A New Direction…
Leading the Way!

MSDP Pilot Study
"Train the Trainer" Session

March 6, 2008

Welcome and Introductions

Quality Management Council

QMC Member	Affiliation
Rita Barrette	DMH
Bruce Bird	Vinfen
Chris Busby	Consumer Quality Initiatives, Inc.
Vic DiGravio, Facilitator	MHSACM
Lauren Falls	Network Health
Carol Flinn-Roberts	Wayside Youth & Family
John Frazier	MOAR
Jim Frutkin	ServiceNet
Ruth Harrigan	Advocates
Frank Holt	DPH/BSAS
Jill Lack	Neighborhood Health Plan
Lisa Lambert	Parent Professional Advocacy League

Quality Management Council (Cont'd)

QMC Member	Affiliation
Pat Lawrence	NAMI MA/Family Member/Advocate
Marsha Medalie	Riverside Community Care
Jackie Moore	North Suffolk Mental Health
Daniel Mumbauer	High Point Treatment Center
Divya Narayan	EOHHS
John Nestor	Amesbury Psychological Center
Kevin Norton	CAB Health & Recovery
Paul O'Shea	Health & Education Services, Inc.
Elizabeth Ross-Wong	BMC HealthNet Plan
Susan Schneider	Member of MOAR
Ronnie Springer	Bay Cove Human Services
Scott Taberner	MBHP
Kathy Wilson	Behavioral Health Network

Compliance Review Team

CRT Member	Affiliation
Paul Acford	Beacon Health
Grace Beason	Department of Mental Health
Madeline Becker	Vinfen
Judith Boardman	Health & Education Services, Inc.
Craig Gaudette	Advocates
Jim Haughey	Behavioral Health Network
Jane Eckert	MSPCC
Kathy Janssen, Facilitator	Riverside Community Care
Carol Kress	MBHP
Fran Markle	High Point Treatment Center
Marcy Morgenbesser	Network Health
Christine Paschal	Wayside Youth & Family
Michele Savage	Bay Cove Human Services
Michael Wagner	North Suffolk Mental Health

CFAAC Membership

CFAAC Member	Affiliation
Karl Ackerman	Transcom
Chris Busby	Consumer Quality Initiatives, Inc.
Deborah Delman	Transformation Center
Maryanne Frangules	MOAR Project Coordinator
John Frazier	MOAR
Phil Hadley	NAMI Massachusetts
Lisa Halpern	Vinfen
Pat Lawrence	NAMI MA/Family Member/Advocate
Susan Schneider, Facilitator	Member of MOAR
Judith Siggins	Learn to Cope

Standardized Documentation Team

1. Assessment Group	
Name	Affiliation
Sherry Davis, Lead	Bay Cove Human Services
Susan Abbott	Vinfen
Steve Chisholm	CAB Health & Recovery
Dave Selden SDT Co-Facilitator	North Suffolk Mental Health
Porter May	Advocates

Standardized Documentation Team

2. Individualized Action Plan Group	
Name	Affiliation
Stephanie Sladen, Lead	Health & Education Services
Rita Barrette	Department of Mental Health
Jan Feingold	High Point Treatment Center
Jordan Oshlag SDT Co-Facilitator	Community Healthlink
Michael Stuart	Spectrum Health Systems

Standardized Documentation Team

3. Progress Note Group	
Name	Affiliation
Nancy Carlucci, Lead	Network Health
Dallas Gulley	Riverside Community Care
Joe Passeneau	MBHP
Anne Priestley	Wayside Youth & Family

Learning Objectives

1. Explain the purpose and benefits of the MSDP statewide standardized clinical documentation processes.
2. Synthesize clinical information in a person-focused, recovery/resiliency oriented, culturally competent, service/action planning process, utilizing standardized documentation as a tool to efficiently provide a quality record of service provision.
3. Identify the use of MSDP documentation to provide a complete and thorough individual person focused clinical record that emphasizes an overall illustration of the person served past, present and current level of functioning based on an assessment of symptoms, behaviors, skills and abilities.
4. Incorporate principles of person-centered recovery/resiliency and best practice outcomes when employing treatment approaches while using standardized forms.

Learning Objectives (Cont'd)

5. Employ and link the continuum of integrated documentation, from Comprehensive Assessment to Service/Action Planning to Progress Notes, to improve the continuity and quality of care.
6. Contribute to an understanding of how an interdisciplinary team approach to service delivery can be facilitated by using MSDP standardized documentation to increase collaboration among providers and improve continuity of care.
7. Organize and prepare required clinical documentation that meets the critical requirement for establishing medical necessity and third party billing and reimbursement for service provided.
8. Provide resources to support participants returning to their local MH/SA programs to provide training for all direct care and support staff that will be involved in the MSDP Pilot Study.

Agenda Overview

Time	Topic Focus
9:00 a.m.	Welcome and Introductions
9:10 a.m.	Purpose of MSDP Standardized Documentation Initiative and Statewide Implementation (Mandate for e-health and Stakeholders involved in process)
9:20 a.m.	Short Term Challenge for Long Term Benefits in e-Health Initiative
9:35 a.m.	Overview of Pilot Timeline, Process, Training Manual and Technical Assistance
9:55 a.m.	Overview of Recovery Focus
10:15 a.m.	Overview of Medical Necessity Service Delivery and Documentation Linkage Requirements
10:30 a.m.	BREAK
10:40 a.m.	Assessment Processes:
12:15 p.m.	LUNCH
1:15 p.m.	Individualized Action Plan Processes
2:45 p.m.	BREAK
3:00 p.m.	Progress Note Processes
3:50 p.m.	Training Tips for Local Pilot Study
4:00 p.m.	The Quality Evaluation Process
4:15 p.m.	Next Steps for the Pilot Study
4:30 p.m.	Adjourn

Purpose of the MSDP Initiative

- Conceived as part of MHSACM e-Health Initiative
- Sub-committee process in Fall 2006 identified need to bring order/structure to how providers document care
- Essential interim step in transition from paper to electronic based records- “e-Health Readiness”

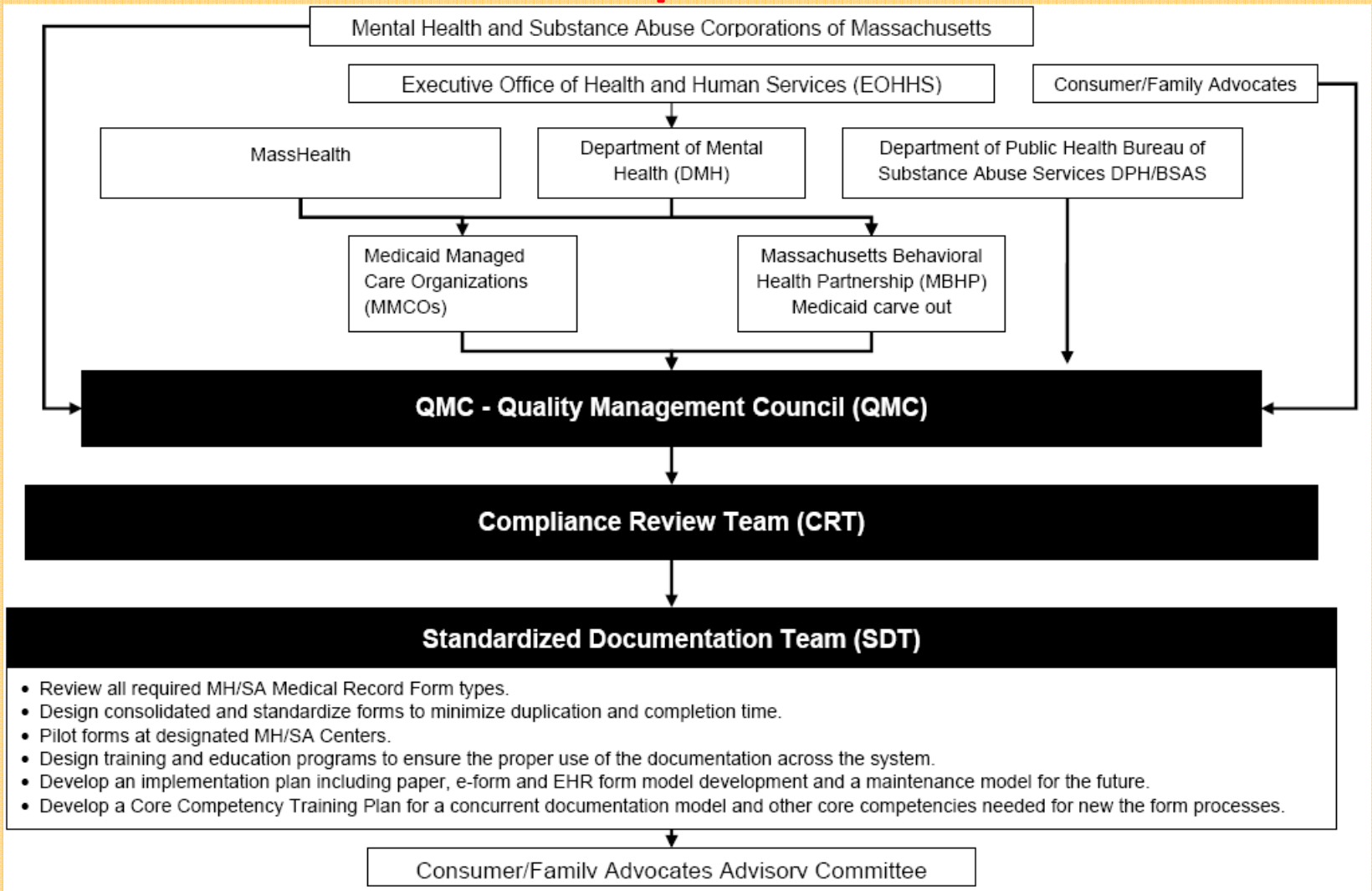
Goals of MSDP

- Develop standardized set of clinical forms that will lead to:
- Improved quality of patient care
- Increased compliance
- More efficient business practices

