# Documentation Best Practices

**Quality Assurance Team (QA)**

**Alameda County Behavioral Health Services (ACBH)**

**Presented by:**
Jeri Mares, Clinical Review Specialist

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# Topics

**Documentation**

- General Principles
  - Anatomy of a Progress Note
  - Types of Progress Notes
  - Progress Notes vs Psychotherapy Notes
- Best Practices
  - Overview
  - Person-Centered Documentation

**Collaborative Documentation**

- What?
- Why?
- How?
- Things to Consider

# General Principles of Quality Documentation

- ✓ It's essential. It's part of a permanent record.
- ✓ It acts as a layer of protection for programs, providers, and clients.
- ✓ It ensures that programs can bill for services and justify the hard work they've done.
- ✓ It ensures that providers avoid liability.
- ✓ It supports the continuity of care.
- ✓ It ensures client safety and quality of care.
- ✓ It supports a partnership between providers and the Mental Health Plan.

# Anatomy of a Progress Note: Required Elements

- ✓ The type of service rendered.
- ✓ A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
- ✓ The date that the service was provided to the beneficiary.
- ✓ Duration of the service, including travel and documentation time, which should be documented separately.
- ✓ Location of the person in care at the time of receiving the service.
- ✓ A typed or legibly printed name, signature for the service provided and date of signature.
- ✓ ICD 10 code.
- ✓ Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- ✓ The plan, or next steps, including but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate.

# Anatomy of a Progress Note: Formatting

- Progress notes come in different formats:
  - **BIRP**: Behavior, Intervention, Response, Plan
  - **DAP**: Description, Assessment, Plan
  - **DRAP**: Description, Response, Assessment, Plan
- These can help us remember the core elements of documentation.
- Regardless of the format, quality documentation should be clear, consistent, descriptive, reliable, accurate, precise, and timely.

# Anatomy of a Progress Note: Beyond the Basics

- Aside from the required elements, the narrative is where quality documentation is distinguished from poor documentation.
- Providers can be **strengths based**, and **recovery oriented** in their writing.
- Providers can be **creative** in how they situate their language.

# Progress Notes VS Psychotherapy Notes

## Progress Notes

- Part of the permanent clinical record.
- Accessible to the client, agency, Mental Health Plan, and other stakeholders.
- Can be subpoenaed.
- Follow a general format and have requirements.

## Psychotherapy Notes

- Belong to the clinician and kept separate from the clinical record.
- Private and not accessible to anyone other than the clinician.
- Extra protections in place under the HIPPA Privacy Rule
- Do not follow a format and are kept to assist the clinician in keeping track of the details that are not included in progress notes.
- Can be used to develop movement and strategies in therapy or to seek clinical consultation.
- Must be kept confidential.

# Ask yourself…

How would you feel if your client read the notes you wrote about them?

How would you feel if YOU were the client, and the notes were about you?

How would you feel if your notes were projected in a courtroom during a litigation?

If the thought of these situations makes you pause & worry, it's probably a good time to get back to the basics of documentation best practices.

# Documentation Best Practices

- Limit the use of jargon.
- Avoid a copy & paste style – write notes that are unique to the encounter.
- Consider your audience and strike a balance between clinical and easily digestible.
- Use caution when documenting information about or provided by Third Parties.
- CalAIM’s goal is to have “lean progress notes.” This makes space for getting back to the basics of quality, person-centered documentation that is not time consuming.
- Utilize actual quotes and document the client’s reports in their own words.
- Follow the sentiment of the **HIPPA Minimum Necessary Rule**, by limiting not only the sharing of PHI but what is documented as well. Document only what is needed for an accurate and purposeful note.
- Do not speculate or use subjective commentary.
- Use person-centered language.

# Person-Centered Language

- **Puts people first**. It holds that people, our clients, are more than a diagnosis, behavior, or challenge they're working on.
- The language used by providers to describe clients matters.
- Language describes and creates our reality. **Word choices matter**. They impact mood, perception, cognition, and our physical health and mental well-being.
- What we write can cause harm or cause healing.
- Person-centered language **focuses on the person** rather than the illness.

# Person-Centered Language

Promoted and taught in graduate schools and training sites.

The ideal standard.

Has been difficult to practice given strict documentation guidelines and the need to justify every encounter.

CalAIM's simplification of documentation standards is an open door to returning to this practice.

# Person-Centered Language: Making the Shift

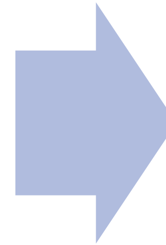
| Term | Alternative |
| --- | --- |
| Delusional | Experiencing delusions |
| Psychotic | Experiencing auditory hallucinations |
| Homeless | Without stable housing or unhoused |
| Addict | Currently using drug of choice |
| Relapsed | Returned to drug use |
| Convict | Currently incarcerated |
| Depressed | Reporting depression |
| In Denial | Pre-Contemplative |
| Unmotivated | Ambivalent |

Client presented as highly **paranoid and psychotic**. She was **disheveled and smelled like she hadn't bathed in days**. She looked like she really has not been taking care of herself.

