Lesson 3 of Course 2B

This is the LAST lesson in this course!

Monitoring of Your Own Client Records – Understanding What, Exactly, Can Go Wrong* In That Chart!

*** And Learn How to Audit Your Own Program's or Practice's Charts, Before The Auditors Arrive!**

Put On Your 'Internal Auditing Hat' Before The Contract Auditors Arrive At Your Door!

In the second lesson of this Course 2B, we reviewed how documentation of the client's needs and his treatment can affect whether or not you get an AUTHORIZATION for treatment, and also whether or not you get to keep your money when they come to AUDIT.

In this lesson we will provide some concrete examples and details of how things can go wrong in your 'charts' – and how to avoid these things. Tighten your seatbelt! Some of these things may look all too familiar to you!

Put On Your 'Internal Auditing Hat' . . .

We want to emphasize that the things that auditors take note of may be hard to see if you are the writer of the notations, or even the program manager. But external auditing entities who are trained to see the 'HOLES' in a chart DO see these things, so WE must sharpen our observations when we look at our own records. Are there gaps? Are there holes in the documentation?

"Holes in my records? They are 3 inches thick! How can there be HOLES?" Well, yes, there can be!

Holes and Gaps In Charts

During this lesson, we will take a close look at each of these documentation issues, in turn – but here's an overview:

- **The PASSIVE REPORTER Syndrome – Assessments and Progress Notes simply 'REPORTING' what the consumer or family member SAYS about the issues and problems – failing to express our own clinical observations and professional conclusions!**
- **The generic, 'ANY-PATIENT ITP' Syndrome – Individual Treatment Plans which look like they could belong to ANYONE.**
- **The PASSIVE OBSERVER Syndrome – 'Process recording' – Simply noting in Progress Notes that he said this and then said that. Failure to document the therapeutic ACTIVITY for which the HMO is paying!**

Holes in charts . . .

- **The 'FAILURE TO HIT THE TARGET' Syndrome – Progress Notes and Treatment Plans that do not pick up on important assessment findings and issues.**

- **The 'FAILURE TO HIT THE TARGET' Syndrome, AGAIN – Progress Notes that do not reflect the diagnosis or the Level of Care (LOC).**

- **The 'COOKIE CUTTER' Syndrome – could be anyone's progress notes. Or the same notes for a single consumer, week after week, after week. And we also see 'cookie cutter' ITPs – not OK!**

- **The 'POOR CONTINUITY' Syndrome – Progress Notes that leave us guessing: Like, where is the client? [The chart just dead-ends with no discharge notation or statement that client is AWOL and not found despite search.] Or, he's here, but where has he been for the past 7 weeks? [Chart has a major gap in notations with no explanation of the pause.] Or what led up to his being admitted to the hospital – no clue provided!**

- **The 'INCOHERENT CHART' Syndrome – Progress Notes that don't tie together – which are inherently contradictory and confusing and/or do not reflect a consistent theme of treatment. May not follow a logical progression, perhaps appearing that some Progress Notes have been lost, or like chart filing has gone awry.**

- **The 'POORLY DOCUMENTED LEVEL OF CARE' Syndrome – deadly if your charts are audited, and the services and Level of Care (LOC) delivered do not match the services and LOC which are authorized !**

- **The 'ZOMBIE CLIENT'' Syndrome – Progress Notes, ITP reviews, and new ITPs which give no clue as to the response of the consumer.**

- **The 'PERPETUAL CARE' Syndrome – ITPs that never change.**

- **The 'FAILURE TO MODIFY' Syndrome, a.k.a., 'Professional Neglect' – ITPs that do not change despite REGRESSION or NO PROGRESS.**

Now for a closer view of how these 'holes in the record' are seen by the auditor!

The PASSIVE REPORTER Syndrome: Assessments and Progress Notes that simply REPORT what the consumer or family member SAYS about the issues and problems – failing to express our own clinical observations and conclusions.

- **We all know why some of us still do this type of documentation – the 'Say Nothing Significant' approach. We were trained to document as little of our own clinical thoughts as possible because (1) you don't want to be judgmental, and (2) you might be called to court to explain your comments.**

- **This type of PASSIVE assessment and progress notation is NOT helpful under a managed care scenario. The managed care company is paying you to give every ounce of professional skill that you can bring to the table, to ASSESS, TREAT, and STABILIZE this person's DYSFUNCTION. They want to know 'What do YOU, as my CONTRACTED PROVIDER, THINK about this case.' Don't be vague or cryptic!**

The 'ANY-PATIENT ITP' Syndrome: Individual Treatment Plans which look like they could belong to ANYONE. Generic and non-specific will not fly!

