GOALS/STRATEGIES/DOCUMENTATION

APSM 45-2 – Records Management and Documentation Manual

PBH Provider Contract

PBH Cardinal Innovations Manual

Information provided in this presentation pertains only to the counties in the PBH Region. This information is specific to the PBH region and may not apply to Local Management Entities (LMEs), providers, stakeholders or individuals outside the PBH catchment area. Presentation slides are brief, bullet-points of information and should not be used out of context.

WHAT ARE GOALS?

- Goals: identifies the individuals desired life outcomes.
- A desired result an individual and supports envisions, plans and commits to achieve
- Goal setting involves establishing measurable, attainable, realistic and time targeted objectives

LONG RANGE OUTCOMES

- Address life areas
- Broad
- Relate back to issues identified
- Addresses needs gathered in the assessment process

SHORT RANGE GOALS

- Steps to take to achieve Long Range Outcome (LRO)
- A statement describing a desired behavior, or what the individual will attempt to accomplish
- Based on wants/needs
- Makes sense to support individual to live a successful life
- Individual preference / need, not staff convenience / preference

SHORT-RANGE GOAL ELEMENTS

- Name of Individual
- Measurable Behavior
- Duration
- Frequency
- Target Date

MEASURABLE BEHAVIOR

- 1 behavior/task per goal
- Observable- should be able to see, count and be able to determine progress
- Specific to strength, need, preference of individual

EXAMPLES OF MEASURABLE TARGET BEHAVIORS

- …will verbalize positive statements about themselves
- … will brush hair
- …will attend weekly group sessions
- …will attend AA meetings

EXAMPLES OF DURATION

- …75% of the time
- … 8 out of 10 meetings
- …2 out of 3 trials
- …with no absences
- …on 10 consecutive trials

EXAMPLES OF FREQUENCY

- …with modeling
- …when asked
- …independently
- …with assistance

TARGET DATE

- …12/31/11
- December 31, 2011

*** No longer than 12 months from start date***

PROVIDER RESPONSIBILITY

- Treatment Team Participation
- Responsible for the development and implementation of the short range goals
- Responsible for the development and implementation of the strategies/task analysis
- Ensure short-range goals and strategies/task analysis are in place prior to plan implementation
- Ensure Short-range goals are signed by the consumer/LRP

WHAT IS A TASK ANALYSIS?

- Outlines how a task is accomplished
- Specific, observable step-by-step training plan for a skill,
- Breaks the skills down into small, logical, sequential steps,
- Task includes observable behavior/skill to be taught,
- Includes variety of teaching methods &/or activities,

*** Strategies/task analysis should be written at the level of detail to support the short-range goals***

GENERAL ELEMENTS OF A TASK ANALYSIS

pbH
Creating solutions, One person at a time

- Individual Name
- Medicaid ID Number
- Short-range goal or #
- Implementation Date
- Target Date
- Responsible professional
- Target behavior
- Pre-requisite skills
- General instructions
- Approximate run time
- Location/schedule
- Trainers
- Materials
- Reinforcement

WHAT IS A STRATEGY?

- Adaptable rather than a rigid set of instructions
- Makes a problem easier to understand and solve
- General plan of action to support the goal
- Can be Integrated into Service Plan
- The amount of detail included depends on needs and functioning levels of the consumer
- Focus towards accomplishments and objectives as determined by team
- Completed by a Qualified Professional

*** Strategies/task analysis should be written at the level of detail to support the short-range goals***

STRATEGY DEVELOPMENT: THINGS TO CONSIDER…

- Who will perform (individual/staff/natural supports responsibilities)
- How will the goal be accomplished
- What's needed to make the individual successful in accomplishing the goal

GROUP ACTIVITY

- ACTIVITY….

SAMPLE TEMPLATES

- Sample Grids and Service Notes can be found on the DHHS website @:

http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/index.htm

DOCUMENTATION

PURPOSE OF DOCUMENTATION

- To support requested services/needs
- Impact of services
- Confirm involvement of the individual
- Evidence of appropriate intervention & modalities
- Service provision and status
- Protection of individual
- **Protection** for consumers, facility, agency, funding and from potential lawsuits.
- Documentation is the **justification for the billing**. Without it, services cannot be billed to any funding source

PURPOSE OF DOCUMENTATION-CONTINUED

- Log of activity
- Justification
  - Continuation of service
  - Utilization of resources
- External Audits

KEYS TO REMEMBER…

- Timely documentation is essential to the integrity of the service record
- Documentation should be legible and grammatically correct.
- Services are not considered rendered until a service entry is in the record
- Billing should never be submitted prior to documentation
- Once billing is submitted, documentation must be in the record.

KEYS TO REMEMBER…

- Notes should not be duplicated or copied (copy cat notes)
- Abbreviations- If used should be indicated in the agency’s policy/procedures
- Documentation should reflect your **thoughts/views/perceptions and purpose for your position**
- Documentation should flow like a story – should make sense & provide follow up throughout the days/weeks/months.