MSDP Initiative Stakeholders

- Mental Health and Substance Abuse Corporations of Massachusetts (MHSACM)
- Executive Office of Health and Human Services (EOHHS)
- Department of Mental Health (DMH)
- MassHealth
- Department of Public Health Bureau of Substance Abuse Services DPH/BSAS
- Massachusetts Behavioral Health Partnership (MBHP) Medicaid Carve Out
- Medicaid Managed Care Organizations (MMCOs):
  - BMC HealthNet,
  - Neighborhood Health Plan,
  - Fallon Community Health Plan
  - Network Health.
- Consumer/Families and Advocate Organizations:
  - National Alliance for the Mentally Ill of Massachusetts (NAMI)
  - The Consumer Quality Initiative (CQI)
  - Massachusetts Organization for Addiction Recovery (MOAR)
  - Massachusetts People/Patients Organized for Wellness, Empowerment and Rights (M-Power)

MSDP Initiative Operational Structure



Benefits of Participating

- ***Quality of Care Benefits***
  - ***Promotes consistent assessment, planning & service documentation***
  - ***Person-Centered and Strengths focus***
  - ***Recovery/Resiliency focus***
  - ***Promotes Information Sharing***
    - ***Promotes effective collaboration with other providers & shared terminology for use by different disciplines***
  - ***Less room for error; Decision support***

Benefits of Participating

- ***Business Benefits***
  - ***Compliant with Federal Mandate for Electronic Health Records by 2014 & a wide variety of regulatory and payer requirements***
    - ***Protection against federal audits***
  - ***Wide array of funders/payers support this initiative***
  - ***Enhances Measurement & Outcomes Focus***

Benefits of Participating

- ***Financial Benefits***
  - ***Free training and forms***
  - ***Compliant with a wide variety of regulatory and payer requirements***
    - ***Some protection against federal audits***
  - ***Saves time and money***
    - ***Reduces redundancy in collecting information***
    - ***Concurrent documentation possible***
  - ***Standardized revisions and updates in future***

Pilot Overview

- Pilot Timeline
- Process
- Training Manual
- Technical Assistance

Pilot Study Timeline

- **Pilot Study Program Staff Training:** Thursday, March 6, 2008

  Note: Program and Form Use Matrix with specific forms will be provided on a CD for each pilot program.
- **Pilot Study Dates:** Monday, March 17, 2008, through Friday, April 25, 2008 (Six-week pilot study)
- **Pilot Study Evaluation Dates:** Begins Tuesday, April 29, 2008 with participating programs submitting individual direct staff, form specific comments and recommendations (using marked up pilot forms) and a pilot evaluation summary
- **Pilot Study Evaluation Summary:** The evaluation materials will be organized into a presentable summary and provided to the SDT in May and QMC at its June meeting.
- **Final Documentation Processes:** The SDT will use the evaluation outcomes to design the final versions of each **documentation process/form to present to CRT and QMC for final review and approval in the summer 2008**

Access to Forms/Manuals

- Each participating Pilot Study Program will be provided all of the following files electronically on the MSDP Pilot Study CD:
  1. Pilot Study Training Manual
  2. Electronic Version of each MSDP Pilot Form type
  3. PDF Version of each MSDP Pilot Form Type
  4. MSDP Pilot Study Training PowerPoint Slides

Pilot Study Training Manual

- **Section 1: Simplifying and Standardizing the Mental Health/Substance Abuse Treatment Process. C**ontains background information about the MSDP effort, the forms development process, and the benefits MSDP documentation processes provide. Also, this section provides specific information regarding Medical Necessity, payer, signature and compliance requirements and a discussion of a person-centered Recovery/ Resiliency approach to services.
- **Section 2: Using the MSDP Assessment Group 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 MSDP Individualized Action Plan (IAP) Group Documentation Processes/Forms. T**his section provides a sample of each Action Plan Group 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 MSDP Progress Note Group 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.
- **Section 5: Appendix** This section contains supporting reference information.

Pilot Study Technical Assistance

- Technical assistance for the MSDP Pilot will be available via e-mail or telephone contact with Pilot Lead, Stephanie Sladen.
- Consultation with other SDT members will occur as needed to provide a thorough response to requests within 1 - 2 business days.
- Contact information:
  - e-mail - ssladen@hes-inc.org;
  - Telephone 978-921-1190, ext. 333;
  - Facsimile 978-927-3724.

The Consumer & Family Advocates Advisory Committee (CFAAC)

- **CFAAC members:**

  Susan Schneider, Christopher Busby,

  Deborah Delman….

- **Prepared for CFAAC by Marcia Webster, MA**

  Consultant to The Transformation Center - E-mail:
  exth64@yahoo.com

Why is Person-driven Documentation Necessary?

"Evidence based medicine is grounded in the concept of person-centeredness..." *

* *Hyde & Falls, et al, Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners…*

"Person-driven" Documentation

- **Background**
  *"[Patient-centered care is] respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions." **
- **What does "person-driven documentation" look like?**
  Clinical and rehabilitation documents are tools for increasing a person's sense of themselves as a whole and capable person 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.
- **Questions, Prompts, & a Process for completing forms should help to…** *Increasing the person's sense of themselves as a whole and capable person with a unique past, present and future.*

**Institute of Medicine, Envisioning the National Health Care Quality Report*

Example: Initial Screening & Assessment

***Caller:* Can you help me? I am going out of my mind!**

Person-driven

- *Screener:* Yes, I will do my best to help you. My name is Judy. What is your name? Can you tell me what happened?
- *I went to the store and I'm sure that someone followed me home…*
- *Thank you for telling me what you are dealing with. It sounds like you don't want to be alone now. What would help you feel at ease for the rest of the day?*
- *I do want to be alone! My cat is the only one that I can deal with right now.*
- *Ok, I think I understand a little better. I know of 2 programs that your insurance might pay for that would give you time alone with your cat every day. They could help you over the next few days more than I can. Would you like to hear about those services?*

Example: Initial Screening & Assessment

Caller: ***Can you help me? I am going out of my mind!***

Illness-driven

- *Screener: I can only help if you tell me what is wrong with you. What symptom are you experiencing?*
- *I guess I'm paranoid…*
- *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.*
- *But I don't want to go to the hospital! They follow me there, too.*
- *I understand, but I want you to be safe while they change your meds. Please wait while I call the insurance company.*

Concurrent Documentation

- Documents services at the time and place they are provided.
- Invites the person to direct the language and description of their own treatment.
- Depends on the provider's expertise and the form itself to keep documentation of medical necessity on track.
- Reduces stress for providers who are often chronically behind in documenting their work.

More about concurrent documentation in New Hampshire and Alabama in Chapter 4 of Ohio's SOQUIC "Implementation Support Manual"

http://www.mh.state.oh.us/cmtymh/soqic/publications/soqic.implementation.support.manual.pdf

"Recovery-oriented"

Quality care respects the nature of recovery; a holistic and often subtle process of personal change.

Key Dynamics of Recovery

- *Over time, most people are successful in their recovery from psychological trauma, disability and addiction.*
- *Recovery can be sustained only if it connects to the person's experience of power and wisdom.*
- *It is impossible to know the timing or path of recovery in some else's life.*
- *Professional expertise and systems can support or interfere. The personal nature of recovery, however, can not be changed.*

"Recovery-oriented" Documentation

What does "recovery-oriented documentation" look like? *It serves to increase the person's attention, awareness, understanding, ownership and/or responsibility for their own, culturally congruent, treatment and recovery. Illness-oriented documents overlook the benefits that the individual's power & wisdom brings to his or her treatment.*

Questions, Prompts, & a Process for completing forms should help to… Foster the person-driven assessment, planning and evaluation in terms of:

1) Strengths and Skills
2) Hope, Attributes, Desires
3) Connections, Supports, Resources

"Sustainable" Documentation

- ***Brings together concepts*** *from the chronic disease model of care and the fields of sustainable environmental and economic growth, organizational development, cultural diversity and adult learning.*

- ***Answers the question "what happened?"*** *rather than "what is wrong with this person?" Affirms the individual's power, control & human connections in the present & the future.*

- ***What does "sustainable documentation" look like?*** *Documents should rest on precise, human, person-first and future-oriented language, rather than on highly specialized words and concepts that are vague or emotionally charged.*

Key Elements of Sustainability

1. Takes a long-range perspective for planning and outcomes
2. Proactive in framing issues and offering supports
3. Shares knowledge across organizational, class and cultural divides
4. Collaborates widely to maximize diverse resources & strengths
5. Local expertise directs local improvements
6. Builds & connects community resources & capacity
7. Small scale organization for flexibility & familiarity
8. Reduces harm, protects, and values ALL people

"Action Plan Review" Example

Person: ***I can't do anything about my drinking, please stop asking about it.***

Sustainable

- Provider: It is difficult, I see you're discouraged. But I have no doubt that you can do whatever you decide. Being sober more often is one thing you wanted to do on your plan. Can we look at all of your goals together?
- Sure, if I have to.
- You know you don't have to. But I need to write an update on these forms. On your "go to work sober" goal, I can say you came here sober. What made you decide to do that?
- If I didn't show, you might get me in trouble with my psychiatrist. He'd stop my anxiety meds and tell my landlord I'm still a drunk. I am a loser, like my girlfriend said.
- Before we look at your goals, can we write up my goals and the steps I will take in my work with you? You'll know what I want to be able to say to people about you and why, and what I need to report to certain people and why.