Bottom line, they DON'T want to see a treatment plan that could apply to 'anyone' – and they don't want to see the same goals and interventions for the patient every time that you review the patient's ITP. They also don't want to see the same ITPs in multiple client charts!

The Managed Care contractor is PAYING you for INDIVIDUALIZED treatment of an individual patient, EVEN IF your state has a standardized treatment approach such as 'Resiliency and Disease Management' in Texas. And in the ITP, they expect to see recognition of this enrollee's various idiosyncratic issues and problems – the nuances of how his diagnosis(es) play out in the real world.

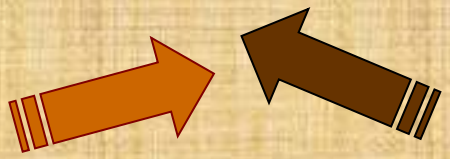
AND also, which of his SPECIFIC functional issues and problems are the most problematic for HIM? And how do you plan to approach these particular behaviors, fears, and deficits?

The PASSIVE OBSERVER Syndrome: This is traditional 'process recording' in progress notes – 'he said this and then said that'. This style of documentation fails to document the therapeutic ACTIVITY and GUIDANCE which the HMO is buying.

Being a 'Passive Observer and Listener' – i.e., reflecting the client's thoughts and feelings back to him or her – is still a valid intervention technique. HOWEVER it is simply 'not enough' in today's Managed Care environment. We must ALSO have clear documentation that the therapist has ACTIVELY GUIDED and ASSISTED the client toward resolution of functional deficits. Progress notes must not simply be a transcription of what the client said during the session.

New therapies – Cognitive Behavioral Therapy (CBT), and Community Skills Development (Rehabilitation) Therapy – are both ACTIVE and PROBLEM FOCUSED, and they target specific issues and goals. The role of the therapist or counselor is to ACTIVELY guide and assist the consumer toward resolution of a functional deficit. This approach may include teaching, role play, development and review of plans with the client, and so forth . . . as well as recognition of his thoughts and feelings. We must see these activities reflected in Progress Notes!

The Passive Observer / Listener / Recorder? Not enough, in today's health care plans!



Treatment under a Managed Care scenario is ACTIVE in nature – working assertively toward resolution of the most serious issues as quickly as possible . . . and then moving (if necessary) to a less intensive Level of Care. Managed Care is NOT PASSIVE!

This means that observing, listening, and reflecting the thoughts and concerns of the consumer back to him or her during a treatment session is NOT ENOUGH.

The HMO expects to see strong evidence IN THE PROGRESS NOTES that all of the activities during the session were TARGETED to active resolution of a functional deficit. This means that there is abundant INTERACTION between the consumer and the counselor. Lots of activity!

Progress Notes MUST clearly indicate the use of ACTIVE, recovery-oriented curriculums or training methods.

We have included some examples of such ACTIVE INTERVENTIONS on the next four slides, for your consideration. CBT is covered on slides 14-16.

In recovery-oriented treatment, the counselor predominantly uses strategic methods and interventions geared to stabilization and forward movement . . . and he or she documents IN THE PROGRESS NOTES that these approaches were used. The consumer's RESPONSE to the interventions is also documented.

With some differences in content, this same principle applies to both REHABILITATIVE work with SMI adults (psychosocial and self-care skills development), and to COGNITIVE BEHAVIORAL THERAPY (CBT) with persons who have problems such as depression, anxiety, social dysfunction, and dual diagnosis issues (MH and Substance Abuse together).

