



## Documentation in an Ohio Health Home

### Introduction & Purpose

Documentation is a critical component in Health Homes not only to ensure consistency in enrollment and orientation activities, but also to provide consumer-specific information that is integral to collaborative, effective care planning and delivery.

As part of implementing Health Homes in Ohio, the state has clarified expected documentation at all stages of interaction with potential and existing clients. Below, each documentation element is addressed in detail and references, examples and other tips are highlighted to facilitate implementation.

### Educating & Engaging Consumers

#### ORIENTATION MATERIALS

Health Homes should provide every client eligible for enrollment with comprehensive orientation materials that define:

- What a health home is
- Services provided by the organization
- The rights and responsibilities of the enrollee
- The responsibilities and expectations of the provider staff
- Point of contact information for care managers and/or other key staff

Attestation by the organization and enrollee of review and receipt of these orientation materials should occur at enrollment.

#### INFORMED CONSENT

Evidence of written, informed consent by the client is required at enrollment (including disenrollment and reenrollment) and must reflect consent for each specific health home service for which the individual is being enrolled. Such documentation must demonstrate full disclosure of client choice to receive services at the health home, as well as their rights for disenrollment and for full disclosure.

The Ohio Health Home rule requires the following:

- Informed consent specific to enrollment in the health home service prior to enrollment;
- Description of the health home service;
- Benefits and drawbacks of enrollment in the health home service,

#### Ohio Health Home Required Documentation

- Service specific informed consent
- Consumer Health Home orientation materials
- Comprehensive health assessment and reassessment
- Integrated care plan
- Documentation of Care Plan Review
- Transition plan
- Clinical summary report
- Crisis and contingency plan
- Client-specific communication plan
- Health Home service log/progress note

including the relationship between the health home service and other services, particularly other care coordination services (e.g. CPST, MCP care management, AOD case management); and

- Consumer's ability to opt out of enrollment in the health home service.

## Defining and Planning Individualized Care

### COMPREHENSIVE ASSESSMENT

Within a Health Home, care managers should ensure that a comprehensive, individualized assessment is conducted within 30 days of a client's enrollment, and that such assessment occurs at least once each 90-day period. Ideally, the assessment is documented in the electronic health record, but such assessment can be captured via paper form as organizations implement electronic systems. In addition, Health Homes may utilize data received via established networks of care providers or support service providers, with consent of the individual.

The purpose of the comprehensive assessment is to:

- Establish a detailed chronology and history of symptoms, diagnoses, and treatment.
- Assess current strengths, supports, and skills.
- Assess limitations, functional impairment, skill deficits, language, or cultural barriers that affect the recommended treatment.
- Identify a "stage of change" for each problem.
- Identify an individual's strengths, strategies, personal and support resources and other external factors that may contribute to treatment success and recovery.
- Inform and clarify the planned services and structure for communication and coordination among multiple providers, the Health Home team, and the client.

Using a standardized electronic or paper assessment form, the care manager should seek a collaborative interview with the consumer, authorized family member(s) or other natural supports to provide both narrative information and objective data that contributes to the assessment. The assessment should indicate a start/end time and date and should be signed by the completing individual. Other treating providers, including primary care providers, support service providers may contribute objective data components (e.g. diagnostic or screening test results) that facilitate the assessment.

While a full list of Ohio assessment domains (*see Table 1*) can guide providers in developing or modifying assessment tools, data elements in a comprehensive assessment should include (at a minimum) the following:

- Demographics, client/family background
- Health history (physical and mental health)
  - Primary Care/Specialist/ER visits and frequency
  - Medications

### Documentation Tip: Informed Consent

- Providers have flexibility in how to implement documentation of informed consent. Existing consent forms can be modified to specify Health Home service consent, for example. A provider may also choose to create a Health Home specific form or document client consent in a service log.

### Documentation Tip: Assessment

- Providers may amend or update existing or most recent assessments in lieu of beginning an entirely new initial assessment upon Health Home enrollment.
- Providers need to have supporting documentation of 90-day reassessment – this can be assessment update forms or progress notes documenting reassessment and updates.