"Action Plan Review" Example

Person: ***I can't do anything about my drinking, please stop asking 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?
- No, I just can't do it. I got so drunk last week and my girlfriend called me a loser, which I am.
- 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?
- Whatever you think. Does my psychiatrist know that I went drinking last week?

Yes, But What If?...

- The person does not have any goals they want to work on.
- We have to have a treatment plan to address the person's harmful/risky behaviors – but s/he won't agree to it.
- I see no strengths in this person.
- S/he will not participate in planning.

Of course!

People in recovery do not always express goals or make changes when and how providers believe they should.

The Provider's Plan

Providers write their own goals & objectives as they relate to the person. **Goals?**

1. *Role-model engagement and collaboration.*
2. *Increase the provider's positive and future orientation with the person.*
3. *Increase opportunities for mutual communication & understanding with the person and the people that are important to them.*
4. *Practice motivational interviewing skills to better help the person contemplate positive change.*
5. *Research ways to decrease risk.*

Result: A Transformed System

Uses Practices & Documentation Tools that

- Assume people can and do recover.
- Provide self-directed services & supports.
- Drives treatment with the goals & values of the person.
- Addresses safety issues in a collaborative relationship between the individual and the provider.
- Allows people to make, and grow from, their own mistakes.

Medical Necessity Documentation and Linkage

Presented by:

David Lloyd, President

M.T.M. Services and Consultants for the

National Council for Community Behavioral Healthcare

Medical Necessity Documentation Linkage

- Audit outcomes by the Office of Inspector General have provided excellent guidance regarding what is needed to demonstrate initial and on-going Medical Necessity
- Move to “tracer” model of review provides increased emphasis on quantitative and qualitative soundness versus just quantitative

OIG Audit Notification Letter for MHCs in Illinois - 12/05

At least one CMHP service, as provided by your facility during FFY 2003 (October 1, 2002, through September 30, 2003), was randomly selected for OIG review. The scope of our audit, as it applies to each selected service, will include, but is not limited to, a review of the following:

- Admission note,
- Mental health assessment or rehabilitation assessment, or related assessment documents,
- Individual treatment plan or rehabilitative services plan (we will generally require two individual plans: the plan authorizing the selected service and its immediate predecessor),
- Notes and other documentation directly relating to selected service,
- Provider certification applicable to the date of service and the location of service delivery, and
- Professional and educational credentials for staff involved with case documentation and the direct provision of selected services.

Five MSDP Documentation "Golden Thread" Linkage Processes

Five major linkage processes are built into the standardized MSDP form documentation system to support compliance with qualitative reviews.

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).

Purpose of Comprehensive Assessment in Medical Necessity Linkage Funding Requirements

- Crucial in determining the DSM or ICD diagnosis
- Assessment of symptoms, behaviors, and skills/abilities needs – all three areas within one assessment
- Documents support for assessed needs that will serve as the basis for identifying treatment recommendations
- Documents prioritize Treatment Recommendations/ Assessed Needs to serve as the basis for Goal(s)/Objectives, Ordered Therapeutic Interventions and Services in the IAP

Primary Purpose of CA in Medical Necessity Linkage Requirements

- The Comprehensive Assessment provides an opportunity for clinician to list the identified treatment recommendations/ assessed needs of the person (based on assessment of all three areas - symptoms, behaviors and skills/abilities needs) as evidenced by information gathered that supports each assessed need (i.e., Anger management as evidenced by anger at spouse, parents, boss and co-workers).

CA Treatment Recommendations/ Assessed Needs

Prioritized Assessed Needs as Evidenced by: A-Active, PR-Person Refused, D-Deferred, R-Referred Out (If deferred, please provide rationale)	A	PR*	D*	R
1.	☐	☐	☐	☐
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
Deferred Rationale(s):				

"Living" Comprehensive Assessment Tool

- While receiving services persons may experience other issues or have symptoms indicating an additional mental health and/or substance abuse need or concern that needs to be addressed through treatment

- Important to complete a CA Update form to make sure that new need is documented as an "assessed need" and incorporated into support for Goals/Objectives in the IAP

"Official Diagnosis" Location

- Official Diagnosis for the person is located ("Housed") in the CA or in subsequent CA Updates
- Need to reconcile in a CA Update a change in Diagnosis by Psychiatrist recorded in either a Psych Evaluation or a Psychopharmacology Progress Note

Individualized Action Plan and Medical Necessity Linkage Requirements

- Treatment Recommendations/Assessed Needs prioritized numerically (i.e., 1, 2, 3, etc.) in the initial Comprehensive Assessment (CA Update, Crisis Assessment & Plan and Psychiatric Evaluation) are linked to and become the core basis for each Goal in the Individualized Action Plan.
- The *linkage occurs* by entering the Treatment Recommendation number, form date and checking the specific form type adjacent to the specifically numbered Goal.

Goal #	**Linked to Assessed Need # _____ from form dated _____:** ☐CA ☐CA Update ☐ Psych Eval. ☐ Other:	
Start Date:	**Target Completion Date:**	
Desired Outcomes for this Assessed Need in Person's Words:		
State Goal Below in Collaboration with the Person Served (Reframe Desired Outcomes):		**Person Understands?** ☐ Yes ☐ No **Person Agrees?** ☐ Yes ☐ No **Person's Initials:**

Structured Progress Notes and Medical Necessity Linkage Requirements

- As the person served continues in treatment, he/she reveals/identifies additional personal information that enhances the original assessed information in the CA
- Progress Notes provide a critical linkage in the section entitled “New Issue(s) Presented Today”. This section accommodates the documenting of this new information and is illustrated below

Structured Progress Notes and Medical Necessity Linkage Requirements

This section provides two check box indicators - "*None Reported*" and "*CA Update Required*," that are to be used as follows:

1. If the client *does not* share any *new information/issues* at the session being documented, check "None Reported".
2. If the client *shares new information/issues* during the session that are assessed by the clinician to **not** constitute a continuing treatment need, record the information in this section of the Progress Note. CA Update is not required.

Structured Progress Notes and Medical Necessity Linkage Requirements

3. If the client shares an issue that can be resolved within the session of service, briefly identify the issue, indicated the interventions provided and the response in the appropriate sections of the Progress Note.
4. *If the client shares new information/issues* during the session 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:

CA Update Process

- **STEP 1**
  - Indicate on the **Progress Note** in the **"***New Issue(s) Presented***"** section**:**
  - Person has self-reported new information
  - Check the "*CA Update Required*" box
  - Note that the new information has been recorded on a CA Update and indicate the date

New Issue(s) Presented today: ☐ None Reported ☐ CA Update Required

CA Update Process

- **STEP 2**
  - Record information/issues provided by the client on the **CA Update** by checking the appropriate data element(s) from the initial Comprehensive Assessment (or an earlier CA Update) in the "*Comprehensive Assessment Sections*" and write the data element title and the information shared by the client in the "*Update Narrative*" section of the form.

Update Indicators Section of the CA Update Form

☐ Annual Update ☐ Re-Admission ☐ Interim Update of New Information	**Date of Most Recent Assessment:**

Child/Adolescent Comprehensive Assessment Sections

Check the box(es) next to the section(s) of the assessment which you are updating. Be sure to label all additional/updated information in your narrative with the heading of the section of the Assessment being updated

☐ Presenting Concerns	☐ Medication Information
☐ Living Situation	☐ Physical Health
☐ Family and Social Support History	☐ Trauma History
☐ Family/Environment Relationships	☐ Mental Status Summary
☐ Sibling/Child (Person served) Relationships	☐ Legal Status and History
☐ Pertinent Developmental Issues	☐ Assessed Needs Checklist Including Functional Domains
☐ School Functioning	☐ Person's Served Strengths/Capabilities/Resiliency
☐ Employment	☐ Person's Served/Family/Guardian Expression of Service Preferences
☐ Substance Use/Addictive Behavior History	☐ Clinical Interpretative Summary
☐ Treatment History	☐ ASAM Dimensions
☐ Other:	

Update Narrative: List each assessment section being updated with narrative explanation below it.