Client was **anxious and unfocused** the whole session. He said he's nervous about an interview, **so we talked it through**. Writer **could not get much accomplished other than focusing on the interview.**

Client **relapsed over the weekend. She didn't contact her sponsor** and has not been **compliant** with her crisis plan. We revised her crisis **plan so she can actually use it when this happens again.**

Client **is depressed and completely unmotivated**. He's been doing the **bare minimum** to get through the day. He's also sleeping a lot. **He didn't read the book** he checked out from the lending library.



April presented with **acute paranoia, stating that "the government is trying to silence me by poisoning my food"**. April was able to acknowledge that **she has been struggling with her ADLs.**

Darian reported **feeling anxious** in session. Writer explored this with him. He stated that he is nervous about a job interview. **Writer used CBT interventions** with Darian and **engaged him in behavioral roleplay** to help reduce interview anxiety.

Sasha reported having "**a really difficult weekend"** and **"taking 3 Norcos to relax."** Sasha stated that **it was difficult to reach out to her sponsor** because **she was embarrassed**. Writer **reviewed her crisis plan** and **added additional resources to better support her.**

Eric reported that he's **"been feeling down this week, and sleeping more than usual."** It's been **hard for him to do much beyond his basic daily tasks**. Writer commended him for making it to his session. Time was spent discussing coping skills and **how to utilize the lending library book as a resource.**

# Person-Centered Language: In Practice

# Why Person-Centered Language?

- ✓ It's destigmatizing.
- ✓ It's positive.
- ✓ It empowers.
- ✓ It uplifts.
- ✓ It puts the person first.

# Collaborative Documentation

- Just like **WHAT** we write, **HOW** and **WHEN** we write it, can be a therapeutic tool.

- Just like the person-centered language that should be used in notes, collaborative documentation is a person-centered approach that yields strong therapeutic alliance and effective & accurate records.

# Collaborative Documentation: Why consider it?

- ✓ Increases service capacity.
- ✓ Increases compliance with documentation timeliness.
- ✓ Improves the quality of documentation and eliminates rushed documentation.
- ✓ Increases client engagement – does the client agree with the goals being worked on? Are the recommendations and the plan clear to the client?
- ✓ Decreases documentation to direct-service ratios.
- ✓ Decreases the need to restrict access to notes as they're created in partnership with the client.
- ✓ It moves us away from the traditional medical model where clients are passive participants in their care and the record that is connected to them.
- ✓ Decreases *Documentation Dread.*

# Collaborative Documentation: How is it done?

- ✓ Takes place during the encounter – it's collaborative and involves the client.
- ✓ There is room for **creativity** and **flexibility** in the process of figuring out what works best for your clinical style and the unique client.
- ✓ Examples: First & last few minutes (check-in & wrap-up style), or concurrent throughout an encounter.
- ✓ Introduce the practice to your client – know how you're going to do this ahead of time.

# Collaborative Documentation: In Practice

- ✓ **Engage the client in the process by repeating key statements & clarifying before documenting.**

Example: *"You said the last two weeks you've been falling asleep easier after doing mindfulness before bed, is that right?"*

- ✓ **Engage the client by summarizing the aspects of the encounter that you intend to document.**

Example: *"Okay, so today we discussed how anxious you've been lately and how it's showing up in your body with "butterflies in your stomach and heaviness in your chest." You also said you've missed some of your medication doses and we agreed that you'll check in with your psychiatrist. You won't be here next week because you're going camping but you're going to be intentional about using your coping skills until we meet again. I think it's wonderful that you're taking the time for self-care by going camping – I know you love nature. Did I miss anything?"*

- ✓ **Be open to questions about what you're documenting.**

Example: *"Do you have any questions about what I'm writing?'*

# Collaborative Documentation: Things to Consider

This practice will not work well with all clients – use your clinical judgment.

What kind of set-up will you need? Consider how this practice will work in your space and what you'll need to be successful.

Confidentiality/HIPPA – be aware of what is viewable to the client, especially on a computer screen.

# The Million Dollar Question…

**Is collaborative documentation time billable?**

# COLLABORATIVE DOCUMENTATION IS BILLABLE!

# Collaborative Documentation

- Documentation is part of a direct service when it’s blended with and done collaboratively during an encounter. Providers are not expected to tease apart minutes spent documenting while also engaging a client in a service encounter.

- ACBH Quality Assurance addresses this in our CPT Code FAQ document posted on the Provider Website:

***Is concurrent documentation (therapy + documentation completed in a session as a clinical intervention) considered documentation time or service time?***

If documentation is occurring concurrently with therapy, the time claimed should be for the duration of the therapy. These concurrent services would be considered therapy (service time) e.g., direct patient care.

- **Note:** This extends to all direct services, not just therapy.
- DHCS and our other county partners throughout the state also support collaborative documentation as a best practice.

# Documentation: Q&A

# thank you.

For questions about the presentation, contact QATA@acgov.org.

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