- Allergies (including medications)
- Physical health diagnoses and/or risk factors (e.g., asthma, diabetes, COPD/respiratory, cardiac conditions, HIV/STD, Sickle Cell)
- Individual's goals; description of hopes/dreams; envisioned life
- Listing of strengths, skills, resources, supports and methods the individual uses to manage their health
- Educational, employment and housing status and detail history
- Presenting issues or concerns
- Challenges, functional concerns or other obstacles that prevent the individual from achieving their stated goals/dreams
- Objective health measures (weight, blood pressure, eye exam, mental health/substance abuse screening scores, blood tests (HbA1c, Lipid, Microalbumin, as applicable)
- Co-occurring diagnoses

Table 1: Ohio Comprehensive Assessment Domains

Comprehensive Assessment Domains		
Client demographics; identifying information	Family environment/relationships	Client Strengths/capabilities
Meaningful activities	Cultural/ethnic issues/information/concerns	History of learning difficulties/barriers to learning
Special communication needs	History of abuse, neglect, violence	Risk assessment
Mental Status examination	Current discharge and transition plans	Client/family/guardian expression of preferences and goals
Level of involvement in the care planning process	Presenting problem(s) including referral source and reason for referral	Primary/family/marital significant other support systems;
Limitations of activities of daily living including instrumental activities of daily living and/or self-care	Mental health treatment history	Alcohol/drug/tobacco use treatment history
Past and current medications including OTC and herbal	Medication allergies or adverse reactions to medications	Transportation capabilities and constraints
Living situation/housing status including any environmental and safety concerns	Pertinent family history	Friendship/social peer support/relationships
Religion/spirituality	School functioning/ education history	Employment history
Income/financial Status including ability to manage own finances	Community supports/self-help groups	Sexual history/concerns
Military history	Legal history	Physical health history
Advance directives when applicable		

### Integrated Care Plan

Within 60 days of the comprehensive assessment, the care team, led by the Care Manager and including the client, will develop an integrated care plan that is individualized, strengths-based, specific, and outlines method for ongoing review and modification as the client meets goals or encounters new challenges.

Integrated care plans should always focus on the individual client's personal goals, strengths, priorities and life needs. This collaborative plan identifies existing physical and behavioral disease states that require follow-up, determines the level of support needed by the consumer to meet treatment goals for each condition, and documents the method and resources for providing that level of support within the targeted time frame.

### Example: Ms. Smith

**HEALTH STATUS:** Ms. Smith suffers from poorly controlled diabetes and asthma resulting in increased ER visits. Ms. Smith also has a diagnosis of schizophrenia.

**CARE PRIORITY:** At least quarterly visits with her primary care physician to improve the control of her diabetes.

As part of Ms. Smith's more specific treatment plan, documentation may specify that a primary goal is to help her reduce the number of ER visits related to diabetes by 30% (from six to four visits) over the next twelve months. Together, they develop the following plan:

**GOAL 1:** Ms. Smith wants to feel better and not use the ER as much.

#### ACTION STEPS:

- Attend her primary care appointments monthly. In order to do this, she is requesting support of the QHHS to accompany her.
- Obtain regular lab work: specify (e.g., monthly HGBA1c test; annual lipid)
- Complete an annual eye and physical exams
- Manage her anxiety about appointments through breathing, talking to QHHS and planning her visits in advance.

#### MEASUREMENT:

- Number and frequency of PCP visits
- Diagnostic test dates and results;
- Number and frequency of ER visits related to diabetes care

**GOAL 2:** Over the next year, Ms. Smith wants to increase her independence with PCP visits and managing her own health.

#### ACTION STEPS:

- She will complete primary care visit form with her QHHS.
- She will speak for herself at PCP appointments and only ask for help from QHHS if she is overwhelmed or confused.
- By six months from now she will prepare for PCP appointment with QHHS and go alone. QHHS will call the next day to see how visit went.