Using CA Update

- CA Update documents a change in Diagnosis
- CA Update should be placed in date order on top of the CA in the chart to provide the appropriate linkage to new services if information provided indicates new services are needed
- Provides an ongoing cumulative history of assessed needs of the person served

CA Update Process Linked to Treatment Recommendations

- "Update Narrative" summary of the new information/ issues identified by the person served provides support for:
  - Change in diagnosis (if needed); and
  - Identifying new Treatment Recommendations/ Assessed Needs (Next Slide) based on this information.

Using CA Update Diagnostic Section

SECTION II – This section must be completed by a licensed clinician

Diagnosis: ☐ No Change ☐ Change indicated below ☐ DSM Codes (or successors) ☐ ICD Codes (or successors)

Check Primary	Axis	Code	Narrative Description
	Axis I		
	Axis II		
	Axis III		
	Axis IV		
	Axis X	Current GAF:	Highest GAF in Past Year (if known):

Using CA Update Treatment Recommendations Section

Treatment Recommendations/ Assessed Needs (☐ No Additional Recommendations Clinically Indicated)
1.
2.
3.
4.

CA Update Process Linked to Treatment Recommendations

- **STEP 3:**
  - If the Treatment Recommendations/Assessed Needs are adequately addressed by the Treatment Recommendations/ Assessed Needs as identified in the original Diagnostic Assessment or earlier CA Updates, then check the box for "***No Additional Recommendations Clinically Indicated***" in the Treatment Recommendations section of the CA Update
  - Determine if existing Goal(s) and Objective(s) address the newly identified recommendations/needs.
  - If **yes**, use the Progress Note to identify the appropriate Goal and Objective and provide the interventions ordered.
  - If **no**, **Step Four** applies.

CA Update Process Linked to IAP Revision

- **STEP 4:**
  - If existing Goals, Objectives, Interventions, Services, frequency and provider types will **NOT** meet the client's newly identified Treatment Recommendations/Assessed Needs, then link the newly assessed needs from the CA Update to an IAP Revision by checking the indicator in the "*Change In IAP Required*" field in the *For Annual or Interim Updates* section of the CA Update.

For Annual or Interim Updates
Change In IAP Required: ☐ No ☐ 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)

IAP Review/Revision Process Linked to Medical Necessity-Based Reimbursement

- **STEP 5:**
  - If the newly identified information documented in the CA Update requires a change in the IAP, use the IAP Review/Revision form to update/modify the existing IAP which will preserve the linkage between newly assessed needs and any new therapeutic interventions.

Important Note:

If intervention provided is not linkable to a specific Goal/ Objective in a Individualized Service Plan (or IAP Review/ Revision), it is not adequately ordered and therefore, not reimbursable.

Link to Medical Necessity Based Reimbursement Summary

- Progress Notes provide an opportunity for specific linkages between the therapeutic interventions provided in the service visit/session to the IAP and/or IAP Review/Revision by *requiring that the specific Goal(s) and Objective(s)* being addressed in the service *be clearly identified within the note*.

Goal(s) Addressed as Per Individualized Action Plan:				
☐ Goal 1 ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal 2 ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal 3 ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal ___ ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal ___ ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___

Break

- Pilot Training will resume at 10:40 a.m.

Personal Information

- Must be completed at the time of initial contact with the person who is seeking services.
- Captures essential demographic, contact and insurance/billing information.
- This form can be completed by support staff or clinical staff.

Adult Comprehensive Assessment

- Complete after the Personal Information form, as the person enters services, in compliance with agency policies and funding requirements.
- The Adult Comprehensive Assessment provides a standard format to assess mental health, substance use and functional needs of persons served. This Assessment provides a summary of assessed needs that serve as the basis of Goals and Objectives in the Individualized Action Plan.
- A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.

Adult CA Sections of Particular Note…

Assessed Needs Checklist Including Functional Domains			
✓	Check All Current Problem Areas	As Evidenced By:	Person Served Desires Change Now?:
	Activities of Daily Living		
☐	Employment:		
☐	Education:		
☐	Housing Stability:		
☐	Housekeeping		
☐	Grocery Shopping		
☐	Food Preparation		
☐	Money Management:		
☐	Clothing		
☐	Laundry		
☐	Personal Care Skills:		
☐	Grooming		
☐	Dress		
☐	Exercise		
☐	Transportation		
☐	Problem Solving Skills:		
☐	Time Management:		
	Addictive Behaviors		
☐	Substance Use/Addiction:		
☐	Other Addictive Behaviors:		

Behavior Management	
☐	Anger/Aggression:
☐	Antisocial Behaviors:
☐	Impulsivity:
☐	Lack of Assertiveness:
☐	Legal Problems:
☐	Oppositional Behaviors:

✓	Check All Current Problem Areas	As Evidenced By:	Person Served Desires Change Now?:
	Family and Social Support		
☐	Communication Skills:		☐ Yes ☐ No
☐	Community Integration:		☐ Yes ☐ No
☐	Dependency Issues:		☐ Yes ☐ No
☐	Family Education: (Family education must be directed to the exclusive well being of the person served)		☐ Yes ☐ No
☐	Family Relationships:		☐ Yes ☐ No
☐	Peer Support:		☐ Yes ☐ No
☐	Personal Support Network:		☐ Yes ☐ No
☐	Recreation/Leisure Skills:		☐ Yes ☐ No
☐	Social/Interpersonal Skills:		☐ Yes ☐ No
	Mental Health/Illness Management		
☐	Anxiety:		☐ Yes ☐ No
☐	Coping/ Symptom Management Skills:		☐ Yes ☐ No
☐	Cognitive Problems:		☐ Yes ☐ No
☐	Compulsive Behavior:		☐ Yes ☐ No
☐	Depression/Sadness:		☐ Yes ☐ No
☐	Dissociation:		☐ Yes ☐ No
☐	Disturbed Reality (Psychosis):		☐ Yes ☐ No

Adult CA Sections of Particular Note…

Prioritized Assessed Needs as Evidenced by: A-Active, PR-Person Refused, D-Deferred, R-Referred Out (If deferred, please provide rationale)	A	PR*	D*	R
1.	☐	☐	☐	☐
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
Deferred Rationale(s):				

Adult CA Update

- This form saves time and effort.
- Used to update information in Comprehensive Assessment.
- Use whenever substantial change in person's status occurs.
- A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.

Adult CA Update

☐ Annual Update ☐ Re-Admission ☐ Interim Update of New Information	**Date of Most Recent Comprehensive Assessment:**

Adult Comprehensive Assessment Sections

Check the box(es) next to the section(s) of the assessment, which you are updating. Be sure to label all additional/updated information in your narrative with the heading of the section of the Assessment being updated

☐ Presenting Concerns	☐ Addictive Behavior History
☐ Living Situation	☐ Addictive Behavior Treatment History
☐ Family and Social Support History	☐ Legal Status and History
☐ Education	☐ Trauma History
☐ Employment	☐ Mental Status Summary
☐ Military Service	☐ Assessed Needs Checklist
☐ Mental Health Treatment History	☐ Strengths/Capabilities/Resiliency
☐ Current Medications	☐ Service Preferences
☐ Past Medications	☐ ASAM Dimensions
☐ Health Summary	☐ Other:

Update Narrative: List each assessment section being updated with narrative explanation below it.

Adult CA Update

Treatment Recommendations/ Assessed Needs (☐ No Additional Recommendations Clinically Indicated)
1.
2.
3.
4.

Child/Adolescent Comprehensive Assessment

- Complete after the Personal Information form, as the person enters services, in compliance with agency policies and funding requirements.
- The Child/Adolescent Comprehensive Assessment provides a standard format to assess mental health, substance use and functional needs of persons served. This Assessment provides a summary of assessed needs that serve as the basis of Goals and Objectives in the Individualized Action Plan.
- A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.

Child/Adolescent CA Update

- This form saves time and effort.
- Used to update information in Comprehensive Assessment.
- Use whenever substantial change in person's status occurs.
- A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.

Mental Status Exam

- Use anytime to assess symptoms and behaviors.
- This is a data gathering tool, with multiple uses, to assess current symptoms and behaviors. This is a component of the comprehensive assessment, or is completed as part of a risk assessment. Also it is provided as a stand-alone document.
- A licensed practitioner as determined by agency policy must complete this form after interviewing the person served, face to face.

Mental Status Exam

- Focus on changing commonly used "clinical" language to less clinical, more "person-friendly" language.
- Examples of old vs. new language:
  - Anhedonia → Inability to perceive pleasure
  - Homicidal ideation → Aggressive thoughts
  - Attitude → Demeanor
  - Compliant → Cooperative
  - Lack of insight → Difficulty acknowledging presence of psychological problems

Risk Assessment

- Used to assess risk of harm to self or others as part of a comprehensive assessment or when assessing a person in crisis.
- Gathers data on relevant risk issues and severity.
- Completed by a masters level clinician or a paraprofessional, under the supervision of a licensed clinician; or a licensed clinician.

