Planning may have been primarily paperwork exercises with little connection to the service interactions they have had with provider staff. For these individuals, involvement in person centered, recovery/resiliency oriented services will involve some relearning. This involves extra effort on the part of provider staff to help instill a sense of hope and engagement.

3. Improved System Learning and Responsiveness

The uncontrolled proliferation of forms is a common problem in behavioral health service settings. Frequently no single person or entity is even aware of all the forms used within their organization.

This situation, in addition to putting an unnecessary strain on an organization’s ability to train new staff or retrain existing staff for new assignments, makes responding to change a daunting task. Conforming to new regulations or accreditation standards can mean analyzing and making changes in dozens of forms.

Similarly, any planning process for programmatic, quality improvement or other rapid cycle change initiatives will frequently identify the need to undertake complex and costly changes in documentation as a significant obstacle. Just the proposition of needing to make changes in numerous forms can sometimes derail an otherwise worthy undertaking.

A standardized set of forms and processes that have been specifically designed to meet applicable regulatory and accrediting body standards, as well as to support clinical practice, makes staff training easier, more consistent, and more effective. In addition, responding to changing conditions can be accomplished in a more efficient and coordinated fashion.

Documentation standardization at the system (e.g. statewide) level greatly increases the benefits discussed above. While all behavioral health organizations have similar core missions and similar documentation change requirements to address evolving regulations and accreditation standards, they have historically been left to their own devices in terms of developing responses. Organizations have not been able to take full advantage of the experiences of other providers (e.g. audit findings) because their core documentation forms and processes are significantly different.

Supervision and monitoring systems also benefit from the adoption of standardized forms and processes. Because forms are consistent, supervisory, medical records, utilization review, and quality improvement staff can use more standardized approaches to supervision and documentation review and can benefit from the experience of others. Standardized monitoring tools can be developed so that benchmarking both within and among provider organizations becomes more practical.

Another benefit of a collaboratively developed standardized form set is its value as a critical step for the potential conversion to an Electronic Health Record (EHR) format. The biggest challenge organizations face when preparing for this transition is identifying and piloting the form elements and processes they want represented. The development of the NYSCRI standardized forms and processes is a major step in preparing for EMR conversion for interested organizations. In addition, statewide system adoption of a common set of standardized forms and processes can create an economy of scale that greatly reduces the cost of EHR conversion and ongoing support for any particular organization.

Adoption of the NYSCRI standardized forms and processes will make it possible for all organizations to take advantage of the experience of other providers and to participate in and benefit from coordinated responses to change, training, and support.

Clinical Focus of the NYSCRI Documentation Process

The New York Standardized Documentation Initiative aims to create a standardized set of forms and processes to be used as tools for documentation across the state, which are fully compliant with a wide variety of regulatory and payer requirements. The recent shift in the field towards electronic medical records, prompted by the Federal mandate requiring all states employ electronic record formats by 2014, points to a pressing need for clinicians and practitioners to shift thinking about documentation itself. Along with the importance of demonstrating medical necessity and moving towards individual and family centered planning and treatment, today's behavioral health care provider must also use documentation to accurately capture the individual's assessed needs, goals for treatment, and work toward meeting the stated goals. As the individuals we serve are ever-changing, the documentation must continue to evolve along with the client and not be a one-time-only, "snap shot", of an individual's history, presentation, and goals. The form set and processes developed by the NYSCRI reflect this need and create a framework for a dynamic system of gathering and documenting the individual's treatment, response to treatment and movement toward chosen goals over time.

The NYSCRI documentation process is one that allows the provider to work collaboratively with the individual served to continuously discover more about the individual's needs and to maintain a clear and dynamic plan. The forms/processes allow for a logical and natural flow of information gathering and service documentation. When used as an "integrated record set", they serve as synergistic tools to:

- Assess the individual in a comprehensive way,
- Ensure the determination of the medical necessity for treatment,
- Guide the development of treatment goals and objectives which meet the needs and desires of the individual served and
- Document interventions and interactions and progress or lack thereof of the individual's course of treatment.

Each form in the set supports the documentation of key service delivery processes from intake to discharge. Each form within the "integrated" record set for any service type addresses some of the essential elements needed to comply with funder and payer requirements. Therefore forms should not be "pulled apart" from each other and used individually. If some of the NYSCRI forms types are used, but not all of the forms, the clinical information may be incomplete and compliance with funder/payer requirements will not be attained.

Mental Health Adult Clinic Standards of Care Interpretative Guidelines

Mental Health Clinic Standards of Care Interpretative Guidelines - Adult

Clinical standards of care are essential for access to and quality of care for individuals served by NYS licensed clinics that provide mental health services. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently throughout the State.

We provide the following description of clinical standards for adult outpatient licensed clinics at this time as a result of recent reviews of care that revealed that too often these standards, which we believe to be fundamental to good care and a longstanding expectation of clinic services, may not be explicitly understood, regularly considered or consistently met. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements.

1. Client care

1. Evaluation

By the time the client arrives for initial evaluation, a single clinician should be designated as responsible for ensuring that a comprehensive evaluation is completed in a timely manner. With the individual's permission, the clinician should pursue information from other available sources, particularly family members, significant others, and current and past providers of services. The evaluation should include:

- A thorough exploration of current concerns, goals, and symptoms
- A review of mental health history including past successes and difficulties, prior interaction with mental health care professionals and past treatments, including medications, adherence, and preferences
- Current or past use, abuse, or dependence on alcohol or other substances
- A thorough understanding of the client's social circumstances, support network, and ongoing life-stressors, including family issues, housing stability and past traumas
- An initial risk assessment, including risk to self and others
- Medical history and treatments

2. Care plan

Every client is required to have a comprehensive care plan, developed in a timely manner and signed by all clinicians participating in the individual's care and by the supervising psychiatrist.

The care plan should be:

- Recovery oriented, including a focus on work and/or education
- Responsive to the individual and family’s cultural and linguistic needs
- Person centered in that the goals are developed with the recipient of service and fashioned to meet the aims and preferences of the client
- Updated according to the client's needs and regulatory requirements

3. Ongoing care

1. Attending to the Consumer and Family

Consistent with the mission of a clinic is the need to be available and accountable to the individuals they serve and their families. This includes flexibility in time and place of appointments, after-hours responsiveness and shared decision making. A clinic may directly provide care, make referrals, and collaborate with other providers, including the client's primary care physician.

2. A Primary clinician

A primary clinician should be identified for each individual served by a clinic in a timely manner.

3. Patient safety and security

The primary clinician should ensure that appropriate and ongoing safety assessments are completed. These would include assessments of risk to self and others as well as making contact with other providers, community agencies and supports, family members and significant others, and past treatment providers when appropriate.

4. Engagement and retention in care

The primary goal for clinic services is client engagement and retention in care in order to assist the individual in achieving his or her goals. The frequency and nature of client contacts with members of the treatment team should be commensurate with the severity of problems and the prescribed treatment plan. Diagnosis and treatment of a co-occurring substance use disorder, when present, is a best practice and will enable clients to remain in care.

The identified primary clinician should be responsible for ensuring that the appropriate level of engagement is occurring at all times.

5. Attention to co-occurring disorders

Clients in mental health clinics commonly show the presence of a co-occurring medical and/or substance use disorder (including alcohol, drugs, and tobacco). The treatment of a co-occurring disorder whether at the mental health clinic, in a chemical dependency program or in primary medical care, is essential to individuals' well being and recovery and should be a primary clinical administrative goal for the clinic.

6. Communication with families

Families or significant others should be contacted as soon as possible, with proper consent, when an individual is beginning treatment, and should subsequently be involved as partners in the development and implementation of the plan of care; families or significant others should also have all information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis.

7. Disengagement from treatment

When an individual refuses or discontinues participation in all or part of the agreed-upon care plan, all members of the treatment team as well as collaborating providers and agencies should be made aware, especially the treating psychiatrist and/or clinical supervisor, and should conduct a review of the client's history, previous assessments of risk to self or others and render an opinion as to any aggravating or mitigating factors related to risk, with the clinician taking appropriate actions for the timely re- engagement of the client, including assertive outreach commensurate with the degree of assessed risk.

2. Clinical administration

1. Caseloads

The clinic supervisor or director should be responsible for ensuring that complex, time-intensive cases are evenly distributed and considered for more experienced clinicians, and that the number of assigned clients permits the appropriate delivery of services.

2. Supervision

Clinic leadership should provide regular guidance and oversight for staff (especially new staff), with attention to individuals' ongoing care as well as emerging problems or crises.

3. Integration and information sharing

When individuals receive services from more than one clinic or agency, efforts will be made to ensure that all involved treatment providers have a shared understanding of the individual's goals and progress, and that the respective intervention plans are integrated, complementary, and reflected in the client's records. Current State law allows clinicians from OMH-licensed or operated facilities or providers under contract with OMH or DOHMH to speak specifically about the care of an individual they are treating as a best practice and when clinical circumstances warrant, without consent of the client. Furthermore, current state law also permits these mental health providers to share relevant clinical information, without consent, when an individual is referred for services to another mental health provider of a facility that is licensed, operated, or contracted by OMH or DOHMH.

4. Communication

Complex care requires that case managers and clinicians from multiple disciplines provide concurrent services, within one agency or among multiple agencies. It is imperative that these individuals have ready access to one another and share appropriate information at regular intervals when there is evidence of emerging instability and during periods of crisis.

Guidelines for sequential screening of risk for violence

Safety, both of the individual and of the public, is a fundamental aspect of psychiatric treatment. Accordingly, the assessment and management of the risk for violence is an essential component of clinical care. For most individuals, it can quickly be established that the risk of violence is low and, in the absence of a possible change in their level of risk, additional assessment is not needed. However, when indications of elevated risk are present, more detailed assessment is required. The process of risk assessment involves the identification of risk factors present, followed by an assessment of the significance of each factor and consideration of how these factors together indicate a certain level of risk.

The following stepwise evaluation is recommended:

- Universal violence risk screening for all individuals served as part of the intake process,
- Targeted violence risk assessment when screening indicates increased risk,
- Violence risk-focused treatment when indicated, and
- Reassessment when the individual's clinical, legal, or contextual status changes.

Although the emphasis of this section is on the assessment of the potential for violence by individuals under psychiatric care, it is important to note that, notwithstanding public perceptions of the dangerousness of individuals with mental illnesses, they are actually more likely to be the victims of violent crime than the perpetrators. The relationship between violence and mental illness is complex and strongly correlated with additional variables besides the presence of mental illness alone, such as a history of prior violence or the influence of co-occurring substance use.

Risk assessment framework

1. Universal risk screening

The routine evaluation of all new clients requires the assessment of risk. All clients should be asked directly whether they have ever fought with or hurt another person and whether they have recently thought about hurting another person. In addition, there are critical events (e.g. past hospitalizations and arrests) that raise the possibility of past violence. As with any clinical assessment, some information may be provided directly by the individual. Whenever possible, collateral sources should be included in the assessment process for additional information or corroboration. Collateral sources include family members, friends, or other significant close contacts and sources of support, as well as prior treatment records.

Recommended areas for screening include determining if there is any history of:

- Physical or sexual aggression towards other people
- Deliberate self-injury
- Emergency room visits or hospitalization related to threatening or violent behavior
- Arrest or orders of protection related to the individual's threatening or violent behavior
- Current or recent thoughts or behaviors that others have interpreted as threatening

Additional screening areas, in cases where a higher index of suspicion is warranted regarding a predisposition to aggression, include a history of:

- Problems with controlling anger
- Expulsion from school related to violent behavior
- Workplace or domestic violence

2. Targeted risk assessment of clients with histories of violence or recent ideation

Should screening yield a history of violent behavior or recent ideation, a more in-depth analysis of the risk of future violence is derived by obtaining the details of violent behavior or ideation and by identifying factors that increase the level of an individual's acuity or protective factors that mitigate risk.

