



# **New York State Clinical Records Initiative (NYSCRI)**

## **STANDARDIZED DOCUMENTATION MANUAL**

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## Section 1 – What is the NYSCRI?

### A. Purpose:

The New York State Clinical Records Initiative (NYSCRI) is a standardized clinical record system designed for outpatient and residential, non-state operated, mental health (MH) and substance use disorder (SUD) treatment services. NYSCRI may be utilized in a paper (PDF), e-Word or Electronic Medical Record (EMR) format and is available in the public domain at no cost to users. The data elements populating the record system support efficiency, compliance, person centered/driven, recovery oriented services. In addition, the system provides specific support for the demonstration of Medical Necessity which is applicable for all payers, including private insurers. All documentation data elements and processes were designed to accommodate and comply with the regulations and standards set by the following entities:

1. **State:** NYS Office of Mental Health (OMH); NYS Office of Alcoholism and Substance Abuse Services (OASAS); NYS Department of Health (DOH)
2. **Federal:** Medicaid and Medicare
3. **National Accreditation:** The Joint Commission (TJC); CARF International (CARF); Council on Accreditation (COA)

The ultimate goal of NYSCRI is to create a single set of statewide data elements and processes that can be used by providers and EMR vendors who wish to incorporate NYSCRI into their EMR systems. These elements and processes can be updated at the statewide level to accommodate changes in regulatory and payer requirements, accrediting body standards and user feedback.

Historically, New York State provider agencies/programs have independently developed and used a wide variety of clinical and medical documentation processes. As a result, there are a significant number of different genres/styles of assessments, service plans, and progress notes in current use. The costs associated with developing a standardized electronic record based on these multiple approaches would be significant for each provider/program individually.

The recent shift in the field towards electronic medical records points to a pressing need for clinicians and practitioners to shift thinking about documentation itself. Along with the importance of demonstrating medical necessity and moving towards individual and family centered planning and treatment, today's behavioral health care provider must also use documentation to accurately capture the individual's assessed needs, goals for treatment, and work toward meeting the stated goals. As the individuals we serve are ever-changing, the documentation must continue to evolve to accommodate these changes and must not be a one-time-only, "snap shot", of an individual's history, presentation, and goals. The form set and processes developed by the NYSCRI reflect this need and create a framework for a dynamic system of gathering and documenting the individual's treatment, response to treatment and movement toward chosen goals over time.

The NYSCRI documentation process is one that allows the provider to work collaboratively with the individual served to continuously discover more about the individual's needs and to maintain a clear and dynamic plan.

The forms/processes allow for a logical and natural flow of information gathering and service documentation. When used as an "integrated record set", they serve as synergistic tools to:

- Assess the individual in a comprehensive way,
- Ensure the determination of the medical necessity for treatment,

- Guide the development of treatment goals and objectives which meet the needs and desires of the individual served and
- Document interventions and interactions as well as progress or lack thereof of the individual's course of treatment.

Each form in the set supports the documentation of key service delivery processes from intake to discharge. Each form within the “integrated” record set for any service type addresses the essential regulatory elements needed to comply with funder and payer requirements; therefore, forms should not be “pulled apart” from each other and used individually. If some of the NYSCRI forms types are used, but not all of the forms, the clinical information may be incomplete and compliance with funder/payer requirements will not be attained.

## **B. How to use the NYSCRI Manual**

The manual is designed to help providers use the NYSCRI forms to effectively and efficiently document the individual treatment process for each individual served.

- Each section of this NYSCRI Manual provides information that will help equip your team with key qualitative and compliance concepts used in the development of the forms. Key clinical practice areas are included to support the provision of recovery/resiliency-based mental health and substance use disorder services.
- The Clinical Tools section may be utilized as a whole or in part to assist in supporting staff development through clinical supervision and/or training.