Initial Psychiatric Evaluation

- Complete after the Personal Information form, as the person enters services, in compliance with agency policies and funding requirements.
- Used to assess the bio-psychosocial health and service needs of the person served. Components of this evaluation are included in the comprehensive assessments. Also it is provided as a stand-alone document.
- This form is to be completed by a psychiatrist, CNS or other APN with credential in psychiatry and prescribing privileges.

Initial Psychiatric Evaluation

Substance Use / Addictive Behavior History:
NOTE: I have reviewed the Substance Use / Addictive Behavior History in the Comprehensive Assessment of _____ (date) with the person and: ☐ No additional history to be added, **OR** ☐ Additional history indicated below:

Substance/Alcohol/Tobacco/Gambling/Other	Age of First Use	Date of Last Use	Frequency	Amount	Method

Toxicology Screen Completed:
☐ **No** ☐ **Yes – If Yes, Results:**

Treatment History
NOTE:I have reviewed the Treatment History in the Comprehensive Assessment of _____ (date) with the person and:
☐ **No additional history to be added,** OR ☐ **Additional history indicated below:**

Type of Service:	MH / SU	Name of Provider/Agency:	Dates of Service:	Completed?
	☐ MH ☐ SU			☐Yes ☐No
	☐ MH ☐ SU			☐Yes ☐No
	☐ MH ☐ SU			☐Yes ☐No
	☐ MH ☐ SU			☐Yes ☐No
	☐ MH ☐ SU			☐Yes ☐No

Tobacco Assessment

- Required for some DPH licensed programs; completed in concert with the comprehensive assessments.
- Optional for other programs following agency policies.
- Assesses current and past tobacco use and readiness to change.
- Completed by staff following agency policy.

HIV Risk Assessment

- Required for some DPH licensed programs; completed in concert with the comprehensive assessments.
- Optional for other programs following agency policies.
- Assesses current and past risk behaviors as well as willingness for testing and treatment.
- Completed by staff following agency policy.

Physical Health Assessment

- Required for JCAHO certified programs and some DPH services; completed in concert with the comprehensive assessments.
- Optional for other programs following agency policies.
- Assess current and past medical issues of the person served that may impact current functioning.
- To be completed by qualified Medical Professional.

Questions for the Assessment Sub-Group

Lunch Break

- Pilot Training will resume at 1:15 p.m.

Individualized Action Plan (IAP)

- To promote principles of recovery, this form serves as what most of us have known as a treatment plan. The name, “Individualized Action Plan” reflects the recovery concept of shared decision making.
- Used to document goals, objectives, and therapeutic interventions.

Individualized Action Plan (IAP)

- Links to needs identified during the assessment phase or ongoing treatment.

Goal #	Linked to Assessed Need # _____ from form dated _____: ☐CA ☐CA Update ☐ Psych Eval. ☐ Other:
Start Date:	Target Completion Date:

Individualized Action Plan (IAP)

- Serves as a tool to collaboratively build a treatment plan, which reflects both medical necessity and the desired outcomes of the person served in his or her own words.

Desired Outcomes for this Assessed Need in Person's Words:	
State Goal Below in Collaboration with the Person Served (Reframe Desired Outcomes):	Person Understands? ☐ Yes ☐ No Person Agrees? ☐ Yes ☐ No Person's Initials:

Massachusetts Standardized Documentation Project

Goal #	Linked to Assessed Need # _____ from form dated _____: ☐CA ☐CA Update ☐ Psych Eval. ☐ Other:
Start Date:	Target Completion Date:
Desired Outcomes for this Assessed Need in Person's Words:	
State Goal Below in Collaboration with the Person Served (Reframe Desired Outcomes):	Person Understands? ☐ Yes ☐ No Person Agrees? ☐ Yes ☐ No Person's Initials:
Person's Strengths and Skills and How They Will be Used to Meet This Goal:	
Supports and Resources Needed to Meet This Goal:	
Potential Barriers to Meeting This Goal:	

GOAL # ____	OBJECTIVE # ____:	Start Date:
Person Served Will:		Duration:
Parent/Guardian/Community/Other Will: (☐ Not Clinically Indicated)		

Therapeutic Intervention(s)/ Method(s)	Service Description/ Modality	Frequency	Responsible: (Type of Provider)

Individualized Action Plan (IAP)

- The design encourages collaboration among programs and across agencies.

Other Agencies/Community Supports and Resources Supporting Individualized Action Plan: ☐ None Reported			
Agency Name:	**Contact and Title**	**Services Currently Provided**	**Release Signed**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Individualized Action Plan (IAP)

- Also supporting a recovery focus, transition/discharge planning is advised from the earliest point in treatment possible. The section provided on the form assists in this process.

Transition/Level of Care Change/Discharge Plan	Anticipated Date:
Criteria - *How will the provider/person served/parent/guardian know that level of care change is warranted?* (check all that apply): ☐ Reduction in symptoms as evidenced by: ☐ Attainment of higher level of functioning as evidenced by: ☐ Services are no longer medically necessary as evidenced by: ☐ Other:	

IAP Review/Revision

- The Individualized Action Plan Review/Revision form has been created to document information from ongoing review(s), revision(s) of treatment goals and objectives and/or periodic rewrites. This form has been designed to minimize duplication of effort in creating subsequent action plans and maximize the documentation of information, which demonstrates evidence and/or rationale for revision.

Review/Revision Date:	Individualized Action Plan Date:	Reviewed by (Name, Title, Program):

☐ Review/Revision:	☐30 day ☐60 day ☐90 day ☐180 Days ☐Other (specify):	**Complete pages 1 and 2 of Individualized Action Plan Review/Revision form and attach as many Goal/Objective sheets as necessary.**
☐ Rewrite:	☐ Annual ☐ Other (specify):	**Use page 1 of Individualized Action Plan Review/Revision and attach new Individualized Action Plan.**

Goal & Objective Status *(Active / New / Discontinued / Completed / Revised)*	**Evidence of Progress, Barriers, and/or Rationale for Addition of New Goal/Discontinuation of Goal, Revision or Rewrite:**
☐ **Goal: ___** ☐A ☐N ☐D ☐C ☐R ☐ Obj. 1 ☐A ☐N ☐D ☐C ☐R ☐ Obj. 2 ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R	**Refer to Progress Note(s) of (Date):** (☐ Not Applicable)
☐ **Goal: ___** ☐A ☐N ☐D ☐C ☐R ☐ Obj. 1 ☐A ☐N ☐D ☐C ☐R ☐ Obj. 2 ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R ☐ Obj. ___ ☐A ☐N ☐D ☐C ☐R	**Refer to Progress Note(s) of (Date):** (☐ Not Applicable)

IAP Review/Revision

- ✓ Use the IAP Review/Revision form to update or modify the IAP in any of the following ways:
  - Revisions – to add a new goal; change goals, objectives or interventions; or change the frequency or duration of services;
  - Reviews - to record the progress of the person served and
  - Rewrites - annually, after three interim revisions, or per agency protocol, a “rewrite” of the actual IAP is warranted. This will facilitate the identification and tracking of treatment goals/objectives and progress made.

IAP Review/Revision

- Use both pages of the IAP Review/Revision form for either a Review or Revision; Additional goal and/or objective sheets should be added as necessary. If you are adding a new goal or objective, attach the goal and/or objective page(s) from the IAP form to the IAP Review/Revision form.
- When a Rewrite is being completed, page 1 of the IAP Review/Revision should be used and the new IAP should be attached.
- If a goal/objective is new and not currently supported by the most recent Comprehensive Assessment, it is important to also complete a Comprehensive Assessment Update form.

Psychopharmacology Plan

- Used for persons receiving outpatient psychopharmacology services only.
- Designed for ease of use and to capture all required information succinctly and accurately.

Detox Plan

- Used for persons receiving inpatient detoxification treatment.
- Modeled after the standard Individualized Action Plan and reflective of the ASAM dimensions of treatment.
- Reflects and supports the short-term nature of this treatment modality.

Multi-Disciplinary Team Review/Response

- As required, use this form to document the review of Individualized Action Plans and other necessary clinical documentation by a multi-disciplinary team.
- This form is designed to be used as a tool to provide feedback regarding required actions by the primary provider.

Transfer/Discharge Summary and Plan

- Use at the time of transition or discharge, including any movement throughout the continuum of care both internal and external.
- Summarize treatment, reasons for transition/discharge, and plans for referral to assist the person in following through on aftercare recommendations.

Questions for the IAP Sub-Group

Break

- Pilot Training will resume at 3:00 p.m.