Ultimately, clinical judgment is necessary in assessing how various symptoms and factors are related to violent behavior. A thorough review of the following areas can be used to guide clinical judgment:

- Details regarding the history of violence or violent ideation, including severity, context, and use of weapons.
- Presence of factors associated with incidents of aggression including:
 - Interpersonal conflict, unstable relationships, poor social support
 - Employment or financial problems
 - Substance use, whether due to active intoxication, withdrawal, or craving
 - Psychiatric conditions or active symptoms, including those related to personality disorder
 - Treatment noncompliance or lack of insight
 - Criminal behavior
 - Ongoing access to weapons
- If there is a history of violent ideation, but not violence per se, is/are there:
 - A plan and available means for acting on the ideation
 - Steps taken in furtherance of the plan
 - Factors that inhibit acting on the ideation
 - Presence of protective factors, including:
 1. Outside monitoring (court, AOT)
 2. Outreach teams (e.g., ACT teams)
 3. Treatment efficacy and compliance
 4. Stable social support, work, and/or housing

Application of risk assessment findings to risk-focused treatment:

It is not necessarily the total number of risk factors present that indicates a heightened risk. A single, severe factor may in and of itself indicate substantial risk concerns. Similarly, protective factors may significantly mitigate risk. After factors have been identified as related to past violence, consideration must be given to how relevant these factors remain in the present or foreseeable future. Risk assessment assists in the characterization of acuity and identification of areas of need; when risk has

been identified, actions to address that risk must be reflected in the initial treatment plan.

Ongoing treatment plans should:

- Reflect interventions taken to manage identified risk factors
- Include efforts to actively engage the individual and involve available supports
- Take into account prior treatment successes and failures
- Monitor the improvement or worsening of significant risk factors to guide any necessary change in management

When an individual already in treatment misses an appointment or drops out of treatment, a review of the violence risk assessment may help guide the clinician's response. An individual with active symptoms, a history of violence, and numerous risk factors for violence requires a greater degree of outreach and engagement. It must be emphasized that no guideline can include every possibility; therefore treatment decisions remain in the domain of clinical judgment, as applied on an individual basis to each particular combination of circumstances and needs. Potential multidisciplinary interventions include:

- Identification and monitoring of warning signs indicative of imminent or increasing risk
- Evaluation of medication regimen and consideration of additional treatment modalities
- Involvement of family, social services, case management, or other supports
- Consideration of social stressors
- Increased monitoring, including increased frequency of clinical contact
- Consideration of AOT
- Increased level of care, including hospitalization

3. Reassessment

There are specific junctures in treatment when reassessment of violence risk, following the framework described above, should take place. If an individual becomes more symptomatic, or if treatment appears to be failing, reassessment should occur. When considering an individual for hospital discharge, an assessment of risk factors for violence and whether risk factors for aggression have been addressed adequately is necessary. Similarly, prior to other changes in client status such as changes in level of hospital restriction or confinement, termination of clinic care, or discontinuation of an AOT order, reassessment of violence risk is indicated.

With any framework for assessment, there remains the possibility that clinicians may encounter cases where the level of risk remains unclear, or

where the management of identified risk factors is complex and difficult. In such cases, adequate supervision and/or consultation for assistance with either further assessment or management recommendations is indicated.

2. Actuarial tools

The methods by which violence risk is assessed have been classified as either clinical or actuarial. Despite improved accuracy over unstructured clinical risk assessment, actuarial tools have important limitations. Past violence is the most significant factor in predicting future violence; actuarial tools will often not identify the risk of individuals who have yet to engage in serious violence. Also, actuarial tools are typically developed on a specific target population; the general clinic population is sufficiently diverse that there is no one particular actuarial tool that has been validated for use with a general clinic population.

The importance of proper training in the use and limitations of any given actuarial tool prior to implementation must be emphasized. These tools should not be approached as simple rating scales. Without an adequate understanding of their application, actuarial tools have the potential to misguide the estimation of risk.

Rather than adding any one particular actuarial tool as a required component in the standard of care for risk assessment in the general population at this time, we recommend the sequential screening of risk for violence outlined here. However, depending on the specific circumstances, actuarial tools, administered by clinicians versed in their administration and interpretation can enhance the accuracy of the risk assessment.

Mental Health Clinic Standards of Care Interpretive Guidelines - Children, Adolescents, and their Families

Clinical standards of care provide context to the Office of Mental Health regulations that define appropriate access to services and quality of care for children and adolescents treated in Clinics licensed by the New York State Office of Mental Health. These standards should be incorporated by all Clinic programs serving children, adolescents and their families as the basic operating framework within which care is provided.

1. Engagement, Assessment and Treatment

1. Engagement

Engagement of the child or adolescent and their family in treatment is the first step in offering family-driven care and is a crucial element for treatment success. The process of building this connection starts with the first contact, whether by phone or in person. There are a variety of ways that engagement can occur, including the use of Parent Advisors and/or staff that have particular skill in building initial rapport with children and families; the development and dissemination of fact sheets, pamphlets and brochures; through follow-up and confirmation telephone calls used to motivate and engage families; and ensuring that the Clinic maintains cultural relevance within the community that it serves. A variety of approaches to family engagement should be used throughout the assessment and treatment process to maintain involvement and promote successful outcomes for the family.

2. Assessment

All individuals shall have a single clinician designated to ensure that an assessment is completed in a timely manner. The assessment process should begin with the child or adolescent and his/her family or guardian if the child is in foster care. Clinicians should be respectful of who the family invites to be part of the assessment process (distant relatives and close friends, in some cultures, for instance, may provide comfort, for example). Additional sources of information, such as school personnel, current and previous therapists, medical providers, and social service and juvenile justice personnel should be sought to help define the concern(s) that brings the child into the clinic for treatment as well as the child and family's strengths. The assessment should include:

- A thorough mental status evaluation, including interview or interactive session with the child or adolescent, as appropriate. Individual clinical judgment will guide whether or not the child or adolescent should be interviewed alone and/or in the company of his/her parents. Parents or guardians should be interviewed, unless there is a strong clinical or legal reason to exclude their input.

- A review of developmental, mental health, and educational history and symptoms, including prior treatments, medications, and response to treatment.
- An assessment of the family, social circumstances, school performance, peer interactions, social networks. Current and previous life-stressors should be assessed.
- Past medical history and treatment should be obtained. Information from the current medical provider should be sought.
- Family history, including mental illness in family members and particular life circumstances or stressors likely to impact the child or adolescent.
- An initial risk assessment, including the child's risk to self and others.
- A comprehensive diagnostic evaluation using the five axes of the current Diagnostic and Statistical Manual of Mental Disorders (DSM) classification.

3. Care Plan (Treatment Plan)

Every child and adolescent admitted for treatment is required to have a comprehensive treatment plan that is developed in a timely manner, driven by the needs and strengths of the child and their family (demonstrated with the appropriate signature on the document), and signed by all clinicians participating in the plan and the supervising physician. The treatment plan should be:

- Clear about the needs, strengths, hopes and expectations of the child or adolescent.
- Specific in regard to the treatments to be employed in the attempt to reach those goals.
- Identify how others in the child's life, including teachers, friends, and community resources will be involved in treatment and/or consulted with regarding treatment results.
- Responsive to the child or adolescent's unique developmental needs.
- Responsive to the family's social, cultural, and linguistic needs.
- Developed and written with the child (as appropriate) and parents or guardians.
- Updated according to the child or adolescent's needs, progress, and regulatory requirements

4. Ongoing Care (Treatment)

1. Primary Clinician (Therapist)

A primary clinician (therapist) should be established in a timely manner for each child or adolescent treated in the clinic. This person must be available to family members on a regular basis, in a culturally respectful manner.

2. Continued Engagement in Treatment

It is the primary clinician's responsibility to ensure that each child and his/her family remain engaged in treatment and are making progress that is consistent with the treatment plan and with the family's expectation of outcomes. Clinicians should feel free to openly discuss issues of motivation and adapt the treatment plan accordingly. Clinicians should be well versed in local Family Support resources and readily refer families.

3. Youth and Family-Driven Care

Clinicians should listen carefully to discover what youth and their families hope to achieve from treatment and this should be reflected in the treatment plan. Ideally, treatment planning is a collaborative process among a young individual, parent, clinician, and other supports, as determined by the family. The mental health treatment goals should be realistic and relevant. Young people and their families should be encouraged to ask questions about treatment goals or to share concerns with what they feel is not working.

4. Collaboration within the Child's Community

Active collaboration with others involved with a child or a family can be an important aspect of treatment. Clinics shall develop a plan for each child to assure continuity and integration of care within the mental health system and with other systems of care. A clinician should be familiar with various care systems and the personnel who are serving the child and/or family. For instance, if a particular youngster routinely gets into trouble in school, the clinician should obtain a release from the parent or guardian to be able to speak with the child's school social worker, teacher, or principal. This will ensure that the clinician is obtaining accurate and relevant information and is able to fully understand the scope of the presenting problem. This will allow the clinician, family and teacher to devise treatment solutions that meet the child's unique needs in a timely and respectful manner.

Additionally, this will allow the clinician to recommend and refer the child to complementary community based treatment services, to maximize therapeutic gains for the child. Using our example, the clinician might choose to advocate for additional services for the child by making a referral to a case management service provider while simultaneously referring the child's parents to a parental support group.

5. Individual & Family Safety

Many children and adolescents are referred to clinic treatment because they have engaged in high risk behaviors that pose some danger to themselves or others. Other youth come to the attention of clinic providers because their statements or behaviors suggest they have considered or might engage in high risk behaviors. Therefore the issues of risk and risk assessment are necessary parts of the assessment and are ongoing aspects of the clinician's role during treatment. Parents should be instructed in how to make appropriate risk assessments of the child or adolescent's statements or behaviors and appropriate steps to take if safety continues to be a concern.

The primary therapist should ensure that appropriate and ongoing assessments of progress in treatment are made, a part of which will include safety assessments as noted above. If there is concern about imminent danger to self or others, appropriate and timely contacts with parents and/or other care givers or agencies is important. All attempts must be made to ensure the safety of the child or adolescent and others. Children and adolescents who are the focus of treatment and their families should have information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis.

6. Lack of Progress in the Treatment Process.

It can be scary and upsetting for parents when they first bring a child to a mental health clinic for evaluation or treatment, but most do so with the intention to work as a member of the team to help their child make meaningful progress. In some situations, life circumstances or personal challenges are too great, and treatment goals are not reached.

When children, adolescents, or parents do not progress in treatment or do not actively participate in the treatment process this should be addressed in therapy and by members of the treatment team, and collaborating providers and agencies should be notified. A review of the child or adolescent's history, treatment progress, and assessment of risk to self or others should be made. The treatment plan should be re-evaluated to find different approaches that might be more successful. For particularly challenging situations, clinics should consider expert consultation through contract or by utilizing tele-psychiatry. Attempts to re-engage the child/ adolescent and parents should be made whenever feasible.

In very rare instances in which parental action or inaction rises to the level of medical neglect, appropriate contacts with social service agencies may be needed to ensure access to treatment if there is a lack of capacity or willingness of the parent or caregiver to engage in or to follow through with treatment recommendations. Of course, mandated reporter protocol should always be observed.