Rehabilitation-oriented activity examples

- **Instructions – Handouts as well as verbal**
- **Modeling and Role Playing or Behavioral Rehearsal**
- **Positive Feedback**
- **Repetition Of Role Play Or Rehearsal**
- **Defining and Teaching a Specific Skill – *such as***
  - **Social and Communication Skills**
  - **Assertiveness Skills**
  - **Problem-Solving**
  - **Anger Management**
  - **Relaxation Skills**
  - **Positive Self Talk**
  - **Self Care Routines**
  - **Home Management**
  - **Food Purchasing and Preparation**
  - **Money Management**
  - **Understanding and Expressing Feelings**
  - **Job Readiness Skills**
  - **Employment Skills**
  - **Medication Compliance Skills**
- **Shaping Behavior By Reinforcing Successive Approximations**
- **Prompting and Reinforcing Behavior In Natural Environment (out in the community – riding the bus, buying groceries, applying for food stamps, etc.).**

This list appears in several State of Texas documents for treatment of SMI adults . . . but it is also consistent with the prevailing, basic standards of care for such treatment within the mental health field, nation wide.

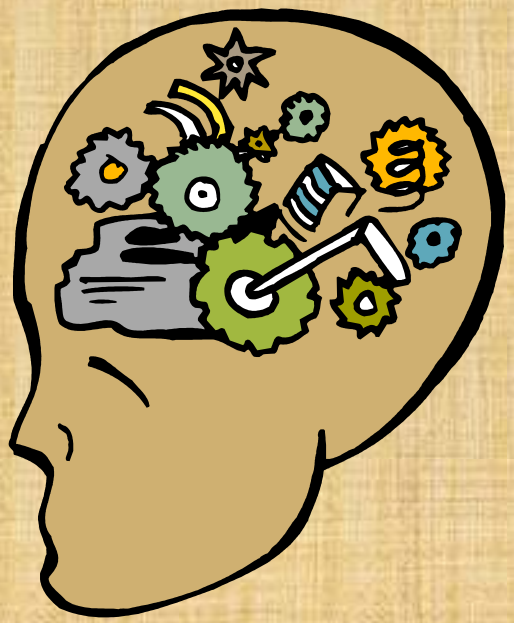
Progress Notes should reveal that activities like these – used with persons with major mental disorders – have been carried out in the session. This is what the HMO is paying for – they need to see it on paper. A combination of check boxes and brief SUPPORTING NARRATIVE is usually sufficient.

- **Cognitive Behavioral Therapy for Adults is intended to be a brief therapy approach, and is characterized by an ACTIVE, COLLABORATIVE PROCESS between the consumer and the counselor. This process must be evident in the PROGRESS NOTES.**
- **The problem solving skills and the improved perceptions that are developed in the therapy session are expected to be generalized to use outside of the therapy setting.**
- **The therapist does not lecture, debate, or try to argue the consumer out of a position. Rather, he seeks to assist the consumer to come to conclusions that are reality-based and rational as a way of dealing with the real word.**

Cognitive Behavioral Therapy (CBT) activities to be documented in Progress Notes

- **The CBT therapist uses exploration, information seeking, and questions to help the consumer to explore the validity of his perceptions & thoughts, to spot faulty logic, to consider alternative perspectives, and to reach reality-based conclusions and workable solutions for use in the real world.**

Examples of some CBT activities to look for, in client records.



- **Counselor and consumer make an agenda for the therapy session, at the beginning of each session.**
- **The therapist works with the consumer to make incremental changes in the KEY COGNITIONS which contribute to the consumer's mental health problems (thoughts, beliefs, and perceptions that worsen depression, anxiety, and social problems).**
- **The counselor then teaches the consumer the skills he needs to self-examine the thoughts when they occur – thought stopping and adjustment.**

CBT activities . . .

- **BEHAVIORAL INTERVENTIONS utilize strategies to change behavior . . . including reinforcement and/or negative consequences, teaching of behavioral skills (e.g., relaxation, assertiveness training), using adaptive coping skills, alternative behaviors, and so forth.**

- **The counselor teaches the consumer PROBLEM-SOLVING STRATEGIES to address issues important to the consumer, through a step-by-step process for identifying and solving problems, and for decision making.**

The 'FAILURE TO HIT THE TARGET' Syndrome: Treatment Plans and Progress Notes that do not pick up on important assessment findings and issues.

Coaching and teaching and interactive work with the consumer to develop skills and more effective behaviors and cognitions are pointless, if we miss the TARGET. In this type of charting flaw, we see providers clearly missing one or more of the MAIN LIFE ISSUES which were apparent in the Assessment.

EXAMPLE: An 18 year old female is depressed, has started to drink, and has become promiscuous. But in the ITP & Progress Notes, there is no mention of the fact that she has full time responsibility for 5 younger sibs, due to mom's terminal cancer, and needs some assistance and relief in order to make progress. [The issue was noted in the Assessment, and never mentioned again.]