Types of Progress Notes

1. Consultation Collateral
2. Group Psychotherapy
3. Health Care Provider Orders
4. Intensive Services
5. Monthly
6. Nursing (long & short versions)
7. Outreach
8. Psychopharmacology
9. Psychopharmacology-Psychotherapy
10. Psychotherapy
11. Shift/Daily Services
12. Weekly

Progress Notes – Key Points

Main content of all notes include:

- Description of **interventions provided**
- **Client's response** to therapeutic interventions, progress and functioning
- Therapeutic **interventions are linked** to specific goals in IAP

*This linkage helps person **attain identified goals***

Progress Notes Standard Components

Therapeutic Interventions *and* Person's Response to interventions

Therapeutic Intervention(s) Delivered in Session:
Person's Response to Intervention and/or Progress Toward Goals and Objectives Today:

Progress Notes Standard Components

- Linkage to specific Goal(s)/Objective(s) in IAP:
  - Group Progress Note:

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan:				
☐ Goal 1 ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal 2 ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal 3 ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal ___ ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective ___	☐ Goal ___ ☐ Objective 1 ☐ Objective 2 ☐ Objective 3 ☐ Objective___

  - Monthly Progress Note:

Goal & Objective Status / Progress *(New / Discontinued / Met / Not Met)*	**Narrative**
☐ **Goal:** ___ ☐N ☐D ☐M ☐NM ☐ Obj. 1 ☐N ☐D ☐M ☐NM ☐ Obj. 2 ☐N ☐D ☐M ☐NM ☐ Obj. 3 ☐N ☐D ☐M ☐NM ☐ Obj. ___ ☐N ☐D ☐M ☐NM	**Summarize the interventions and specify measurable data that demonstrates the person's progress towards his/her goals this month**:

  - Nursing Progress Note:

Goal(s)/Objective(s) Addressed from IAP:

Progress Notes Standard Components

- New Issues Presented Today and CA Update:

New Issue(s) Presented today: ☐ None Reported ☐ CA Update Required

Progress Notes Standard Components

- When a New Issue is Presented There Are Four Options:
  1. If no new issue reported – check "None Reported"
  2. If the new issue can be resolved during the session – document the issue, note the resolution in the "Person's Response Section" of the progress note.
  3. If the issue has been previously assessed and is part of the Goals and Objectives, document the progress or lack of progress achieved in the "Person's Response Section."

When a New Issue is Presented

4. If any new issue(s) represent a therapeutic need not already assessed as a need and addressed in the IAP:
   - **Check "CA Update Required"**
   - **Document that the new issue has been recorded on a Comprehensive Assessment Update of the same date**
   - **Write detailed narrative on the appropriate CA Update as instructed in the manual.**
   - **The newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service additionally requiring use of the IAP Review/Revision form**

Progress Notes Standard Components

- Medicare "Incident to" Services: Below are the MSDP forms that contain the Medicare "Incident to" checkbox:
  1. Group Psychotherapy Progress Note
  2. Psychotherapy Progress Note
  3. Intensive Services Progress Note
  4. Nursing Progress Notes

Standard *Medicare "Incident to" Services Only* box:

❑ Medicare "Incident To"	**Name and credentials of Medicare Provider on Site:**

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.

Progress Notes Standard Components

- Billing Strip Instructions in MSDP Manual Section One Page 58:

Standard Billing Strip Sample:

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided
Provider Number	Specify the individual staff member's "provider number" 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.

Consultation/Collateral Contact

- Used for billable or non-billable face-to-face or telephonic consultation or collateral contacts.
- Identifies next action step and responsible party.

Service *(check ONE service only)*	**Purpose** *(check purpose(s) for the indicated service)*
☐ **Case Consultation** ☐ **Family Consultation** ☐ **Collateral Contact**	☐ Assessment of the appropriateness of current treatment ☐ Treatment coordination/planning ☐ Termination/Aftercare planning ☐ Clinical consultation/Second opinion (*not* supervision) ☐ Supporting treatment objectives for the person's served care ☐ Other:

Actions that will occur as a result of this contact:	**Responsible Party:**
1. 2. 3. 4.	1. 2. 3. 4.

Group Psychotherapy

- Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact.
- Used for outpatient group psychotherapy.

DOCUMENTATION OF PERSON'S SERVED PARTICIPATION AND RESPONSE TO GROUP TREATMENT

Behavior in Group:

- ☐ Showed insight
- ☐ Showed interest
- ☐ Active in discussion
- ☐ Non-verbal but engaged
- ☐ Showed leadership
- ☐ Offered constructive input
- ☐ Supportive to others
- ☐ Withdrawn
- ☐ Disruptive
- ☐ No apparent interest
- ☐ Appeared distracted
- ☐ Not supportive to others

Person's Served Mood: ☐ Stable ☐ Depressed/Sad ☐ Anxious ☐ Angry ☐ Hopeful ☐ Other:

Healthcare Provider Orders

- Use when a person is either living in a DMH-funded program or is receiving DMH-funded Supported Housing Services.
- Serves as ongoing communication tool amongst providers.
- Can be used in outpatient behavioral health settings as the progress note for a medication visit.
- Ensures thorough and current medication list.

MEDICATION ADMINISTRATION (Check one of the three listed below):

☐ **1—Not Capable of Self-Medicating At This Time**

☐ **2. Self Medication Training Plan**
- ☐ May Pour But Cannot Hold Medications Under Staff Supervision
- ☐ Able To Package and Self-Medicate for: ☐ 1 dose ☐ 1 day ☐ 3 days ☐ 5 days ☐ 7 days ☐ 14 days
- ☐ Other:

☐ **3—Capable of Fully Self-Medicating**

Understands that he/she is responsible for storing medications and taking all medications as ordered.
Understands the dosage, purpose and common side-effects of all medications prescribed.
Understands what might occur if he/she does not take medications as prescribed.

Intensive Services

- Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact.
- Use for all individual and group services as part of CBAT, ICBAT, PHP, IOP, SOAP, and DDART.
- Incorporates all therapeutic services specifically provided by the program during the course of the day.

Type of Service: ☐ Group Name: Medicare Only: ☐ 915 ☐ 942 ☐ 904 **No in Group:**	☐ Individual intervention / Medicare Only: ☐ 914	**Start Time:** **Stop Time:**

Daily Clinical Summary:
Functioning - Observed or Reported (may include mood, affect, behavior, cognitive functioning, etc.):
Stressors/Extraordinary Events: ☐ None Reported
New Issue(s) Presented Today/ Plan /Additional Information (if applicable): ☐ None Reported ☐ CA Update Required

Monthly

- Used for services requiring monthly documentation.
- Required for Residential Services (DMH)
- Summarizes progress made by the individual toward the IAP goals and significant changes in the person's environment over the course of the month.

Goal & Objective Status / Progress *(New / Discontinued / Met / Not Met)*	**Narrative**
☐ **Goal:** ___ ☐N ☐D ☐M ☐NM ☐ Obj. 1 ☐N ☐D ☐M ☐NM ☐ Obj. 2 ☐N ☐D ☐M ☐NM ☐ Obj. 3 ☐N ☐D ☐M ☐NM ☐ Obj. ___ ☐N ☐D ☐M ☐NM	**Summarize the interventions and specify measurable data that demonstrates the person's progress towards his/her goals this month:**

Nursing (Long or Short)

- Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact.
- To be completed by a LPN, RN, BSN, or MSN.
- Use either long or short version depending on amount of space needed.
- Can be used as a shift note by a nurse in any Detox, SOAP, or DDART program.

Nursing (Long or Short)

- Nursing Progress Note Short:

Measurements: If appropriate, please complete the following pertinent information: ☐ Not Pertinent		
Vital Signs:	**Height/Weight/BMI:**	**AIMS findings:**

Issues to be Referred to Physician/APRN:

- Nursing Progress Note Long:

Relative Changes in Person's Condition: (For face-to-face visit)	☐ **No significant change from last visit**	**If Notable, Comment:**
	Mood/Affect: ☐ Notable	
	Thought Process/Orientation: ☐ Notable	
	Behavior/Functioning: ☐ Notable	
	Danger To: ☐ None ☐ Self ☐ Others ☐ Property	☐ Ideation ☐ Plan ☐ Intent ☐ Attempt ☐ Other:

Outreach Services

- Used in home visit community support interactions with the person and family receiving services.
- Required for CRS, CSP, FST, Flex Support Programs, and PACT.

Type of Service(s)	☐ Assessment of Needs ☐ Crisis Management	☐ Monitoring ☐ Advocacy	☐ Eliminating Barriers ☐ Education/Training	☐ Coordinating/Linkages ☐ Empowerment/Skills Building

Psychopharmacology

- Used by psychiatrists and/or Advanced Practiced Registered Nurses/Clinical Nurse Specialists when a person is seen only for outpatient medication management or as part of a more intensive (bundled) service such as when meeting with a person receiving services in a Partial Hospital Program.

Psychopharmacology

Prescriber's Evaluation
Takes meds as prescribed: ☐ yes ☐ no ☐ n/a ☐ Detail
Side effects: ☐ yes ☐ no ☐ n/a Detail:
Allergic Reactions: ☐ yes ☐ no ☐ n/a Detail:
Changes in Medical Status: ☐ yes ☐ no ☐ n/a Detail:
Other meds: ☐ Over the counter ☐ herbal ☐ none ☐ other Detail:
Mental Status Exam including significant changes *(If risk issues are present, document the actions taken)*:

Baseline Lab Tests Ordered ☐ yes ☐ no **Labs Reviewed** ☐ yes ☐ no
If Labs not received, describe action to be taken:

AIMS findings (if applicable):
Weight/height or BMI (if applicable): **Blood Pressure/VS's** (if applicable):
PCP Contacted? ☐ yes ☐ no

Diagnosis: ☐ No change ☐ Yes, CA Updated Required

Psychopharmacology/Psychotherapy

- Used by psychiatrists and/or Advanced Practiced Registered Nurses/Clinical Nurse Specialists when that individual is the provider of both the medication management and psychotherapy services.