2. Clinical Administration

1. **Caseloads:** The clinic supervisor or director is responsible for ensuring that complex, time-intensive cases are evenly distributed and considered for more experienced clinicians, and that the number of Individuals assigned to a clinician permits appropriate delivery of services.
2. **Supervision:** Clinic leadership should provide regular clinical guidance and oversight for staff, particularly new staff, with attention to ongoing treatment needs as well as emerging problems or crises the child or adolescent (or family) may have.
3. **Integration:** When children or adolescents receive multiple services, the Clinic is responsible for ensuring that all of the adults and services involved have a shared understanding of the youth's treatment goals and progress. The Clinician should also be committed to ensuring that any and all plans for the family are integrated and complementary. This should be reflected in the clinical record.
4. **Communication:** Complex care requires that case managers and clinicians from multiple disciplines provide concurrent services within one agency or among multiple agencies. It is imperative that these individuals have ready access to one another and share appropriate information at regular intervals, and when there is evidence of emerging instability and during periods of crisis. While receiving appropriate consent from parents or guardians is good practice and usually advised, mental health providers are authorized under both State and Federal law to share clinical or identifying information with other treating mental health providers, without consent.

Why is Person-driven Documentation Necessary?

By the NYSCRI CFAAC

The NYSCRI form processes and training manual guide clinicians and rehabilitation providers (in a variety of programs and throughout the state) toward meeting documentation requirements for medical necessity in a timely fashion. A standardized system is one remedy for the fragmentation of communication, resources, and personal dreams that is often created by the current health and mental health care system. The forms themselves prompt for documentation of evidence-based services that are person-driven, culturally sensitive, and affirming of meaningful life goals.

What is being Documented?

In 2006, the Institute of Medicine made several recommendations for clinicians and organizations to improve the quality of mental health and substance abuse treatment services that included:

- *Incorporating informed, [person]-centered decision making throughout their practices;*
- *Adopting recovery-oriented and ... self-management practices that support [individual] preferences for treatment;*
- *Maintaining effective, formal linkage with community resources to support ... self-management and recovery; and*
- *Having policies that implement informed, [person]-centered participation and decision making in treatment, ... self-management and [action] plans.*¹

In this section of the manual, there are references to “person-centered”, “recovery-oriented”, “culturally competent”, “collaborative” and “sustainable” models of care. These approaches, as well as many others, rest on a common framework that we call “person-driven”. Language, structures, and decisions that are driven and fueled by the individual using services, the whole of the individual, are essential to effective care.

The surge of interest and funding for evidence-based practices in behavioral healthcare has affirmed the focus on person-driven treatment:

*“Evidence based medicine is grounded in the concept of person-centeredness ... [meaning] acknowledging individual differences and characteristics, including different biology, culture, beliefs, values, preferences, history, abilities, and interests.”*²

¹ IOM (2006). *Quality Chasm Reports: Improving the Quality of Health Care for Mental and Substance-Use Conditions.*

² Hyde, PS, Falls, K, et al, *Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-based Practices.*

How to document person-driven, recovery-oriented, and sustainable services is described in more detail below. Each are illustrated with examples from the “golden thread” of one individual’s hopes, dreams, and goals as this thread shows itself in documenting medical necessity.

“Person-driven” Documentation

Background

Studies show that orienting health care around the preferences and needs of people using medical treatment has the potential to improve patient’s satisfaction with their care, as well as their ... outcomes.³

Historically, the nation’s mental health system was not guided by individuals’ life goals and ambitions. In July of 2003, The President’s New Freedom Commission on Mental Health reported the following state of affairs:

- *“Currently, adults with serious mental illness [diagnoses] ... have limited influence over the care they receive ...”*
- *“The extreme fragmentation of the system of care means that many [individuals using] behavioral health services are ... [not] fully [participating] in their own plans for recovery.”*
- *“... [Individuals] and their families do not control their own care.”⁴*

Person-centered planning is driven by the individual who is receiving services, but works best when it includes other people who can contribute valuable information to the process. During person-centered planning, an individual identifies his or her strengths, capacities, preferences, needs, and desired outcomes.⁵

The Institute of Medicine defines patient-centered care as:

“Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care... [Patient-centered care is] respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions.”⁶

In 2006, The Institute issued ten rules to guide the redesign of health care. The first four of these expressly embrace the core values of person-driven care:

1. Care should be based on continuous healing relationships.
2. Care should be customized based on the individual's needs and values.
3. The [individual] is the source of control.
4. There should be shared knowledge and a free flow of information.⁷

³ Agency for Healthcare Research and Quality, National Healthcare Quality Report, Dec. 2005.

⁴ *Achieving the Promise: Transforming Mental Health Care in America.*

⁵ Cook et al., 2004

⁶ *Envisioning the National Health Care Quality Report*

⁷ IOM (2006), *Improving the Quality of Health Care for Mental and Substance-Use Conditions.*

What does “person-driven documentation” look like?

Clinical and rehabilitation documents are tools for increasing an individual’s sense of themselves as a whole and capable individual with a unique past, present and future. Paperwork driven solely by the provider or the system, however, can fragment an individual’s experience of their lives moving forward.

Person-driven paperwork encourages self-responsibility and allows the individual to direct (or learn to direct) and take ownership of health and life-oriented goals.

The process for completing forms should help to...

Assess, evaluate and plan for a continuum of services (engagement, treatment and rehabilitation). Such services should be consistent with the individual’s, family, and community experience of over time.

“Initial Screening & Assessment” Example

Individual: *Can you help me? I don’t think I can handle things anymore!*

Illness-driven

Provider: I can only help if you tell me what is wrong with you. What symptom are you experiencing?

Individual: I guess I’m paranoid...

Provider: It sounds like your medications don’t manage your schizophrenia very well. We might be able to get you into a bed at the local psych unit.

Individual: But I don’t want to go to the hospital! They follow me there, too it won’t help.

Provider: I understand, but I want you to be safe while they change your meds. Please wait while I call the insurance company.

Person-driven

Individual: Can you help me? I don’t think I can handle things anymore!

Provider: Yes, I will do my best to help you. I’m sorry that you are not feeling well. Could you tell me a little bit about what’s happening?

Individual: My heart is pounding! I think someone is going to hurt me! Everyone hates me! Even my family...someone is going to hurt me! I only feel safe at home...with my cat.

Provider: Ahhh. I like cats, too. And they really do help with anxiety. Well, it might be valuable to talk a bit about whether you “feel” like someone is going to hurt you, or whether there is someone specific looking to do you harm. We can also work to find other things that can relieve some of that anxiety.

Individual: I only feel better when I am alone.

Provider: I understand. Well, I can show you some techniques that will help you relax when you leave your house and I know of some services that can help you get back to your regular routine. Maybe we can find some places or people that can be supportive at this difficult time. Would you like to try?

Collaborative Concurrent Documentation

Documenting services at the time and in the place they are provided is an excellent way to ensure a person-centered documentation process. **Collaborative Concurrent Documentation** gives the provider a concrete tool for inviting the individual to *direct the description, course, and ultimate outcome of their own treatment*. At the same time, **Collaborative Concurrent Documentation** employs the provider's expertise, and the form itself, to keep documentation of medical necessity on track.

Concurrent Documentation allows the service provider to proactively confirm:

- The goals and actions addressed during the session;
- The therapeutic interventions provided by direct care staff;
- Feedback concerning progress made and perceived benefit of the service; and
- The obstacles to progress (clinical or process) and the strategies to overcome them.

In addition, documenting at the time of service reduces stress for providers who are chronically behind in documenting their work.

“Recovery-oriented” Documentation

Background

Quality care respects the process of recovery and supports the purpose of mental health services to enable people to pursue personal life goals.

The following points describe some key dynamics of recovery:

- All individuals have the capacity for personal growth and recovery from psychological trauma, disability, and addiction.
- Recovery can be sustained only if it connects to the individual’s personal history, life experiences, preferences, and strengths.
- It is impossible to know the timing or path of recovery in some else's life.
- Professional expertise and systems can support or interfere with an individual’s recovery. The personal nature of recovery, however, cannot be changed.

In 2006, SAMHSA issued a Consensus Statement on Mental Health Recovery, which identified ten fundamental components of recovery⁸:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope

In 2005, The American Psychiatric Association endorsed and affirmed the application of the concept of recovery to the comprehensive care of those with mental illness: *“The concept of recovery emphasizes an individual’s capacity to have hope and lead a meaningful life, and suggests that treatment can be guided by attention to life goals and ambitions.”*⁹

⁸ retrieved 1-19-08 at <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>

⁹ The American Psychiatric Association, Use of the Concept of Recovery Position Statement, July 2005

What does “recovery-oriented documentation” look like?

Clinical and rehabilitation documents can build, support, and sustain hope. They can also increase the individual’s awareness, understanding, ownership, and responsibility for their own culturally congruent treatment and recovery. Illness-oriented documents, however, overlook the benefits that each individual can bring to his or her treatment. Recovery-oriented documentation focuses on the understanding that recovery, as defined by the individual, is not only possible but expected.

The process for completing forms should help to...

Drive the person-centered assessment and support the planning and evaluation of progress and barriers with respect to: 1) personal life goals; 2) strengths and skills; 3) hope and desires; and 4) supports and resources.

1. **Personal Life Goals** – are the core of recovery-oriented services. Individuals seen as “unmotivated” are frequently caught in the dilemma of moving towards goals that are not self generated and/or not meaningful for that individual at that time. The “job” of recovery resides in the belief in a meaningful and productive life, regardless of perceived disability or impairment.
2. **Strengths and Skills** - Are derived from recognition of the individual’s choices and actions in the past or present that are: skillful, successful, productive, satisfying, fun etc., OR that are intentional, purposeful, executed with skill, etc., even if they do not result in an ideal outcome. These skills and strengths are clearly delineated (how, when, where, etc.) as powerful tools toward meaningful life goals.

Progress Note Example

Individual: I don't want to meet today. I really blew it at the store last week.

Illness oriented

Provider: Yes, ES called to say that you ended up in Partial, I'm sorry about that. Has the new medication helped with your paranoia?

Individual: A little, but I still can't go back to work.

Provider: That's ok; we can put your work plan on hold. You have to take care of yourself and your illness first. Have you told your Vocational Rehab counselor about your worsening symptoms?

Individual: No, I don't want them to know. Last time I lost a job they said I had to go to a day program for 6 months before they'd help me find another one.

Recovery-oriented

Provider: Yes, I heard that things were a bit rough. Judy from the Vocational program said that you called them for support. What happened after that?

Individual: Well, not much. She said that I could go to partial or meet with my Job Coach, so I met with my Job Coach. I wanted to keep working, but I got more anxious and couldn't concentrate. I ended up going home. I'm a total failure...again!

Provider: Well, I have a different take on it. It sounds to me like you were more successful in your goal to keep a job than you may think. You did not lose your temper at work like you did in the past and you did recognize that you needed some support to make your way through the difficulty you were experiencing. Now we need to figure out a better strategy to manage conflicts with the boss...You've come a long way managing conflicts here, so you just need a little bit more practice on the job. Then maybe you CAN work under that kind of pressure AND get that raise that you were aiming for.

- Hopes and Desires-** Many people have lost motivation through perceived failure and painful experiences. Hope evolves from the beliefs, dreams, values, and characteristics that an individual aspires to. Hopes and desires strongly motivate learning, change, and productive action.