### Integrated Care Plan Elements

- Goal and Priority Statements
- Goal Timelines
  - Action Steps
  - Client
  - Care Manager
  - Primary providers
  - Other care/community support professionals
  - Family/Supporters
- Measures for Success/Modification
- Required diagnostic tests or screenings (and frequency they should occur)
- Required support services (e.g., housing, education, transportation, job supports)
- Medication management plan
- Health education needs (e.g. for consumer; for family members)
- Self-help education or support needs
- Process for referrals to external providers or services
- List of all "care team" individuals with contact information
- Schedule for periodic review

### MEASUREMENT:

- Documentation of primary care visit forms
- Progress notes on success in PCP interaction and question formulation
- Frequency of Care Manager participation in PCP visits declines over 12 months

It is vital that the development of the integrated care plan occur with a person-centered approach and with a goal for continuous review and improvement. The plan should include specific timing and method for follow-up review with the consumer, family member(s), primary care providers (PCPs), medical specialists, housing or other community support specialists, courts, schools etc. on a periodic basis. Formal reassessment should occur at least once each 90-day period. In addition, the plan should reference Health Home policies related to ongoing communication and review (e.g., process for care team meetings, “rounds” with embedded PCP, external care team interactions) as well as outline and document and specific communication needs related to the individual.

While general policies about transitional care and communications will be in place within each Health Home, the individual Integrated Care Plan should contain specific criteria and protocols relevant to the individual’s needs and preferences in the following areas: care transition, crisis or contingency planning and communications. These elements are developed collaboratively with the client and relevant care givers and supporters to anticipate changes in intensity or type of service and to ensure transparent, respectful communication and decision-making. Note that Ohio state law on advanced directives should also be factored into this planning and documentation (see box).

### Ohio Advanced Directives for Health & Mental Health

**Durable Power of Attorney for Health Care:** In the durable power of attorney for health care, you name an attorney-in-fact to make health care treatment decisions (medical treatment, mental health treatment or both) for you, if your attending physician determines that you have lost the capacity to make health care decisions for yourself. If you wish, you may state specific instructions to your attorney-in-fact, such as when to consent to treatment, when to refuse treatment, and when to withdraw consent to treatment. The durable power of attorney for health care is defined in ORC sections 1337.11 through 1337.17.

**Declaration for Mental Health Treatment:** In the declaration for mental health treatment, you declare your instructions for the use or continuation of mental health treatment, or for the withholding or withdrawal of mental health treatment. If you wish, you may designate a proxy to make mental health treatment decisions according to your declaration. The declaration for mental health treatment is defined in ORC sections 2135.01 through 2135.14.

### TRANSITION PLAN

- Addresses referrals and needed services to facilitate transition when integrated care plan goal(s) is/are met
- Outlines circumstances that may lead to discharge from HH
- Identifies desired steps and actors in care transitions
- Identifies communication protocol and points of contact in the event care transition or discharge will occur

### CRISIS/CONTINGENCY PLAN

- In collaboration with a client, this plan provides advance guidance about desired points of contact, decision makers (if applicable) and communications in the event of crisis or emergency
- Addresses potential for additional supports during crisis situations (e.g., respite, hospitalization)
- Identifies factors or circumstances that define the beginning and end points for the “crisis plan” (i.e., what is the definition of “crisis” or contingency)

### COMMUNICATION PLAN

- The individual-focused communications plan promotes consistency in communication among team members, with the consumer and/or family/supporters and with respect to varying stages of care (e.g., routine vs. crisis)
- Follows established policies for communication in the Health Home as outlined by the Health Home Team Leader. At a minimum, these meet the following criteria:
  - Identifies team and provider key contacts and defines roles among provider team (both internal and external).
  - Clarifies relationships and communication structures/steps between administrators and clinicians in multiple settings (primary care, specialty care, Health home).
  - Ensures routine, rapid and effective information exchange (clinical summaries, medication profiles, updates on progress toward meeting care plan goals).
  - Ensures rapid and effective exchange between care team members, providers, and the consumer/family.
  - Ensures information is provided in a format that is understood by and useful to the consumer.

### Monitoring and Documenting Progress

Implementation of the integrated care plan requires ongoing documentation of progress toward individual goals; assessment of unanticipated or new needs for treatment or support; and summary of clinical viewpoints in a way that can be shared with the care team, and most importantly with the client and family.

Throughout the process of Health Home documentation, service providers should consistently strive to achieve this through collaborative and, as much as possible, concurrent documentation practices. Such an approach maintains fidelity to the principles of person-centered care and helps model for the consumer/client and family how to clarify a need and develop a plan to meet that need. The added benefits are an active “voice” for the individual and their family/supporters in the care team and the opportunity to increase the transparency to the individual of what is in the clinical note/chart/client record of the health home.