RECORD CORRECTIONS

- Corrections to be made by the staff who recorded the entry
- Draw one line through the error or inaccurate entry, original entry should be legible
- Document the corrected entry legibly above or near the original entry
- Document the correction date with staff initials

RECORD CORRECTIONS

- An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear
- Omitted words cannot be inserted in the appropriate place above the record entry, the information should be made after the last entry in the record. Never "squeeze" additional information into the area where the entry should have been recorded
- Correcting fluid or tape shall not be used for correction of errors

SERVICE NOTES

- Name of Individual (on every service note page)
- Service Record Number (on every service note page)
- Medicaid ID Number (on every service note page)
- Full Date of service provided (month/day/year)
- Name of the service provided
- Duration of service (periodic & day/night)
- Purpose of contact – must relate to a goal
- Intervention /treatment/support provided by staff
- Assessment of consumer’s progress toward goals
- Signature of service provider to include: Professionals - credentials, degree, or licensure
- Paraprofessional – signature & position / title

SERVICE NOTES

- **Date of service** provided (month/day/year)
- January 1, 2011 1-1-11
  1-1-2011 1/1/11
- Year must have at least 2 digits
- **Duration of service**
- This is time billed.
- 1:15 = 1 hour 15 minutes

PROGRESS SUMMARY

- Progress summary requirements:
- Individual’s name
- Date of quarterly review and dates the review covers
- Progress towards goals
- Recommendations for continuation, revision or termination of goal
- Signature of individual completing review

PROGRESS SUMMARY

- Completed quarterly
- Should be documented within 7 working days of close of the quarterly progress period.
- Considered a ‘late entry” if not completed within required timeframe

PURPOSE OF CONTACT

- Should always drive the clinical intervention
- Ask yourself:
  - What am I trying to accomplish for this
  - consumer?
  - What do I want to be the final outcome?
- NOT the name of the service

INTERVENTION

- Treatment provided by staff
- Describes clinical activities that relate to the goal(s) and strategies
- Ask yourself:
  - What clinical service did I provide for the consumer?
  - What intervention was provided?
  - What did I do to help the consumer meet his/her goal?
  - What was the length of time of intervention by staff?
- NOT describing what consumer did or said
- Staff interventions justifies the billing

ASSESSMENT

- Consumer's response to the intervention
- Description of consumer's progress or lack of progress towards the goal(s)
- Ask yourself:
    - How did the consumer respond to the intervention?
    - What was the outcome/result of the intervention?
- NOT describing what staff did with the consumer or a one-word statement

GRIDS

- A grid can be used for services as approved per funding requirements.
- Grids must be completed daily to reflect services provided

GRID REQUIREMENTS

- Name of Individual
- Service Record Number
- Medicaid ID Number (for all Medicaid eligible individuals)
- Full date the service was provided (month/day/year)
- Goal(s) being addressed
- A letter specified in the key to reflect the intervention/activity
- A number specified in the key to reflect the assessment of the consumer's progress toward goal(s)
- Duration
- Initials of the individual providing the service - must correspond to a full signature and initials on the signature log section of the grid.
- The grid shall provide space where additional information may be documented as needed

DOCUMENTATION

- Group Activity…

TIMEFRAMES

- Service notes and grids (as applicable) are written or dictated within 24 hours of the day that the service is provided
- Reimbursement: documentation must be properly documented within 7 work days that the staff member is on duty from date of service.

DOCUMENTATION TIMEFRAMES

- Late Entry Requirements
- Document entry as “Late Entry”
- Date documentation was made
- Date documentation should have been documented
- Past 24 working hours = Late Entry
- Example: “Late entry made on 4/15/11 for 4/12/11

BILLABLE VS. NON-BILLABLE – “LATE ENTRY”

- Late entries- **billable**; service note written or dictated within 7 work days

- **Non-billable**, service note or grid is written, dictated or revised after the 7 day timeframe has lapsed

SERVICE NOTE TIMELINE

Day 1 [DOS, or Closing DOS Period]	Day 2 [Within 24 hours of DOS, or Closing DOS Period]	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
Service Note Due	Service Note Due	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature	Late Entry; Dated Signature
May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct	May Revise or Correct **MAY NOT BILL**

COMMON ERRORS

- No staff signature or title
- Signature is not legible
- Missing required element(s)
- Does not relate to the goal/strategies
- Time billed does not justify staff interventions

REASONS TO COLLECT DATA

- Performance
- Individual’s response to the service
- Determine need for adjustments in the service
- Help assure proper care and treatment
- Prevent duplication of services
- Coordinate services.

DATA COLLECTION

Data collection must support goal and strategies

- **Example GOAL:** John will wash his hands with no assistance from staff over 10 consecutive sessions by 7/31/11.
- **DATA:** Reflect if assistance was given or not.
- **DATA ANALYSIS:** If documentation has 10 cons. sessions with no assistance, criteria is met

REFERENCES

- APSM 45-2 – Records Management and Documentation Manual
- PBH Provider Contract
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CONCERNS/GRIEVANCES

For concerns, requests, suggestions for better services or grievances contact: Anonymous concern line: 1-888-213-9687

LOCAL QM CONTACTS:

Jodi Meacham,Quality Monitoring Manager

Jodi.Meacham@pbhsolutions.org

Ron Aldridge, Quality Management Specialist

Ron.Aldridge@pbhsolutions.org

Joynettia Foster, Quality Management Specialist

Joynettia.Foster@pbhsolutions.org

Valerie Russell, Administrative Support Professional

Valerie.Russell@pbhsolutions.org

Contact Number: 336-513-4222

QUESTIONS