Notice & Ask: about the people, stories, music, activities, religion, etc. that inspire someone to act or that the individual looks to for guidance.

Action Planning Examples

"I noticed that you just moved into an Apartment Treatment program from the Community Residence. Congratulations. I remember when you first moved into the CR. You have really progressed. Any future plans?"

"Right now I want to learn about the town I am living in and learn how to get around. I don't know my apartment mate at all. I hope we get along. I really want to someday have my own apartment."

 "What made you apply for Vocational Rehabilitation Services?"

"Well, I worked about five years ago. I didn't like the job but I would like to support myself. I heard that I can get training here."

 "It's good to see you. I'm sorry that you have been feeling badly."

"I am feeling better. I met some peers at the hospital who told me that they developed a Wellness Plan that helped them stay healthier. Some of them even went back to school and now work. I would like to be healthier and work."

There can be uncomfortable dreams, desires, or attributes that are difficult for the individuals to deal with, and/or uncomfortable for the provider and others to hear and acknowledge as well.

“Psychopharmacological Progress Note” Example

Individual: I’m going to show that guy at work what it’s like to have your co-worker stab you in the back.

Provider: You sound really frustrated that your co-worker said that you made a mistake. I don’t know that I’ve seen you quite this angry.

Individual: You better believe it. I didn’t do what he said and he has no right to interfere in my life. I need to stick up for myself.

Provider: Well, I guess that people always have opinions about things that are not their business and conflicts at work can be difficult but it sounds so different from your thoughts last week when you were going over all the things you love about your job - it’s not like you to be quite that sensitive. Maybe we can look at some of the things that might be impacting you, in addition to your co-worker - your recent change in meds, your job coach quitting, this guy’s personality, etc.

4. **Connections, Supports, Resources** - Individuals diagnosed with mental health issues frequently have limited connections, supports, and resources. These interactive aspects of life, where people encounter each other, community activities and other resources outside themselves, are instrumental to the achievement of goals.

“Comprehensive Assessment” Example

Individual: I thought we were done with the paperwork. Why do you need to know about my past?
Illness-oriented

Provider: We are almost done. I just have to ask you about your history of trauma and abuse. Did anything like that ever happen to you?

Individual: Sure, I was abused. It’s in my chart, so I don’t want to rehash it. Didn’t the last therapist tell you about all that?

Provider: I have some information, but I’d like to learn about it directly from you. Why don’t you just go over this list and you can tell me if it applies to you.

Recovery-oriented

Provider: Well, it seems important to know a little bit about the relationships or, maybe places you go that help you stay balanced...grow.

Individual: Ummm. Well, I go to church every week with a friend. I’m not so sure that I am religious, like my friend, but the minister there seems to say important things that help. I also joined a hiking club that takes walk in local parks - the people are friendly and I feel more part of life after being in nature.

Provider: Anyone else?

Individual: Well, my brother doesn’t seem to understand a lot about my problems but he is trying and it feels good that he wants to support me. I think he believes in me.

“Sustainable” Documentation

Background

Key elements of sustainability that apply to quality mental health and addiction services and, at the same time, support medical necessity include the following:

- Adopt appropriate small (1 – 6 months), medium (6 – 12 months), and long-term (1 – 3 years) time frames, dependent on complexity of barriers, for planning and achieving outcomes;
- Be proactive rather than crisis-driven in framing issues, building support, and responding to potential obstacles;
- Share knowledge across systemic, organizational, and cultural divides
- Collaborate widely to maximize diverse resources and strengths
- Depend on local expertise to direct local improvements
- Build community resources and capacity and connect them with each other
- Organize on a small scale to maintain flexibility and familiarity.
- Work to protect, reduce harm and value each individual.

What does “sustainable documentation” look like?

Documents should rely on specific, practical, person-first, and future-oriented language, rather than on highly specialized words or concepts that are vague or emotionally charged. Since collaborative concurrent documentation is done in tandem with the individual you are working with, use language that he or she will understand and relate to.

The Dialogue, Questions, and Process for completing forms should help to...

Show respect and value for the individual’s aspirations and efforts, in addition to clearly describing assessment, progress, plans, interactions, needs, etc. to other service providers, the service user, and to future readers.

Use specialized terms only when required for documenting medical necessity and follow up with an explanation in everyday language. Avoid terms that are vague or stigmatizing, for example: “decompensated”, “a borderline”, “requires treatment/disabled forever”, “frequent flyer”, “in denial”, “compliant” and “appropriate”.

Use clarifying details when using a diagnosis or acronym. In addition, generalizations do not support individualized goals. Spell things out to describe the individual in the context of her/his environment: Specific behaviors in a specific situation at a specific time.

Answer the question “what happened?” rather than “what is wrong with this individual?”
Affirm the individual’s power, control, and ability to connect in the present and the future.

“Intensive Services Progress Note” Example

Individual: If I don’t get back to work tomorrow, I’ll lose my job again.

Short-sighted

Provider: I understand there is a lot of pressure at work. Does your boss know that you have a chronic mental illness?

Individual: Definitely not! I’d be out the door. What are you going to tell him?

Provider: I won’t call anybody, that’s up to you. If you comply with your medications and follow your therapist’s recommendation to come to the program, I think you’ll be less paranoid when you go to the store next time. So, will you agree to stay for the full week of groups?

Individual: I guess so. If they fire me, they fire me. The job sucks and it doesn’t pay much anyway.

Sustainable

Provider: Okay, so let me make sure that I’ve got this right...You are here today to figure out how to keep your job...you don’t want to get fired, even though you started hearing voices, again?

Individual: Yes, I have been doing much better. I don’t want to end up back in program or a hospital or something.

Provider: Got it. I know that you worked very hard to put together a Wellness Plan. I know that you said that it is very important to monitor your moods, listen to music, reach out to your girlfriend, and take meds at the right time, in order to keep the voices at bay. Let’s take a closer look at what it would take to be able to go back to work as soon as possible.

“Action Plan Review” Example

Individual: I can’t do anything about my drinking, stop asking me about it.

Short sighted

Provider: You said 3 months ago that you wanted to be sober more often because it will help your housing and work goals. Has something changed?

Individual: No, I just can’t do it. I got so drunk last week and my girlfriend called me a loser, which I am.

Provider: But that doesn’t mean you have to give up on your goals. We can revise it so that you need to stay sober 4 days a week instead of 6 days a week. How would that be?

Individual: Whatever you think. Does my psychiatrist know that I went drinking last week?

Sustainable

Provider: You seem really discouraged. Last time we met you seemed to be in a very different place. Your convictions were very strong that you wanted to stay sober in order to improve your housing circumstances and go to work. I’m thinking that that conviction can pull you through difficult times if we work together. Can we sit together and try to figure out a strategy?

Individual: If we have to.

Provider: We don’t have to, but I would like us to write this note together and not just have my take on things. Even though you “slipped,” I would like to note that you did come here today sober, which is a small step toward reaching your goal. Do you know what gave you the strength to do that?

Individual: If I didn’t show or came here drunk, you might have gotten me in trouble with my psychiatrist. When he gets mad, he doesn’t give me my anxiety meds and then he’ll tell my landlord I’m still a drunk. I am a loser, like my girlfriends says.

Provider: Well, I’m hoping that over time you won’t see yourself as a loser, but I’m wondering whether you might agree that before we look at your goals, we work together on something a little different. I actually have goals for my work with you. I would like to work on being the most helpful and supportive that I can be. I can also show you who I am accountable to with regard to your circumstances and why. Maybe understanding this process will be helpful.

OVERALL HEALTH IS ESSENTIAL TO MENTAL HEALTH

“OVERALL HEALTH IS ESSENTIAL TO MENTAL HEALTH!”

It's hard to deny the reality of this statement from NASMHPD's 2006 Technical Report: Morbidity and Mortality in People with Serious Mental Illness; yet according to the report:

“It has been known for several years that individuals with serious mental illness die younger than the general population. However, recent evidence reveals that the rate of serious morbidity (illness) and mortality (death) in this population has accelerated”.

“In fact, individuals with serious mental illness (SMI) are now dying 25 years earlier than the general population.”

WHY IS THIS HAPPENING?

The report found that the individuals we serve are dying because, *“People with serious mental illness ... suffer from a high prevalence of modifiable risk factors ... [including] smoking, obesity, substance abuse, and inadequate access to medical care”* (among other factors).

In addition, *“...the second generation antipsychotic medications have become more highly associated with weight gain, diabetes, dyslipidemia, insulin resistance, and the metabolic syndrome; and the superiority of clinical response ... has been questioned. Other psychotropic medications that are associated with weight gain may also be of concern.”* Moreover, *“Symptoms [of mental illness] can mask symptoms of medical/somatic illnesses ... Psychotropic medications may mask symptoms of medical illness and contribute to symptoms of medical illness and cause metabolic syndrome, Polypharmacy [may place people at a higher risk of morbidity and mortality] ... [and there is a] Lack of access to appropriate health care and lack of coordination between mental health and general health care providers.”¹*

SO WHAT CAN WE DO?

Here are some suggestions from Michael J Sernyak, MD, et al:

“We encourage clinicians to adopt a structured system for conducting and recording metabolic monitoring and to develop collaborations with family physicians, diabetes specialists, dieticians, and recreation therapists to facilitate appropriate medical care for antipsychotic [psychotropic]-treated patients.

“Clinicians should screen patients for metabolic disturbance, should track the effects of antipsychotic [psychotropic] treatment on metabolic parameters, and should facilitate access to appropriate medical care.

“Mental health systems need to incorporate monitoring protocols into standard care, promote collaboration with other medical disciplines, and dedicate resources for lifestyle management [education].”²

Additionally, a Physical Health Request Letter is located as an optional form in download sections of the NYSCRI forms web site to serve as a starting point for referrals to medical specialists and primary care physicians.¹⁰

¹⁰ References:

1 Joe Parks, MD, et al, *Morbidity and Mortality in People with Serious Mental Illness*, National Association State Mental Health Program Directors, October 2006

2 *Metabolic Monitoring for Patients Treated With Antipsychotic Medications*, (Can J Psychiatry 2006;51:492-501)

Yes, but what if...?

- The individual does not have any goals they want to work on?
- We have to address the individual's harmful/risky behaviors with a treatment plan and they won't agree to it?
- I see no strengths in the individual?
- The individual is not able or refuses to participate in planning?
- The individual does not want to take medication?

The treatment and recovery progress is not linear and varies from individual to individual. It makes sense that people will not always be willing or able to express goals and make changes for themselves when providers believe they should. Someone's choice to not use treatment or rehabilitation in obvious or active ways is not necessarily a sign that they are not, cannot, or will not ever be engaged in the recovery process.

When it seems that someone is not involved in their treatment, providers can create and document their own goals and objectives to engage the uninvolved individual as all individuals have capabilities to be inspired and ultimately work productively toward important life changes.

Provider interventions and planning should be aimed at:

- Increasing the provider's positive and future orientation with the individual
- Increasing the communication with and understanding of the individual
- Increasing the individual's motivation for contemplating positive change
- Increasing independence of the individual.

Progress for provider plans would be measured by both the provider's actions, and ultimately increased receptivity of the individual. Revisions to the plan would be based on the individual's responses and feedback.

Documentation of provider plans and interventions should include recommendations and evidence related to collaboration between treatment team members and other people that the individual wants involved.

Medication compliance may be one of the top concerns and priorities of mental health workers; however, person driven care includes respecting personal preferences in regards to medication. When individuals are educated and able to make informed decisions about how to utilize medications most effectively there is less chance that people will make decisions based on misinformation or "magical" thinking about the pills.