## **C. NYSCRI's Scope**

The NYSCRI helps providers meet documentation requirements for the following programs types identified below:

OMH	OASAS
Assertive Community Treatment (ACT)	Outpatient (Part 822) - Outpatient Rehabilitation - Outpatient Clinic Opioid Treatment Program (Part 822.5, formerly Methadone Treatment Program Part 828)
Case Management	Residential (Part 819) - Intensive Residential Rehabilitation - Community Residence - Supportive Living
Clinic Treatment (Children and Adults)	
Comprehensive PROS without Clinical Treatment	
Comprehensive PROS with Clinical Treatment	
Continuing Day Treatment (CDT)	
Day Treatment (Children)	
Intensive Psychiatric Rehabilitation Treatment (IPRT)	
Partial Hospitalization	

OMH	OASAS
Residential - Adult - Apartment/Support - Apartment/Treatment - Community Residence for Eating Disorder Integrated Treatment Program (CREDIT) - Congregate/Support - Congregate/Treatment - SRO Community Residence	
Residential - Children - Children & Youth Community Residence - Crisis Residence	

## Section 2 – Benefits: What Does The NYSCRI Mean For You?

### A. Compliance

1. ***Meets National Accreditation Compliance Requirements:*** All forms/processes were reviewed in detail by teams representing the respective accrediting/regulatory body standards to prompt for necessary data to be included in the record.
2. ***More Objective Reviews/Audits:*** The move to standardized documentation minimizes the subjective nature of audits and site reviews.
3. ***Provides a Reduced Compliance Risk Environment:*** More objective reviews due to use of standardized forms/processes within MH/SUD centers provides a clinical service delivery environment that facilitates a higher level of compliance statewide.
4. ***Promotes a System Learning Environment:*** Standardized documentation improves the ability to provide system wide change opportunities that promote compliance including efficient centralized modification of form processes to accommodate audit findings (i.e. feedback from audits in one part of the state may assist in improvements to the form set which benefit providers in other parts of the state).

### B. Quality of Care

1. ***Enhances Clinical Care Approach:*** Specific attention has been given in the NYSCRI clinical documentation processes to develop “identified needs” (symptoms, behaviors, functional/skills deficits, and support/coordination deficits) that impact the individual’s level of functioning which will help ensure the services ordered meet Medical Necessity requirements.
2. ***Client-Centered Recovery/Resiliency Focus:*** The new standardized forms/processes contain a more client-centered and recovery/resilience focus on individuals’ served needs, strengths, and personal life goals that support the assessment of peer/family support; employment; meaningful activity; power and control concerns; community involvement; education; and access to resource needs. Integrating the recovery/resiliency needs of those we serve is critically important to engagement and improvement in the clinical care of individuals served while at the same time addressing the need to demonstrate Medical Necessity and address important funding and regulatory requirements.
3. ***Reduction of Redundant Collection of Clinical Information:*** Individuals served, families, and advocate representatives have provided excellent feedback regarding how the standardized processes have reduced redundant information gathering by eliminating multiple assessments and service plan development per individual served, regardless of the number of clinical services he/she receives at the provider agency. The standardized forms/processes have at their core the principle, “Establish a documentation process that will commit to asking the individual a question only once unless there is a justifiable clinical reason to ask the same question twice”.
4. ***Enhanced Measurement and Duplication of Positive Outcomes:*** Standardized clinical documentation processes have demonstrated an improvement in the ability to measure clinical outcomes and enhance the ability to duplicate positive outcomes.

5. **Enhanced Accessibility to Services:** Streamlining the intake process through reducing/eliminating redundant diagnostic assessment and service planning processes has produced a reduction in the total time it normally takes to admit individuals into services, which has also had a positive impact on reducing "intake no shows/drop outs".