Strategies for successful collaborative/concurrent documentation:

- Establish a shared physical view of the documentation (screen/form)
- Seek permission first for note taking during a session
- Emphasize team effort and importance of documenting progress
- Frame collaboration as an invitation to participate and be involved in care
- Review goals and objectives for the discussion
- Ask for individual’s desired goals or needs
- Ask for feedback – was collaborative approach helpful? Did the notes accurately reflect discussion? Was anything left out?

## PROGRESS NOTES

Progress notes are an essential component of documenting provided services and specific metrics toward achievement of an individual's health and life goals. Each individual providing a service(s) to the client of a health home completes the progress note in an EHR or in a paper form as a checklist or brief narrative that contains:

- Specific service or support provided;
- Indication of integrated care plan goal to which the service applies;
- Assessment of positive or negative impact on goals;
- Any significant changes or events in the life of the consumer that affects the goal(s);
- Recommendations for care plan modification, if necessary; and
- Recommendations for follow-up or referral, if necessary.

### Example: Ms. Smith

**GOAL:** Increase Ms. Smith's independence in primary care visits.

**ACTION TAKEN:** Ms. Smith agreed to ask doctor two questions on this visit. Ms. Smith was comfortable with one question but then felt anxious. Developed new strategies for next visit: tell doctor she gets scared when he talks too fast, do deep breathing in waiting room before visit, ask two questions with QHHS support.

## Clinical Summary

In similar fashion, the clinical summary documents progress toward a client's goals as part of routine information sharing about an integrated care plan. A clinical summary may include written and verbal summary (e.g. at care team meetings) of an individual's progress or setbacks. Summaries may be tailored to their intended recipient (e.g., consumer, healthcare professional, family/significant other) and are designed to summarize a series of actions, events, progress notes to provide an overall picture or trend assessment.

## Conclusion

Documentation is a critical component in Health Homes to ensure transparency and consistency in enrollment and orientation activities, and to uphold the principles of person-centered care planning and delivery of services. The guidance offered by this paper is intended to help organizations structure their policies and procedures effectively in line with state rules and expectations for Health Homes.

### Documentation Tip: Progress Notes

Generally speaking, narrative notes cannot be captured by EMRs for aggregate reporting. Therefore, any narrative field should be kept to a minimum size and radio/checkbox buttons and dropdown boxes should be used as much as possible to enhance consistency.

### Documentation Tip: Clinical Summaries

While the state no longer requires documentation of clinical summaries every 30 days, providers should consider soliciting feedback from consumers, Managed Care Plans, primary care partners, and internal staff when designing the clinical summary format, content and frequency.

## References/Resources

- Ohio Code Citations: <http://codes.ohio.gov/oac/5122-29-33>
- OAC 5122-27 Minimum Requirements for Integrated Clinical Records: <http://codes.ohio.gov/oac/5122-27>
- OAC 5122-29-04 Documentation Requirements for Mental Health Assessment Service: <http://codes.ohio.gov/oac/5122-29-04>
- SAMSHA TIP 42: <http://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA12-3992>
- National Academy of State Health Policy (NASHP) Developing and Implementing Health Homes (July 2012): [http://www.nashp.org/sites/default/files/health.home\\_state\\_option\\_strategies.section.2703.pdf](http://www.nashp.org/sites/default/files/health.home_state_option_strategies.section.2703.pdf)
- MTM Services materials on concurrent documentation: <http://mtmservices.org>
- Center for Medicaid and Medicare Services (CMS) resources: [http://www.medicare.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-Summary-5\\_081012.pdf](http://www.medicare.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-Summary-5_081012.pdf)  
<http://www.medicare.gov/mltss/docs/PCP-CMSdefinition04-04.pdf>  
<http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions.pdf>
- Advanced Directives for Mental Health and Health Care in Ohio: <http://www.disabilityrightsohio.org/sites/default/files/ux/advancedirectives.pdf>
- Defining Patient Perspective: <http://www.safetynetmedicalhome.org/sites/default/files/Patient-Perspective.pdf>
- Patient Visit Sheet: <http://www.safetynetmedicalhome.org/sites/default/files/Patient-Visit-Sheet.pdf>