Some individuals may choose not to take psychotropic medications; it is the clinician's responsibility to work collaboratively with the individual and to take this expressed goal seriously. Without a respectful collaborator individuals are going to make decisions on their own – sometimes (oftentimes?) with poor results. What can you do as the clinician to keep people engaged? What other possibilities, treatments, services - including holistic modalities - can be explored with the individual you are working with? When we are

engaged in collaboration the goal becomes less about compliance and more about success.

Self-Assessment as an Engagement Tool

“Self-knowledge is the beginning of self-improvement.”

-Baltasar Gracián

Engagement is perhaps the most important time in a developing relationship between a mental health provider and the individual to be served.

“Why should I be involved?” is perhaps the question many people ask themselves and providers when told they need help.

“Mental illness is something you shouldn’t be ashamed of and can be treated very successfully - we can help you manage the symptoms you have and you can learn to live with it,” seems to be the response and motto of the modern mental health system.

But where is the motivation to follow through?

Beyond a bland approach we can help individuals get the most out of mental health services when it is clear why one is involved from the start. Give people a reason to feel confident about the service you’re offering because it’s reliable, respectful, and clear in purpose. Enabling people to succeed is the purpose and engaging people with their own goals is the most direct way of connecting with individuals.

The engagement process is something every provider needs to develop and work on for themselves - but its elements are simple (it’s ‘conversation 101’):

- What do you want to do with your life?
- What do you like to do that makes life valuable?
- Who are the most important people in your life?
- What stops you from achieving your goals? (Side-bar: people know what hinders, they don’t often think in terms of illness though; Engage them where they are at – engage the individual and the actual experience, not the illness.)

Take this engagement process outside the cold and rote (as perceived) assessment procedures you may use.

Have a conversation in a space that isn’t necessarily a therapist’s or doctor’s office. Put it in a questionnaire at the beginning of service, or when re-engaging someone you’ve lost direction with.

For example:

Get to understand an individual’s goals by removing all the barriers that usually stymie inspiration and imagination. Ask the individual you’re working with to imagine, if just for a moment, what he or she would be doing with their lives if mental illness didn’t exist, or if that they didn’t have to worry about money or anxiety, obligations, or other problems or barriers. What kind of answers would you get? It’s a starting point -Try it.

Above all let people know you care about their personal life goals and that you want to see them succeed. Motivation for involvement in mental health services comes not from a desire to “manage an abstract illness” but from an individual’s self-interest, that is, an interest in the direction of their own life.

Ultimately, person centered documentation uses tools and practices that:

- Assumes individuals can and do achieve personally meaningful goals
- Respect & recognize the innate strengths & skills individuals possess
- Provides self-directed services and supports
- Fuels treatment with the goals and values of the individual.
- Encourages & empowers the individual to overcome obstacles
- Addresses safety issues in a collaborative relationship between the individual and the provider
- Teaches the individual to recognize and create their own options
- Allows individuals to make, and grow from, their own mistakes.
- Enables individuals to pursue life goals independently!

This document was adapted from an original version created by Marcia Webster, MA, of The Transformation Center, Western Massachusetts and Massachusetts CFAAC members Susan Schneider, Christopher Busby, and Deborah Delman.

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Solution Focused/Motivational Interviewing Approaches

Listen to the conversation in most staff meetings today and you will invariably hear some comment about paperwork. “There is too much, it is not in line with our clinical approach, it seems just silly, repetitive, burdensome, and takes us away from providing direct work.” As the demand for evidence based, outcome supported work increases, the need for specific documentation to support our clinical work has also increased. Overlay this on an industry that is short on resources and facing an ever-increasing demand for services, and the result is a profound sense of needing to move the therapeutic process along rapidly; rushing the people we serve. Feeling rushed does not enhance the therapeutic alliance we all strive for with the people we serve. We know both through research (Miller, S. 2000) and our own experience, the therapeutic alliance is a key factor in fostering a successful treatment encounter.

The goals of the NYSCRI are to provide tools for collecting clinical information that is both relevant to our work and assists us in documenting this work in a way that supports medical necessity and compliance standards. Like most tools, if not used as intended, misuse of the forms can be counterproductive. As with other tools that support our clinical work, when we employ them, we need to remember one of the basic tenants of our training – follow the individual we are serving.

The founders of Solution Focused Therapy, Insoo Kim Berg and Steve deShazer, emphasized in their teaching and writing (deShazer, 1985) that the questions you ask become the focus of the work and important to the individual served; therefore, we need to be very careful what we help to focus on by the questions we ask. The intake process has taken on many goals; gather and impart information, establish a contract for the work to be done, begin to build the therapeutic relationship, establish a diagnosis, determine assessed needs, establish at a minimum the beginning of working goals, and of course, complete the myriad of forms. It is important to remember that these are our (our supervisor’s, our agency’s) goals, not the goals of the people we serve. The people that we serve are coming to us for help – not to complete forms. The most efficient manner to complete the assessment forms would be to lead the individual served from the start to the end, utilizing mainly closed-ended questions. But efficiency and building the therapeutic alliance are not often synchronized. To say that the balance of following the individual served and gathering the information needed to fulfill all of the goals of the first encounter is challenging, is an understatement. Experience shows that gently guiding people from “what brings you here today?” to an open-ended question that helps to elicit goals (i.e. the miracle question in solution focused therapy, developing discrepancy in Motivational Interviewing), will in fact reveal a significant amount of the information needed to accomplish our goals of the first encounter while maintaining rapport.

The information that is not offered/ gathered as part of the narrative can always be gathered at the end, once the therapeutic alliance has been established. Machine-gunning the individual with questions and avoiding reflecting listening will help you to produce a

complete and thorough diagnostic assessment. However, without taking the time to establish true rapport, your efforts will be in vain as the chances of the individual returning for a subsequent session are greatly diminished.

One Motivational Interviewing manual (Matino, S. et al, 2006) suggests using a “motivational interview sandwich outline” in which you begin with open-ended motivational interviewing questions, move into your agency’s assessment questions, and return at the end to motivational interviewing. This approach recognizes and operationalizes the importance of balancing rapport building and remaining client-centered, with information gathering.

During the intake, we must also work with the individual served to distinguish between those goals that are important, and those that are important and medically necessary. Just because a goal is important to the well-being of the individual and well-formed, does not mean that it meets the current requirements of medical necessity and therefore will be eligible for reimbursement from Medicare and Medicaid. A reality of the work we currently do is that there is a sixth axis to the DSM – insurance/funder. As stated elsewhere in this manual, the foundations of medical necessity are found in the assessment.

deShazer, S. (1985). *Keys to Solution in Brief Therapy*. New York: W.W. Norton and Company.

Martino, S., Ball, S.A., Gallon, S.L., Hall, D., Garcia, M., Ceperich, S., Farentinos, C., Hamilton, J., and Hausotter, W. (2006) *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency*. Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University.

Miller, S. & Duncan, B. (2000). *The Heroic Client: Doing client-directed, outcome-informed therapy*. San Francisco: Jossey – Bass

Resource:

<http://www.motivationalinterview.org/library/MIA-STEP.pdf>

Satisfying Reimbursement and Compliance Requirements

Clinical documentation serves many purposes; among the most important purposes are:

- Clinical: management and focus of the treatment process, especially where a treatment team is involved.
- Provider Agency: management of best practices, utilization management, resource allocation, utilization review, and an audit trail for claims to third parties.
- Payer: determination of medical necessity, covered services, and the post or pre-payment review of claims for payment.

The integrated NYSCRI forms were designed to enable providers to fulfill key compliance and reimbursement elements, which include:

- Medical necessity for each service provided
- Documentation linkage requirements, especially the linkage of services to the plan of treatment and assessed needs.
- Signature and credentialing requirements to make sure all services are properly ordered as well as provided by appropriately credentialed individuals.

The NYSCRI forms were developed to allow providers/programs to successfully meet the documentation requirements of state and federal regulations, accreditation standards, and requirements of major payers, including;

1. **State Payers:** NYS-OMH, NYS-DOH, OASAS
2. **National Accreditation:** TJC; CARF, and COA
3. **Federal Payers:** Medicaid and Medicare
4. **Medicaid/Medicare Documentation Support Focus:** Medical Necessity; Individual Served Participation; and Individual Served Benefit

Good clinical practice and use of the NYSCRI documentation process will assist both providers and programs to meet payer requirements and achieve high quality medical recordkeeping practices. The forms, when properly completed will substantiate diagnostic and service eligibility requirements, functional deficits where they are critical to supporting rehabilitative services, and treatment goals and strategies all within an umbrella of recovery-based programming and person-centered planning.

The consistent use of the NYSCRI documentation across New York's mental health and chemical dependency delivery systems, positions providers/programs to mitigate reimbursement and compliance-related risk.

Medical Necessity

Medical necessity is a critical concept for providers/programs to understand. It is a core standard of payment for Medicaid, Medicare, and most third party payers. *Medical necessity* is:

- First – establishing that a individual seeking behavioral health services is qualified (by diagnosis and functional status) to receive particular services at a particular level of care ... and

- Second – that each service provided to the qualified individual is planned for and necessary to address identified needs as assessed by qualified professional staff.

The concept is sometimes viewed as applicable only to a *medical model*. However, Medicaid and Medicare both require that rehabilitative as well as recovery-based services they pay for meet these standards as well.

Medicaid Definition of Medical Necessity

Medical necessity starts with a practitioner who, based on a comprehensive evaluation of an Individual, determines that the Individual has a mental health or substance abuse disorder AND either current signs and symptoms or current problems with daily functioning caused by the impact of their disorder/illness that require services necessary to help the individual recover from or better manage their disorder/illness. Key here for purposes of medical necessity is an understanding of payer rules (and they often are different) as to who can diagnose mental illness and/or chemical dependency and who can order services. Most payers will rely minimally on state licensure laws that determine scope of practice for each license but in some cases payers will require more experience and higher credentials than state law. If the service is not ordered by the appropriately credentialed person the first requirement of medical necessity is not met.

For example:

A social worker cannot order medication management services to be provided by a physician. They cannot by state law either provide or supervise medication management services and so, therefore, cannot determine if these services are medically necessary.

The second requirement of medically necessary services is that they must be considered to be reasonable and generally effective for the specific diagnosis and clinical picture of the individual. They must help them to either get better, prevent them from getting worse, or prevent new problems that are threatened by the Individual's diagnosis(es). Services must be directed at signs and symptoms or functionality that is directly related to the diagnosis.

In addition to medical necessity, services provided must be covered under the insurance benefits package the individual has.

Consistent with the definitions above, Medicaid expects documentation to support that services are:

- Delivered at an intensity that is appropriate and that will likely be effective
- Provided in the lowest level of care that is reasonable and safe

Diagnostic services must also be medically necessary and the services ordered to assist in a diagnostic assessment must be capable of providing unique, essential, and appropriate information that cannot be obtained in an interview process. This would include services such as, psychological testing, neurological consults, lab work, etc.