EXAMPLE: A 27 year old male was assessed to be using COCAINE DAILY, is anxious and depressed, and has become explosive at work. We work on the depression, anxiety, and explosiveness, but nowhere in the chart, after the Assessment, is there mention of the Chemical Dependency.

Example: An individual has a long-term diagnosis of Major Depression without psychotic features, and has two serious suicide attempts mentioned in his Assessment. The staff target three things in the ITP and in the Progress Notes – inability to hold a job, his tendency to verbally attack others, and his periodic habit of gambling the rent money away. But nowhere in the ITP or in the CBT Progress Notes, do we see mention of anything specifically related to his DIAGNOSIS. Beyond prescriptions in the chart for anti-depressive medication, nothing is present regarding the 'effective management of depression and its primary symptoms' or 'avoiding suicide attempts' as TARGETED GOALS of the treatment.

The 'Failure To Hit The Target' Syndrome – again! Here, ITPs & Progress Notes do not relate to the DIAGNOSIS.

It would be very clear to an auditor that this chart could belong to any number of individuals with diagnoses OTHER THAN major depression. As far as we can see in the record, the individual has not been assisted in his treatment program to recognize the precursors of his depression or to take diversionary action as an alternative to recurrence of suicide attempts.

The 'Cookie Cutter' Syndrome – Here, we see the same general Progress Note for the consumer, week after week after week. All the notes look essentially the same. Could be ANY consumer's progress notes! And we see 'cookie cutter ITPs' as well!

1. **This is a common flaw in clinical records – where the content of each session looks to be essentially the same as the previous 10, and the notes appear to be generic – could belong to ANY CLIENT.**

2. **Because of their 'sameness', there is nothing in the notations that suggests progress or that movement is occurring. This is NOT what the managed care company is paying for! Such charts begin to trigger 'UTILIZATION' questions in the mind of the auditor.**

3. **And even worse, what if most of the notes written by the counselor look very much alike, regardless of the consumer she is treating? A 'red flag' for auditors!**

The 'POOR CONTINUITY OF CARE' Syndrome!

1. **Here, Progress Notes just seem to STOP, or have huge gaps where there is no explanation about why treatment halted or did not occur for a period of time. These records cause an auditor to wonder, "Where is the patient?" OR "Where has he been for the past 7 weeks?" OR "What led up to his being admitted to the hospital? How long was he there?" OR "Why aren't they dealing with what precipitated his going to the hospital?"**

2. **It may leave the auditor (or others reading the chart) with the impression that the consumer dropped out of site but no one bothered to look for him. (This is critical with SMI patients.) Or that we don't want to be bothered with what led to his emergency admission to the hospital 2 months ago.**

3. **And perhaps worst of all, the consumer may have gone to the hospital, and when he returns we just pick up where we left off, as if nothing has happened. Deadly – especially if a critical event occurs shortly thereafter.**

The 'INCOHERENT CHART' Syndrome. Where Nothing Ties Together! Confusing!

1. Parts of the chart – or the entire chart – may not 'hang together' very well, i.e., it does not present a CLEAR, COHESIVE PICTURE of the client and his diagnosis . . . or his targeted issues . . . or what we are doing about it (what type of treatment and interventions) . . . or how the client is responding. Bottom line, the picture is CONFUSING.

2. Includes Progress Notes that don't tie together – which appear to be contradictory – don't follow a consistent theme of treatment. Leaves so MANY questions! Not good!

3. Or, Progress Notes may not follow a logical progression . . . which gives the feeling that some notes have been lost or that the filing in the chart has gone awry. Auditors have VERY LITTLE patience with this. They have no time to play detective!

The assumption of managed care is that the NEED for an intensive Level of Care (LOC) will REDUCE as the client makes PROGRESS.

The 'ZOMBIE CLIENT' Syndrome. Progress Notes, ITP reviews, and new ITPs give no clue as to the RESPONSE of the consumer to the treatment process.

Here, the problem is that it is difficult to know how the client is responding to treatment. The response of the client is not mentioned or is vague. Since the HMO is paying for an assertive attempt at a good outcome, how he or she is doing is important to auditors!