Therapeutic Interventions Delivered in Session:
Person's Served Response to Intervention and/or Progress Toward Goals and Objectives Today:

Psychotherapy

- Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact.
- Use for outpatient individual, couple, or family psychotherapy.

Risk Assessment

Danger To: ☐ None **OR** Check all that apply below and record action taken in Therapeutic Interventions section below

☐ **Self**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt / ☐ **Others**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

☐ **Property**: ☐ Ideation ☐ Plan ☐ Intent ☐ Attempt

Shift/Daily

- Required for Child Day Services, Crisis Stabilization Unit (CSU), Detox Level III, Intensive Residential Treatment Program (IRTP), and Respite.

Type of Program:

☐ CSU/ Respite Bed ☐ DMH Funded Supervised Living Program ☐ Detox ☐ Other:
☐ Overnight Substance Use Program ☐ Overnight Child/Adolescent Program

☐ **Shift Note:** ☐ 1st Shift (Day) ☐ 2nd Shift ☐ 3rd Shift (Night) ☐ **Daily Note**

Weekly

- Used to document therapeutic interventions over the course of a week and the person's response to the interventions.
- Summarizes services/interventions and the person's responses/progress.
- Required for Psychiatric Day Treatment and Transitional Support Services (TSS).

Services Provided	☐ Peer Support ☐ Skills Group ☐ Group Therapy ☐ Activity Therapy ☐ Individual Session ☐ Other:	**Monday Date:**	**Tuesday Date:**	**Wednesday Date:**	**Thursday Date:**	**Friday Date:**	**Saturday Date:**	**Sunday Date:**
		No. Hrs:	**No. Hrs:**	**No. Hrs:**	**No. Hrs:**	**No. Hrs:**	**No. Hrs:**	**No. Hrs:**

Questions for the Progress Note Sub-Group

Pilot Study Support Needed

- **Leadership**:
  - Designate a leader for the organization
  - Empower the leader
- **Organizational Support**:
  - Ensure ongoing support from all levels of management
    - Keep everyone informed
    - Clarify and educate
    - Address issues as they arise
- **Consider Your Audience:**
  - Early adopters
  - Followers
  - Resisters

Dealing with Loss

- Many participants will be perceiving this process as a loss of the old way of working (which it is)
- Keep in mind the stages people go through with this process:
  1. Denial
  2. Negotiation
  3. Anger
  4. Drop Out
  5. Acceptance of the need to change

The Stages of Change

- **Consider how to move someone from one stage to the next…**
- **Pre-contemplation**
  - Establish rapport, ask permission and build trust
  - Raise doubts or concerns in the staff member about current methods of work
- **Contemplation**
  - Normalize ambivalence
  - Help the staff member "tip the decisional balance scales" toward change
- **Determination / Preparation**
  - Clarify the staff member's own goals and strategies for change
  - Offer a menu of options for change and supervisory support
- **Action**
  - Engage the staff member in the change process and reinforce the importance of continuing to work toward the desired change
  - Support a realistic view of change through small steps
- **etc**

Training Tips

1. Do not treat the Comprehensive Assessment as a sequenced interview that has to follow the instrument line by line. It is to serve as a document of findings resulting from an interview. Clinicians are free to approach the gathering of information in a manner that is a "good fit" for the client/family and the clinician.
2. The **Comprehensive Assessment** has two versions, one for adults and one for children/adolescents.
3. ***All elements are required to have a notation*** even if it is to document "None Reported" or "Not Clinically Appropriate". This will give the impression to reviewers that the element has not been ignored.
4. Try to capture as much information on the form prior to the arrival of the person served. This will permit more face-to-face interaction between the person served and the clinician and possibly contribute to an enhanced relationship and session.

Training Tips

5. Please try not to get frustrated and remember that these MSDP documents are a work in process. Your input is vital. The documents are the result of a statewide initiative of stakeholders. We have attempted to incorporate the standards included in our directives; however some things may have been omitted. We will need your feedback when you identify an omission.
6. Other forms already in existence with agencies documenting client rights, mental status exams, lethality assessments and registration are not part of the MSDP initiative. A sample Personal Information Sheet, Risk Assessment and Mental Status Assessment are being provided as samples for your review and possible use, if your agency does not have locally produced versions of these forms.

Remember…

- This is a **PILOT STUDY**
- We expect:
  - Problems
  - Difficulties
  - Mistakes
- We do not expect to quit..

Evaluation Levels and Tools

- Program Level Evaluations
  - To be completed after local pilot trainings
  - Assessment of Local Program Pilot Training and "Kickoff"
    - Evaluate quality of today's training and supports received
    - Evaluate success of agency training
  - One evaluation per program participating in the pilot

Evaluation Levels and Tools

- Tools you will use:
  - MSDP Local Program Pilot Implementation Survey (Attachment A)
  - MSDP Pilot Study Program Type List (Attachment B)

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Attachment A

♦ MSDP Local Program Pilot Implementation Survey ♦

Instructions:

This survey is intended to obtain feedback regarding the training you recently provided to participating staff at your program site and to identify areas that may need additional attention in order to successfully carry out the pilot at your program

One of these survey forms should be completed for each program participating in the pilot at your agency

Use the attached "Program Type" code list when entering "Program Type" on the survey

To expedite completion of the survey and to reduce redundancy please read all questions before responding

Please complete the survey below by April 28, 2008 and submit it to:
MSDP Project Manager at: mtmserve@aol.com

Agency/ Organization Name: _____

Address: _____

_____

Program Name: _____

Program Type (See List Attached): _____

Name(s) of the MDSP Co-Facilitator(s) for the above program:

Attachment B

MSDP Pilot Study
Program "Type" List

Version: 2-6-08

Community Based Acute Treatment (CBAT)	Intensive Community Based Acute Treatment (ICBAT)
Community Rehabilitation Services (CRS)	Intensive Outpatient Program - Substance Abuse (IOP)
Community Support Program (CSP)	Intensive Residential Treatment Program
Child Day Services	Opiate Treatment Program
Crisis Stabilization Unit (CSU)	Outpatient Mental Health
Day Rehabilitation	Outpatient Substance Use Disorder
Detox - Enhanced Acute Treatment Services (EATS)	Partial Hospitalization Program (PHP)
Detox - Level III (Inpatient: Pregnant Women)	Program of Assertive Community Treatment (PACT)
Detox - Level III.7 (Inpatient)	Psychiatric Day Treatment
Detox - Level III.5 (Inpatient: Residential/Dual Diagnosis)	Rehabilitative Treatment in the Community (RTC)
Detox - Level III.5 (Short Term Intensive Inpatient Treatment)	Residential Services - Adult DMH
Detox - Level IV (Inpatient: All Inclusive Detox Adult/Adolescents)	Residential Services - Adult DPH
Detox - Outpatient	Residential Services - Child/Adolescent DMH
Detox - Adolescent	Residential Services - Child/Adolescent DPH
Dual Diagnosis Acute Residential Treatment (DDART)	Respite

Evaluations and Tools

- Direct Staff Form "Mark-up" Process
  - To be completed during pilot study
  - Evaluation of pilot forms
  - Notations made directly on blank forms by participating program staff
  - Each participating staff member required to mark up one form for each mandatory type piloted
- Direct staff members' chance to influence the final product
- Comment on form layout, data elements, spacing issues, etc.

Evaluations and Tools

- Tools you will use:
  - Set of blank pilot forms
  - Red Pen
  - MSDP Pilot Form Markup Instructions and Cover Sheet (Attachment D)
  - Program Type List (Attachment B)

Attachment D

◆ MSDP Pilot Form Markup Instructions and Cover Sheet ◆

All staff members involved in piloting draft MSDP standardized forms are being asked to submit 'marked-up' copies of each form they used during the pilot period. While you will also be participating in a "Program Level" Evaluation Summary, your individual comments and suggestions regarding the content and layout of the draft forms is very important.

Instructions:

1. Compete the "Form Markup Coversheet" (attached)
2. Take a 'blank' copy of each pilot form you used during the study and, using a red pen, mark your comments for improving the form right on the form.
3. While you can comment on any aspect of the form(s), here are some areas of particular interest:
   a. Missing data elements that you think should be included on the form. These can be entire sections, new questions, choices within questions, or prompts you think would be helpful.
   b. Unnecessary data elements that you think could be eliminated without affecting the quality of information collected.
   c. Redundant data elements. Collecting the same or very similar information more than once.
   d. Space issues. This can include the need for more space or less space in any sections of the form(s).
   e. Any other suggestions or comments that you have regarding form improvement.
4. Please write clearly and succinctly.
5. Submit your "Form Markup Coversheet" attached to all marked-up forms to your Program MSDP Co-Facilitator by: April 21, 2008

Evaluation and Tools

- Program Level Pilot Evaluation
  - To be completed during last week of pilot

- Tools you will use:
  - Staff Cue Sheet (Attachment C)
  - Evaluation of overall pilot (Attachment E)

Attachment C

♦ MSDP 'Program Level' Pilot Evaluation Summary ♦

Staff Cue Sheet

READ THIS DOCUMENT BEFORE BEGINNING TO PILOT MDSP FORMS

This is not a survey! You do not have to answer these questions now. The purpose of this 'cue sheet' is to let you now the kinds of questions that will be asked at the conclusion of the pilot so that you can pay particular attention to these aspects of the forms you will be piloting.