Medicaid Criteria for Payment of Medically Necessary Services

Even though a service may be medically necessary, it may still not be reimbursable. Criteria that Medicaid uses to determine whether medically necessary services can be paid include:

- Outpatient services are voluntary and initiated by the individual, or the individual's family/guardian *(Note: Payers believe with some justification that people who come freely to services and are actively involved in developing their individualized action/service plans are more likely to participate actively in their treatment and to comply with their treatment regimen.) In some cases, inpatient admissions can be involuntary and these criteria would not need to be met.*
- The individual's right to select both the provider agency and the specific providers of their choice. Again, this promotes the active participation of the individual served in his/her own care and is a fundamental right addressed in the State Medicaid Manual. In some cases, as in New York, federal Medicaid waives the requirement for absolute choice by allowing managed care entities to limit their provider pools.
- The services are provided by an eligible provider. In addition to ordering the service, an eligible provider must also render the service. *(Note: Most payers list the credentials they require for the provider of each service covered under their benefit plans. For most payers credentials include a combination of licensure (if required), education, and experience. Providers are expected to comply with these credentialing requirements as a condition of payment.)*
- The service must be provided in compliance with the Medicaid definition for the service as defined by the eligible service codes in the CPT or HCPCS code books. Although some states have been quite liberal in their use of a code and expanded on some definitions, providers should be careful to maintain internal coding integrity.
- The service must be the lowest cost service that effectively addresses the problem of the individual served.

Medical Necessity in Mental Health and Chemical Dependency Services

In operational terms Medical Necessity requires that:

1. The individual must have one or more diagnoses – either ICD-9 CM or the latest version of the DSM and the diagnosis(es) must currently “endanger life, cause suffering or pain, interfere with life functioning, threaten to cause or to aggravate a handicap, or result in illness or infirmity”. In other words, a diagnosis is not enough. There must be negative manifestations of the diagnosis in the clinical picture of the individual for services to be medically necessary.
2. The services provided must be the lowest cost and least intensive that are appropriate, potentially effective, and available.
3. The services or help provided by the mental health or chemical dependency systems of care can be directed towards:
 - a. Diagnosing mental illness and/or chemical dependency.
 - b. Preventing the worsening of the diagnosed illness.
 - c. Alleviate the symptoms, functional deficits, or other manifestations of the diagnosed illness.
 - d. Correct or cure the diagnosed illness.
4. The service must be documented in a medical record that is available for review.

Medical Necessity and Recovery

Recovery-based, rehabilitative service models must also meet *medical necessity* criteria if they are going to be billed to a third-party payer who covers rehabilitative services. Federal Medicaid law defines a rehabilitative service as “*any medical or remedial services (provided in the facility, a home, or other setting), recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.*”¹ *Medical necessity*, therefore, is not just based on diagnosis (with its attendant signs and symptoms) but also on functional criteria.

This federal definition is very compatible with the description of the Rehabilitation Model found in the IAPSRs² publication, *Best Practices in Psychosocial Rehabilitation*. This rehab model “*focuses on the functioning of the individual in the normal, day-to-day environment, and looks at the strengths and skills people bring to the rehabilitation process and supports in the community. Although an individual may still be symptomatic, the rehabilitation process helps an individual learn ways to compensate for the effects of the mental illness through environmental supports and coping skills. The individual with the mental illness becomes the expert in managing the disability.*”³

Both the federal and IAPSRs definitions focus on improving the functioning of the individual. Both also make it clear that the services are directed toward keeping the individual served in community settings and, therefore, contemplate the necessity for services to be provided in multiple settings in order to maximize benefit to the individual. In addition, the IAPSRs definition stresses the active participation of the individual served. The individual served must actively participate in the development of their individualized action/service plan and they must become the experts in their own recovery. IAPSRs is also specific about their expectations of benefit to the individual served, using a strengths-based model to promote:

- Greater functionality
- Independence
- Integration into their community and support network

The rehabilitation option model, therefore, uses a functional test as the basis for a *medical necessity* determination for covered services, and then adds the generally accepted criteria of benefit, participation, and individual planning.

What is clearly very important about the rehabilitation option and its coverage by Medicaid is the difference in the approach to services and the impact this has on the overall model of care.

For example:

Recovery is a holistic treatment process that deals with all aspects of an individual’s life. Under this model, the individual served becomes knowledgeable about his/her mental illness/chemical dependency, works with other community and environmental supports toward self-defined realistic goals, and eventually manages his/her mental health/chemical dependency. Community providers support the individual’s efforts using their training, research, and knowledge.

Some of the services included in a recovery model are not reimbursable under the Medicaid program’s rehabilitation option, or under most third-party payers’ benefit plans. Providers must be clear about which services:

- Do meet Medicaid and other payer criteria and can be appropriately billed
- Do not meet Medicaid and other payer criteria and, therefore, must be funded by alternative sources. In particular, providers should pay attention to state and federal regulations and service definitions about educational, vocational, recreational, social, and peer services.

The New York State Office of Mental Health has been a vocal advocate of recovery models of care and has used its array of resources to support the development of these models. Medicaid is one of these resources that, with judicious use, can assist individuals served and providers in making recovery/resiliency programs possible.

Medical Necessity and Provider Documentation

One of the primary means for determining *medical necessity* is the review of the provider’s documentation. The “big three” areas of documentation that support medical necessity are:

1. The diagnostic assessment and any updates or additional diagnostic testing done at the outset or during the treatment episode,
2. The individualized action plan and any reviews, updates, or modifications,
3. Each and every billable progress note. These must describe an ordered, covered service that is necessary to realize the clinical outcomes of treatment.

Together, all of these documents make the initial and continuing case for the medical necessity of the services being delivered and billed. Documentation is a requirement of all payers, and in particular, all Medicaid/Medicare providers are required to keep such records as are necessary to establish medical necessity and to fully disclose the basis for the type, extent, and level of the services provided.

In reviewing documentation for medical necessity, the reviewer looks for key elements in the documentation, such as the following:

1. Is there a diagnosis that meets payer criteria? Is there sufficient documentation in the initial assessment or additional diagnostic work that provides evidence that this is the correct diagnosis?
2. Is there an assessment of functioning for the individual served? Are there sufficient symptoms, behaviors, and functional deficits or the threat of developing deficits to support the level of care ordered?
3. Is there an individualized action plan, signed by the appropriate provider, for an array of services that are generally accepted as being appropriate for the diagnosis, functional level, and assessed needs of the individual served?
4. Are the services rendered in accordance with the individualized action plan and with payer definitions? This is called “active treatment” and includes the requirement that services are “skilled interventions” rendered by appropriately credentialed providers.
5. Is there evidence of participation by the individual served? There are two issues here. First, the individual must have the cognitive ability to be able to participate in treatment and to benefit from it. And, second, the individual served must be willing to participate in treatment and, therefore, benefit from it. For example, individuals

with early Alzheimer's may be able to benefit from talking therapies for depression and other mental illnesses until their disease has progressed to the point where there is no potential for therapeutic progress. Individuals with severe or profound mental retardation are generally not covered for talking therapies but can be covered for medication management if warranted and medically necessary to control behaviors. In any case where services that are not "generally accepted" as beneficial to an individual served with certain diagnoses are being provided, the practitioner should expect that auditors and payers will expect an explanation and will look for it in the clinical documentation.

6. Is the individual "committed" to outpatient treatment? This is very different than a situation where a judge tells an individual that they can choose between jail or treatment and are effectively being coerced into treatment. In these cases, medical necessity must be determined independent of any court decision or recommendation for a third party payer to be billed. A commitment to outpatient treatment is different than the choice between jail or treatment. In these cases the Individual chooses one form of treatment over the other and there must be sufficient evidence of the need for mental health services.
7. Is there evidence that the individual being served is actually benefiting from treatment? This is a critical issue in medical necessity. Most services are directed towards improving the health status of an individual. Medicaid and other third party payers want to see that improvement recorded in the medical record or want to know why they should be continuing to pay for services that do not appear to be effective. There is also a concept in medical necessity that considers situations, especially those with significant chronic conditions, where services may be primarily directed towards the prevention or the slowing down of further deterioration and the need for higher levels of care. However, again there must be evidence in the medical record that these "maintenance" services are necessary and that they constitute the lowest cost effective service for this individual and their particular clinical picture.

The forms developed by NYSCRI have been designed to encourage the complete and accurate documentation of the diagnosis/condition, functional level and/or deficits, identified assessed needs, treatment goals, and level of care decision-making for the individual served. There are cues to remind providers to document the individual's participation and benefit from treatment. And, there are places for providers to sign, date, code, and time the interventions so they may be appropriately and accurately billed. As with all forms, they cannot make up for sloppy or inadequate content, but they do help the writer organize their information in ways that make it easier for reviewers to locate and to determine medical necessity.

NYSCRI Forms Support Medical Necessity

The NYSCRI forms are an integrated documentation toolset that is designed to:

- Facilitate the complete and accurate documentation of the condition, functional level and/or deficits, assessed needs, treatment goals and objectives, and level of care decision-making for the individual served.
- Provide linkage between the Comprehensive Assessment, the Individualized Action Plan and the Progress Notes, as well as the Comprehensive Assessment Update and Individualized Action Plan Review/Revision to demonstrate on-going progress and medical necessity.

- Contain cues to remind providers to document the participation in and benefit from treatment for each individual served.
- Contain fields for providers to date, code, and time stamp the interventions so they may be appropriately and accurately billed.
- Contain fields for all required signatures and credentials of individuals authorizing/recommending treatment and action plans.

¹ Social Security Act, Section 1905(a)(13)

² International Association of Psychosocial Rehabilitative Services

³ Hughes, R. and Weinstein, D. editors, *Best Practices in Psychosocial Rehabilitation*, IAPSRs, 2000, p. 42.

Medical Necessity Documentation Linkage Requirements

(Note: Reprinted with permission from Chapter Seven of *How to Deliver Accountable Care* written by David Lloyd and published by the National Council of Community Behavioral Healthcare)

The common thread of concern and findings within qualitative audits is that the documentation model utilized does not continuously support the need for the intensity, frequency, and duration of the service(s) being provided to the Medicaid and/or Medicare eligible individual.

A key issue in the audit findings is the lack of a link (Golden Thread of Necessity) between the assessed therapeutic needs that results in specific goals supported by measurable objectives with specific therapeutic interventions ordered to be provided by specific clinicians within specific service modalities/locations (outpatient individual, group, IOP, Residential, Psychopharmacology, etc.) within the provider organization.

The Five major linkage processes that are designed into the NYSCRI form documentation system to support compliance with qualitative reviews are identified below.

1. **Comprehensive Assessment (CA)** – Identifies Treatment Recommendations/ Assessed Needs
2. **CA Updates** – Identifies New Treatment Recommendations/ Assessed Needs
3. **Individualized Action Plan (IAP)** – Links goals to specifically numbered Treatment Recommendations/Assessed Needs
4. **IAP Review/Revision** - Links goals to specifically numbered Treatment Recommendations/Assessed Needs and/or changes in Objectives, Therapeutic Interventions, Frequency, Duration and/or Responsible Type of Provider.
5. **Progress Notes** – Links interventions being delivered to specific Goal(s)/Objective(s) and identified client response and outcomes/progress towards Goal(s)/Objective(s).

Each of these primary documentation processes should be designed and implemented at the same time within the community provider organization in order for each of them to serve as very important support for medical necessity linkage requirements. Outlined below are the primary linkage and support functions for each process:

Purpose of Comprehensive Assessment in Medical Necessity Linkage Requirements

1. Establishes a baseline measurement for the **Symptoms, Behaviors, and Skills/Needs Deficits of the individual served** and documents how each of these areas impact the individual's ability to **function, which is the basis for developing the individualized action plan.**
2. The more specific/objective the information gathering process during the assessment, the easier it is to demonstrate the necessity for treatment.