We do understand that some individuals with mental health diagnoses or CD issues WILL NOT respond to the treatment process – but if so that needs to be made clear, along with what we have done to attempt to bring about response. This leads us to the final 2 chart flaws or 'holes' that we will bring to your attention, on the next two slides . . .

- **Since Managed Care works on the premise that the HMO is paying the provider to work actively toward PROGRESS and GOOD OUTCOMES . . . and since the assumption is that the Level of Care will CHANGE OVER TIME . . . ITPs which do not change from review to review are a major issue. The managed care contractor EXPECTS for a there to be a change in the treatment activities and goals from review to review.**

The 'PERPETUAL CARE' Syndrome: ITPs that never change.

If no changes occur from ITP to ITP, the assumption is that either:

1. Nothing has changed with regard to the enrollee's condition. He is neither better or worse. He is simply STATIC and perhaps STAGNANT . . . OR

2. The counselor is not tending to business.

Neither is a good thing!

Failure to modify the ITP in the face of a client's regression may well be viewed as PROFESSIONAL NEGLECT – a legal albatross.

The 'FAILURE TO MODIFY' Syndrome, a.k.a., 'Professional Neglect'.

- **ITPs that do not change despite obvious, documented REGRESSION or NO PROGRESS are a major problem. Failure to modify the consumer's ITP when he is becoming sicker and more dysfunctional is particularly grievous. Not only is this an AUDITING issue – it is also a serious LEGAL RISK issue. If the consumer continues to deteriorate and a critical incident occurs (such as a suicide or homicide) the first thing that your lawyer will look for in the consumer's record is "Were they doing everything that they could do when he started to backslide?" And that inherently includes MODIFICATION OF THE TREATMENT APPROACH, as documented in a REVISED ITP.**

In closing . . .

- **If it is not written in your client's treatment record, as far as the auditor is concerned, it never happened.**

- **Client records are very WYSIWYG – what you see is what you get, in terms of a 'grade' from the auditor. It's best to take a regular hard look at your records, and see what's missing, what is not written down, and what needs to be clarified.**

- **The condition of the clients' treatment records can have enormous impact upon the financial wellbeing of a program or practice – more so NOW than EVER BEFORE!**

Test: Do each of your progress notes tell us these things?

Through use of check boxes and brief supporting statements or narratives, does each progress note tell us . . .

1. **How is the client FUNCTIONING today or this week, in terms of the symptoms and issues that are the primary targets of treatment?**

2. **What were the specific GOALS for today's session?**

3. **What did we actually DO today, in terms of specific ACTIONS AND ACTIVITIES?**

4. **How did the client RESPOND?**

5. **What is PLANNED for the NEXT contact, in terms of ACTIVITIES?**

And remember the issue of the 'Poorly Documented Level of Care'? This can sink your ship!

CRITICAL ISSUE: Above ALL ELSE – your client's record MUST support the Level of Care for which the HMO or other such managed care contractor is paying you! If they are paying for one of the more intensive Levels of Care, and your documentation looks like the client DOES NOT MEET THE CRITERIA for that Level of Care (i.e., he does not really need that level of intensity), you may have to repay some or all of the money that you have been paid for the period of time that the documentation did not appear to 'match the level'.

- **The Bottom Line with HMOs and other such auditors: "Does this chart justify what we are paying them to do the treatment – and is this Level of Care (LOC) really needed – and is it working?" We MUST do 'Internal Utilization Management' to assess this LOC issue, on an ongoing basis.**

Be prepared for both announced and unannounced audits. It's worth the ongoing effort.

We must be prepared for both announced and unannounced audit activity. Even if most on-site audits are announced and pre-arranged, a record audit may come at any time, in the form of a call from the MCO for a copy of key pieces of a client's record for purposes of Utilization Management, or in response to a client's complaint. OR the HMO may ask that you send a copy of the ENTIRE client record. So ongoing, impeccable maintenance of our Assessments, ITPs and progress notes is a MUST!

'You've GOT to be kidding! They're coming WHEN?'

Congratulations!

You have completed the final lesson in Course 2B.

You must pass Quizzes 1. 2. and 3, and must complete our short *Feedback* form for Course 2B, to receive your online certificate.

To reach the links for the quizzes, simply close this page. You will see your list of Study Guides and Quizzes displayed in the previously opened window. If you want to come back later to take the quizzes, just log on to your My Home Page. Click through on the links – and you're there!

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