- How many times did you use each new form during the pilot study? (You will need to keep track of this!)
- To what extent did you use the Training Manual?
- To what extent did the forms collect the kinds of information you need to do your job well?
- To what extent did the forms collect unnecessary information?
- To what extent did the forms support compliance with payer requirements?
- To what extent did the forms support compliance with accrediting body standards?
- To what extent did the forms support a "Person Centered, recovery Oriented" approach to services?
- Once you became used to the new forms, how long did they take you to complete? (total completion time including time completing during the session and post session completion) (You will need to keep track of this!)
- How would you evaluate the clinical flow within the MSDP Pilot Study Forms?
- How do the new pilot forms compare to you're the equivalent previous forms in terms of

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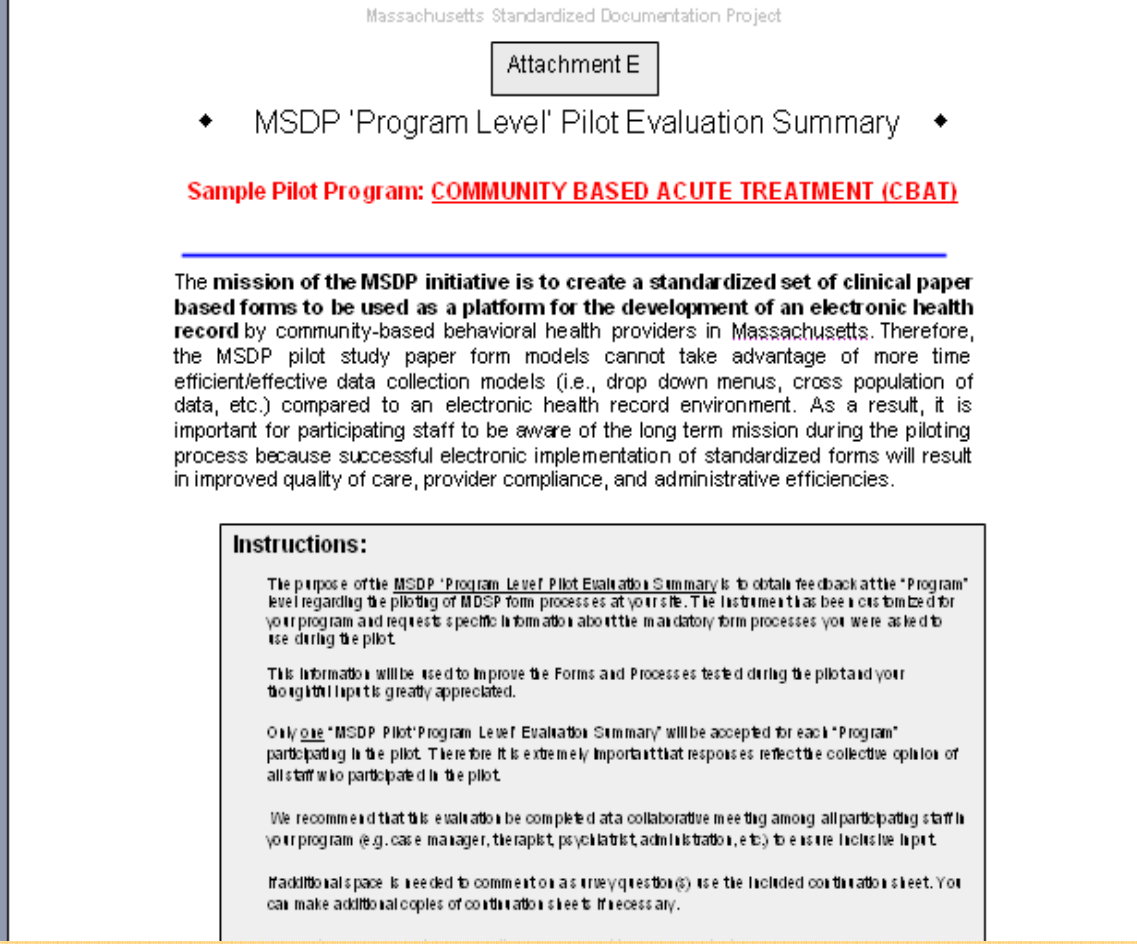

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Attachment E

◆ MSDP 'Program Level' Pilot Evaluation Summary ◆

Sample Pilot Program: COMMUNITY BASED ACUTE TREATMENT (CBAT)

The **mission of the MSDP initiative is to create a standardized set of clinical paper based forms to be used as a platform for the development of an electronic health record** by community-based behavioral health providers in Massachusetts. Therefore, the MSDP pilot study paper form models cannot take advantage of more time efficient/effective data collection models (i.e., drop down menus, cross population of data, etc.) compared to an electronic health record environment. As a result, it is important for participating staff to be aware of the long term mission during the piloting process because successful electronic implementation of standardized forms will result in improved quality of care, provider compliance, and administrative efficiencies.

Instructions:

The purpose of the MSDP 'Program Level' Pilot Evaluation Summary is to obtain feedback at the "Program" level regarding the piloting of MDSP form processes at your site. The instrument has been customized for your program and requests specific information about the mandatory form processes you were asked to use during the pilot.

This information will be used to improve the Forms and Processes tested during the pilot and your thoughtful input is greatly appreciated.

Only one "MSDP Pilot 'Program Level' Evaluation Summary" will be accepted for each "Program" participating in the pilot. Therefore it is extremely important that responses reflect the collective opinion of all staff who participated in the pilot.

We recommend that this evaluation be completed at a collaborative meeting among all participating staff in your program (e.g. case manager, therapist, psychiatrist, administration, etc.) to ensure inclusive input.

If additional space is needed to comment on a survey question(s) use the included continuation sheet. You can make additional copies of continuation sheets if necessary.

Answer the following questions for each of the mandatory forms piloted in your program:

9. A

To what extent does each form below collect the data elements you need to do your job well?	Missing Many Important Data Elements	Missing Several Important Data Elements	Missing a Few Important Data Elements	Contains Most Important Data Elements	Contains All Important Data Elements
Form	1	2	3	4	5
Individualized Action Plan					
IAP Review/ Revisions					
Consultation/ Collateral Contact (note)					
Intensive Services (note)					
Psychopharmacology (note)					
Transition/ Discharge Summary and Plan					

9. B

Please list important data elements that are missing from each form (if any).

Form	Unnecessary Data Elements
Individualized Action Plan	
IAP Review/ Revisions	
Consultation/ Collateral Contact (note)	
Intensive Services (note)	

Program Evaluation Focus Areas

1. Identification of how many times each pilot form/process was used by direct care staff during the pilot study.
2. Evaluate to what extent does each pilot form used collect the data elements direct care staff need to do their job well
3. Evaluate to what extent does each pilot form used contain unnecessary data elements
4. Evaluate to what extent does each pilot form support compliance with regulations and payer requirements (DMH, MBHP, Medicare, MCOs, CMS, etc)

Program Evaluation Focus Areas

5. Evaluate to what extent does each pilot form used support compliance with accrediting body standards (CARF, JCAHO, COA, NCQA, etc)
6. Evaluate to what extent does each pilot form used support a 'Person Centered, Recovery Oriented" approach to services
7. Evaluate the overall clinical flow/ clinical content of the MSDP forms/documentation processes
8. Compare each new pilot form used with the equivalent form being used just prior to the pilot in terms of support for quality clinical/ recovery focused services
9. Evaluate to what extent did the pilot forms used unnecessarily collect information more than once

Pilot Evaluation Timeline Key Dates

- **March 7-14:** Local program training and pilot "kickoff"
- **March 17-April 25:** Pilot study period
- **March 10-14:** Completion and Submission of MSDP Local Program Implementation Survey
- **March 11-21:** SDT Reviews Implementation Surveys
- **March 25-April 21:** Forms mark-up
- **April 21-25:** Completion of Program Level Evaluation Tool
- **April 28:** Pilot study exit interview

Next Steps for Pilot Study

1. We have provided both a paper form and electronic WORD form for each of the MSDP form types. Each program can chose which format they prefer to use during the pilot study based on computer availability. If using paper forms, you will need to make copies of the core forms for your pilot staff when you return.
2. Provide local staff training within the next week to be able to start pilot study on Monday, March 17th.
3. It is helpful to train using a "filled-out" set of forms. Therefore, it may be helpful to pick a person being served from your facility that your staff is familiar with. This also helps explain how the outcomes and recovery process are reflected in the new forms.
4. Q & A