3. Use of standardized assessment tools in conjunction with the initial assessment can help support the assessed functioning baseline and help justify continued necessity.
4. The assessment contains an integrative summary of prioritized therapeutic treatment needs of the individual served that can be the only supportive medical necessity basis of goals in the action/service plan.

Figure 1 below provides the Treatment Recommendations/Assessed Needs section of the NYSCRI Comprehensive Assessment and the CA Update forms is illustrated below:

Figure 1:

| Prioritized Assessed Needs: A-Active, ID-Individual Declined, D-Deferred, R-Referred Out | <i>A</i> | <i>ID*</i> | <i>D*</i> | <i>R*</i> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p>*Individual Declined/Deferred/Referred Out-Provide Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred/Referred Out below). <input type="checkbox"/></p> <p>None</p> <p>1.</p> <p>2.</p> <p>3.</p> | | | | |

Purpose of Comprehensive Assessment Updates In Medical Necessity Linkage Requirements

The key “dis-link” observed in the typical chart is the lack of current, continuous updates of newly assessed therapeutic needs identified by the individual served and/or direct care staff after the initial comprehensive assessment is completed. In many cases the Progress Note has been used to record any additional assessed needs after the initial assessment is completed which makes it the “primacy” documentation in the chart.

The challenge with the Progress Note being the primacy documentation tool in the chart is that it is very difficult to demonstrate to reviewers the qualitative assessed basis for the services ordered in the IAP if the additional assessed needs are buried in hundreds of Progress Notes. The Progress Note is not designed to support the qualitative weight and data elements needed to provide an updated assessment of treatment needs/recommendations, diagnostic changes and a prioritized summary of assessed therapeutic needs and justification for treatment that

can be linked to Goals in the Individualized Action Plan. The standardized CA Update (adult and child versions) is an appropriate assessment form to record additional assessed information after the treatment process has begun that will provide a direct link between the assessed therapeutic need and the goal(s) in the Individualized Action Plan.

Purpose of Individualized Action Plan and IAP Review/Revisions in Medical Necessity Linkage Requirements

1. **Goals:** Utilizes assessed prioritized therapeutic needs from the comprehensive assessment (or subsequently dated CA Updates) to link to a corresponding goal in the IAP. The Goal linkage section from the NYSCRI Individualized Action Plan is shown below (Figure 2). As indicated, each numbered Goal in the IAP can be specifically linked to a numbered assessed Treatment Recommendation/Assessed Need from the Comprehensive Assessment, or CA Update, or Risk Assessment or Initial Psychiatric Evaluation. The *linkage occurs* by entering the Treatment Recommendation number, form date and checking the specific NYSCRI form type adjacent to the specifically numbered Goal.

Each goal needs to reflect the individual’s desired outcome for the assessed needs (i.e., if the assessed need is anger management, the individual’s desire may be, “I would like to stop losing my cool all the time!” and this desire, in the individual’s own words, becomes the basis of a goal in the action plan.)

Figure 2

| | | | |
|---|-------------------------------|-----------------------------|-------------------------------------|
| Goal # | | | |
| Linked to Assessed Need # _____ from form dated _____: <input type="checkbox"/> CA <input type="checkbox"/> CA Update <input type="checkbox"/> RFA <input type="checkbox"/> Psych Eval. <input type="checkbox"/> Other: _____ | | | |
| Start Date: _____ | Target Completion Date: _____ | Adjusted Target Date: _____ | as per IAP review form dated: _____ |
| Desired Outcomes for this Assessed Need in Individual’s Words: _____ | | | |
| Goal (State Goal Below in Collaboration with the Individual Served/Reframe Desired Outcomes): _____ | | | |

By establishing this link to the Treatment Recommendations/Assessed Needs from the Comprehensive Assessment/CA Update(s), the IAP fully supports an integrated clinical formulation that effectively addresses the assessed symptoms, behaviors and functional needs of the individual served.

2. **Objectives:** Develops measurable Objectives that support step-by-step attainment of each goal. Objectives that end in “ing” (i.e., “increasing”, “decreasing”, or “improving”, etc.) usually do not have the ability to specifically measure attainment. Perhaps the best and most humorous example of the need to develop very specific and measurable objectives was a handwritten notation from an auditor that read “Improving client’s relationships”. The auditor’s note read “With NATO? With Mexico?” Difficult to know if and when the objective was achieved. In training

staff, the concept of writing very specific objectives produces a level of anxiety in that in many cases objectives have historically been more general/non-measurable, which has provided a lower goal/objective attainment rate. The more the Goal in the plan is formulated to be a broad long term achievement effort, the more objective and measurable the objectives supporting that goal need to be in order to show attainment and benefit to the individual served from the services provided to support ongoing Medical Necessity determination. Figure 3 provides the NYCRI IAP Objective Section that includes the measurable/attainable objective, the start date and duration, efforts the individual served will take, his/her family/others, if clinically appropriate, the intervention methods (see item three following), the service description/modality, frequency and providers responsible.

Figure 3:

| | | | | |
|---|-------------------------|---|-----------|---------------------------------|
| OBJECTIVE # ____: | | | | |
| Start Date: | Target Completion Date: | Adjusted Target Date: as per IAP review form dated: | | |
| Intervention(s) / Method(s) / Action(s) | | Service Description/ Modality | Frequency | Responsible: (Type of Provider) |
| | | | | |
| | | | | |
| | | | | |

3. **Intervention(s) / Method(s) / Action(s):**

The concept of documenting specific interventions, methods, or actions that will be used to support attainment of each Objective seems to create a significant change in practice. In many cases, Interventions and Services have been used interchangeably. The service such as individual therapy is not the intervention, method, or action but rather the service location/modality that is being ordered in the plan where the therapeutic interventions will be provided. The ability to order specific interventions in the clinical formulation of the Individualized Action Plan provides needed support/clinical guidance to provide and document the specific therapeutic interventions provided in the structured Progress Notes. This linkage from the progress note to the IAP is a critical Medical Necessity documentation linkage requirement. (i.e., If the assessed need is Anger Management as evidenced by..., and the corresponding Goal in the plan is, "Like to stop losing my cool all the time", and the measurable Objective is "Reduction of anger episodes per week from 10 to 7 based on individual's self report", then the intervention could be, "Help individual identify anger triggers". The ordered service (location) could be Outpatient Therapy or Anger Management Group, etc.

4. **Services:** The IAP will serve as the order for interventions and services if the following elements are incorporated

- a. Goals and Objectives with start date and target date of completion
- b. Service Code or Descriptor link to specific therapeutic interventions for each Objective
- c. Disposition to specific Clinical staff with appropriate credentials to deliver the ordered interventions in the service location/type ordered
- d. Indication of Frequency and Duration of Services ordered

Purpose of IAP Review/Revision in Medical Necessity Linkage Requirements

In many cases the Progress Note has been considered an adequate IAP Update. When the need to utilize an IAP Review/Revision is presented, numerous times staff will respond, “It’s in the Progress Note and, therefore, it is in the Chart which has been good enough in the past!” Typical historical quantitative audit standards perhaps allowed the practice of “if the documentation is in the chart, that is adequate”; however, qualitatively if the intervention being provided is not linkable to a specific objective and goal in an Individualized Action Plan (or subsequently dated IAP Review/Revision) then it is not ordered and not reimbursable. Therefore, the use of an IAP Review/Revision is essential with the usual reasons for use being:

1. Attainment of Goal and/or Objective that requires the development of an additional Goal(s) or Objective(s)
2. Need to increase the Frequency and/or Duration of an ordered intervention
3. Need to modify or add interventions in number or intensity
4. Need to modify or add an ordered service/modality

The standardized IAP Review/Revision form is a critical part of maintaining a Medical Necessity Linkage between the assessed need and the documentation of the interventions provided that are appropriately linked to a specific goal(s)/objective(s).

Purpose of Structured Progress Notes In Medical Necessity Linkage Requirements

The Progress Note provides an opportunity to provide specific linkages between the interventions provided in the service to the IAP (IAP Review/Revisions) by requiring that the Goal(s) and Objective(s) being addressed in the service session be clearly identified within the note. In many cases, staffs have indicated their inability to record the specific Goal(s)/Objective(s) they are addressing in the Progress Note as a result of not having the IAP available or completed. Again the practice of providing services without a plan and/or without the ability to link the interventions provided in the session to specific Goal(s) and Objective(s) in the IAP seemed to meet most quantitative review requirements. However, in most cases this practice does not meet current qualitative reviews criteria. The NYSCRI standardized structured progress notes for individual psychotherapy, group psychotherapy, psychopharmacology services, nursing services, intensive service activities, etc. have been designed to address the need for specific elements of information to be recorded on each note.

Figure 4 provides the critical linkage portion of the standardized Progress Notes which is the section entitled “New Issues Presented Today”. If the individual served shares totally new information with the worker that was not included in the original assessment and the worker assesses that the information shared constitutes an ongoing need then one of two actions is required:

Figure 4:

| | |
|--|--|
| New Issues / Stressors / Extraordinary Events Presented Today: <input type="checkbox"/> New Issue resolved, no updates required | |
| <input type="checkbox"/> New Issue, CA/IAP Update Required? | <input type="checkbox"/> None Reported - |
| Explanation: <input type="text"/> | |

This section of the Progress Note provides three check box indicators - “None Reported”, “New Issues Resolved, no updates required”, and “New Issue, CA/IAP Update Required”, that are to be used as follows:

1. If the individual served *does not* share any *new information/issues* at the session being documented, check “None Reported”.
2. If the individual served *shares new information/issues* during the meeting that are assessed by the worker to **not** constitute a continuing treatment need, check “New issues resolved, no updates required” and record the information in this section of the note.
3. *If the individual served shares new information/issues* during the meeting that were *not included in the original Comprehensive Assessment, (or an earlier CA Update), and the clinician determines that the information shared does constitute a continuing treatment need*, the linkage requirements are:
 - a. Check “New issue, CA/IAP updates required?” and record the new information in this section of the note. Indicate on the Progress Note that the individual has self-reported new information and it will be recorded on a CA Update. The new information provided by the individual served should be recorded on the CA Update form by checking the appropriate element of the Assessment that is being updated, then writing the element and the information in the open narrative section of the form. Figure 5 provides this section of the CA Update.

Figure 5:

| | | | |
|--|--|---------------------------------------|--|
| Reason for Update: <input type="checkbox"/> Update of New Information | | <input type="checkbox"/> Re-Admission | <input type="checkbox"/> Annual Update – Date of Admission: <input type="text"/> |
| Date of Most Recent Comprehensive Assessment: <input type="text"/> | | | |
| Adult Comprehensive Assessment Sections for Update | | | |
| Check the box(es) next to the section(s) of the assessment (including addendums), which you are updating. Be sure to label all additional/updated information in your narrative with the heading of the section of the Assessment or Addendum being updated. | | | |
| <input type="checkbox"/> 1. Presenting Concerns | <input type="checkbox"/> 11. Mental Health and Addiction Service Treatment History | | |
| <input type="checkbox"/> 2. Living Situation | <input type="checkbox"/> 12. Psychiatric Illness History | | |
| <input type="checkbox"/> 3. Family Information | <input type="checkbox"/> 13. Medication Information | | |
| <input type="checkbox"/> 4. Development History | <input type="checkbox"/> 14. Trauma History | | |
| <input type="checkbox"/> 5. Social Supports | <input type="checkbox"/> 15. Mental Status Evaluation | | |
| <input type="checkbox"/> 6. Legal Status | <input type="checkbox"/> 16. Past Risk and Alerts | | |
| <input type="checkbox"/> 7. Legal Involvement History | <input type="checkbox"/> 17. Prioritized Assessed Needs | | |
| <input type="checkbox"/> 8. Education and Employment | <input type="checkbox"/> 18. Self Assessment | | |
| <input type="checkbox"/> 9. Military Service | <input type="checkbox"/> 19. Other: <input type="text"/> | | |
| <input type="checkbox"/> 10. Substance Use/Addictive Behavior History | <input type="checkbox"/> 20. Other: <input type="text"/> | | |
| Update Narrative: List each assessment section being updated with narrative explanation below it. | | | |

Figure 6 below provides the important linkage element on the second page of the CA Update which provides a place to record the Prioritized Assessed Needs with justification for treatment or indicate that there are no additional recommendations clinically indicated.

Figure 6:

| Treatment Recommendations / Assessed Needs: <input type="checkbox"/> No Additional Recommendations Clinically Indicated A-Active, ID-Individual Declined, D-Deferred, R-Referred Out (If declined/deferred/referred out, please provide rationale) | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | A | ID* | D* | R* |
| 1. [REDACTED] | | | | |
| 2. [REDACTED] | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. [REDACTED] | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. [REDACTED] | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *Individual Declined/Deferred/Referred Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred or Referred Out below). <input type="checkbox"/> None | | | | |
| 1. [REDACTED] | | | | |
| 2. [REDACTED] | | | | |
| 3. [REDACTED] | | | | |

Figure 7 provides a linkage section to cue the clinician to determine if existing Goal(s) and Objective(s), therapeutic interventions, services/modalities, provider type, duration and frequency addresses the newly identified assessed therapeutic needs. If yes, then the clinician should go back to the Progress Note and check the appropriate Goal and Objective and provide interventions ordered.

Figure 7:

| |
|---|
| Change In IAP Required: <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, complete the IAP Revision/Review Form to record needed changes in Goal(s),Objective(s), Interventions, Services, Frequency, and/or Provider type) |
|---|

- b. If there is not an existing Goal and Objective that meets the newly assessed needs or if an existing Goal and Objective needs to be changed/ revised to add new interventions, service/modalities, frequency, responsible staff, duration, etc. then worker can complete an IAP Review/Revision. The newly created Goal and Objective(s) in the IAP Review/Revision can be noted on the Progress Note as interventions are delivered for the newly created Goal/Objective(s).

NYSCRI Integrated Documentation Approach

In addition to the primary link based clinical documentation processes, there are several others that were simultaneously developed by the NYSCRI Standardized Documentation Team to ensure that appropriate linkages are designed into the total documentation process. Each process is supportive of another and the total clinical documentation process is utilized to continuously document support and an update of Medical Necessity.

Signature Requirements Matrix for NYSCRI Documentation Process

Each provider agency must independently determine its own policy and procedures regarding signature requirements for each of the NYSCRI forms. Most of the forms provide for multiple provider and/or supervisory signatures to accommodate provider agencies' internal policies/procedures. The development of each form was guided by state and federal regulations as well as the standards of the major accrediting bodies in allowing for provider, individual served, and supervisory signature lines.

Signature Instructions

Signature instructions for all forms universally require a legible signature. This is critically important. Federal and state auditors will throw out perfectly good claims on an audit if they cannot determine who provided the service. Additionally, day-to-day practice requires an understanding of who had an interaction with an individual served, and subsequently entered information into the medical record. The Joint Commission standards require that provider agencies develop a register of provider names and their signatures in order to be able to identify particularly obscure or sloppy signatures. (This is good practice regardless of your accrediting body.) Additionally, signature instructions universally require that a provider's or supervisor's signature be accompanied by their credentials and the date of the signature. This is both a payer/payment issue, as well as a risk management issue.

- Most states have laws regarding the licensure of professionals and the services or service array they are eligible to provide as a result of their licensure.
- Some states may issue certification requirements or licensing requirements for facilities that also are concerned with the credentials of providers and the services they are allowed to provide.
- Most payers have very specific standards for the type of provider credentials they will reimburse for specific services.
- In many cases, both the state and the payers have similar requirements. In some cases, payer standards are more stringent than state law or may cover providers who are not the subject of state laws, such as paraprofessionals. In those cases, payer rules must be followed in order to bill for a service.
- Provider agencies may issue their own requirements that exceed state and payer requirements, but cannot allow for lesser credentials.

Signature instructions also require that each provider date their signature. This may or may not be the date of service. Providers should not, under any circumstances, back-date their signature to match the date of service.

Credentials Instructions

In listing the credentials of the provider, it is recommended that the following generally accepted conventions apply:

1. If the provider is licensed, he/she should list next to his/her name the highest level of licensure achieved that is related to the service being recording. For example, if an individual who is an RN and also an independently licensed social worker is providing psychotherapy, then social work credentials would be recorded. If a medical-somatic service is being provided, the RN credentials would accompany the signature.
2. If the provider is not licensed and the service requires a certain educational degree, record the degree, e.g. B.A.S.W., B.S.R.N., B.S.
3. If the provider is not licensed and the service requires specialized training and certification, record the certification, e.g. CASAC.
4. If the Provider is not licensed and the service requires that the provider have a certain amount of educational or specialized training or experience that is not easily recorded as credentials, then agency policy/procedure should be followed regarding the credentials that should accompany the signature. For example: *“The provider must have 2 years of experience in providing services to the seriously mentally ill population.”* In many cases, the provider should also list or abbreviate his/her job title, such as CM or case manager. Providers are encouraged to consult state laws, regulations and certification standards to define internal policy for signatures and credentials required to authorize services. In **all** cases where licensure, training, education, and/or experience are required, the documentation that provides proof of this should be kept in the Provider Agency’s personnel files and available to auditors.

NYSCRI Process Billing Strip Instructions

Below are the instructions for completing the Billing Strip on all NYSCRI07 forms. Individual sections of the Training Manual will not repeat these instructions.

Standard Billing Strip Sample:

| Date of Service | Staff Identifier | Loc. Code | Service Code | Mod 1 | Mod 2 | Mod 3 | Mod 4 | Start Time | Stop Time | Duration in Minutes |
|-----------------|------------------|-----------|--------------|-------|-------|-------|-------|------------|-----------|---------------------|
| | | | | | | | | | | |

Instructions to complete the Billing Strip:

| Data Field | Billing Strip Completion Instructions |
|-------------------------------|--|
| Date of Service | Date of session/service provided |
| Staff ID | Specify the individual staff member's ID as defined by the individual agency. |
| Location Code | Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use. |
| Procedure Code | Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use. |
| Modifier 1, 2, 3 and 4 | Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4. |
| Start Time | Indicate actual time the session started. Example: 3:00 PM |
| Stop Time | Indicate actual time the session stopped. Example: 3:34 PM |
| Total Time | Indicate the total time of the session. Example: 34 minutes |
| Diagnostic Code | Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures. |

General Medicare “Incident to” Services Information

Medicare provides for payment for certain services that are provided “incident to” the services of a physician or “certain non-physician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants”.

Incident to services are those that are integral to the services of the professional but are not provided directly by them. This allows in certain cases for providers not eligible to bill Medicare directly to bill for their services provided under the direct supervision of an eligible supervising professional.

There are a number of rules that must be followed in order to bill services “incident to” and the Medicare Carrier for New York should be contacted in order to make sure all requirements can be met.

One of the most important of the “incident to” rules is that each and every service must be provided under the “direct” supervision of a Medicare eligible professional. These professionals can only supervise services they can either provide or supervise under their scope of practice under state law. They must also be available and in the office suite at the time the service is provided.

The NYSCRI forms allow for the provider to document compliance with the direct supervision rule with a checkbox to alert billing that the service was provided “incident to” and the name and credentials of the supervising professional. Medicare will be easily able to audit compliance with this requirement and providers will have sufficient back up for the claim. Below are the NYSCRI forms that contain the Medicare “Incident to” checkbox:

1. Group Psychotherapy Progress Note
2. Psychotherapy Progress Note
3. Psychopharmacology – Psychotherapy Progress Notes
4. Partial Hospitalization Progress Note
5. Nursing Progress Notes

Standard Medicare “Incident to” Services Only box:

| | |
|---|---|
| <input type="checkbox"/> Medicare “Incident To” | Name and credentials of Medicare Provider on Site: |
|---|---|

Instructions for Completing the *Medicare "Incident to" Services Only* Box

| Data Field | Billing Strip Completion Instructions |
|--|---|
| Medicare "Incident To" Services Only | Check the box when service is to be billed using the "incident to" billing rules. |
| Name and credentials of Medicare Provider on Site: | Enter the name of the supervising professional who provided the on-site supervision of the "incident to" service. Note: The presence of an appropriate licensed supervising professional is one of the key requirements for an "incident to" service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare Carrier's Local Medical Review Policies. |

NYSCRI Compliance Grids

Compliance Review Team (CRT) Data Element Grids to Support Form Development Process

The Reasons for the Compliance Grids

Compliance Grids were developed by the NYSCRI Compliance Review Team (CRT) as a way to monitor development of the clinical forms. The Compliance Review Team was charged with ensuring that the forms, once completed, would allow a provider to successfully meet the clinical documentation requirements of the major accrediting bodies: TJC, CARF, and COA, as well as the documentation requirements of the major payers for community mental health and chemical dependency services in New York State. Although every private payer was not consulted, the CRT believes that the standards reflected in the compliance grid fairly represent the documentation requirements of most commercial payers.

The compliance grids list the areas of information that need to be documented within each NYSCRI form type and provide information on which payers and/or accreditors require the information for clinical documentation purposes. These grids look only at the actual standards or regulations; they do not consider quality of the documentation or other indicators that might also create audit risk for agencies and providers. Accreditors are generally looking at clinical documentation for evidence that provider agency policies and procedures related to documentation and clinical care are being followed and are resulting in quality care and positive clinical outcomes.

The Compliance Grids can be found in the download section of the NYSCRI download web site. The grids cite the most recent standards available to the CRT from payers, regulators, and accrediting bodies at the time of the publication of the grids. Future changes to rules, regulations, and standards may make the information contained in the grids dated and less useful for training and/or other purposes.

How to Interpret and Use Compliance Grids

The grids list each area of information required for core NYSCRI form types and cite, as applicable, the particular regulation, rule, or standard requiring the information. The following table outlines the regulations and standards employed in developing the NYSCRI Compliance Grids.

| NYS Regulations | | | | Accreditation Standards | | |
|---------------------|---------|----------|-------|----------------------------------|----------------------|----------------|
| OMH | OMH SOC | DOH (CM) | OASAS | TJC | CARF | COA |
| Federal Regulations | | | | Support for Federal Requirements | | |
| Medicaid | | Medicare | | Medical Necessity | Client Participation | Client Benefit |

The **NYS-CRI Compliance Grids** are designed as follows:

- Column A: The number given to the element identified by the CRT
- Column B: The name or description of the element and/or required information
- Column C - G: State Regulations – NYS-OMH, NYS DOH, NYS-PROS, OMH SOC, NYS OASAS
- Columns H - J: Accrediting Bodies – TJC, CARF, COA
- Columns K - L: Federal Payer Requirements: Medicaid and Medicare
- Columns M – O: Support for Federal Requirements: Medical Necessity, Individual Served Benefit, Individual Served Participation.

To use the grid, find the form you are interested in, read down the left side of the form to find the documentation area, read across to find citations in the applicable state regulations, accreditation standards, and federal payer’s standards. Finally, read the comments relating to that area.