### **C. Efficiency**

1. **Staff Retention:** Proactive adaptation of current service delivery processes to accommodate efficient, low redundancy, standardized documentation models provides the ability for staff to "finish their work" by the end of each day resulting in higher morale.
2. **Enhances Cost Efficiency:** With the current funding environment, it is imperative to develop more cost efficient documentation processes. A standardized low/no redundancy documentation process has proven to be more cost effective than historical program/unit based unique models that were replete with redundant recording of information. Additionally, standardized documentation forms/processes have dramatically reduced training costs. Outside of NYSCRI, as standards and regulations change, the burden has been on individual providers to ensure that their form processes continue to be compliant and to negotiate with individual EMR vendors to support required changes.
3. **Enhances System-wide Accountability:** Standardized documentation has proven that it will enhance system-wide accountability in the following areas:
  - a. More accurately determines the cost of services by utilizing standardized documentation and reduces the volume of processes
  - b. Provides a more objective comparison of clinical processes/services delivered statewide
  - c. Provides individuals served and families the ability to expect the same clinical documentation process regardless of which provider agency in the state they access

### **D. Foundation for EMRs**

1. All final forms/processes will be provided to providers in a format that will support time and cost effective EMR development.
2. Providers may choose to purchase their EMR systems from among a number of Vendors who provide the form elements automatically within an electronic record format.

## Section 3 – Compliance and Medical Necessity

### A. Satisfying Reimbursement and Compliance Requirements

Clinical documentation serves many purposes; among the most important purposes are:

- Clinical: management and focus of the treatment process, especially where a treatment team is involved.
- Provider Agency: management of best practices, utilization management, resource allocation, utilization review, and an audit trail for claims to third parties.
- Payer: determination of medical necessity, covered services, and the post or pre-payment review of claims for payment.

The integrated NYSCRI forms were designed to enable providers to fulfill key compliance and reimbursement elements, which include:

- Medical necessity for each service provided.
- Documentation linkage requirements, especially the linkage of services to the plan of treatment and assessed needs.
- Signature and credentialing requirements to make sure all services are properly ordered as well as provided by appropriately credentialed individuals.

### B. Medical Necessity

*Medical necessity* is a critical concept for providers/programs to understand. It is a core standard of payment for Medicaid, Medicare, and most third party payers. *Medical necessity* is:

- First – establishing that an individual seeking behavioral health services is qualified (by diagnosis and functional status) to receive particular services at a particular level of care
- Second – that each service provided to the qualified individual is planned for and necessary to address identified needs as assessed by qualified professional staff.

The concept is sometimes viewed as applicable only to a *medical model*. However, Medicaid and Medicare both require that rehabilitative as well as recovery-based services they pay for meet these standards as well.

#### Medicaid Definition of Medical Necessity

*Medical necessity* starts with a practitioner who, based on a comprehensive evaluation of an Individual, determines that the Individual has a mental health or substance use disorder AND either current signs and symptoms or current problems with daily functioning caused by the impact of their disorder/illness that require services necessary to help the individual recover from or better manage their disorder/illness. Key here for purposes of medical necessity is an understanding of payer rules (and they often are different) as to who can diagnose mental illness and/or substance use disorder and who can order services. Most payers will rely minimally on state licensure laws that determine scope of practice for each license but in some cases payers will require more experience and higher credentials than state law. If the service is not ordered by the appropriately credentialed person the first requirement of medical necessity is not met.



**For example:** *A Social Worker cannot order medication management services to be provided by a physician. They cannot by state law either provide or supervise medication management services and so, therefore, cannot determine if these services are medically necessary.*

The second requirement of medically necessary services is that they must be considered to be reasonable and generally effective for the specific diagnosis and clinical picture of the individual. They must help them to get better, prevent them from getting worse, or prevent new problems that are threatened by the Individual's diagnosis. Services must be directed at signs and symptoms or functionality that is directly related to the diagnosis.

In addition to medical necessity, services provided must be covered under the insurance benefits package the individual has.

Consistent with the definitions above, Medicaid expects documentation to support that services are:

- Delivered at an intensity that is appropriate and that will likely be effective.
- Provided in the lowest level of care that is reasonable and safe.

Diagnostic services must also be medically necessary and the services ordered to assist in a diagnostic assessment must be capable of providing unique, essential, and appropriate information that cannot be obtained in an interview process. This would include services such as psychological testing, neurological consults, lab work, etc.

### **Medicaid Criteria for Payment of Medically Necessary Services**

Even though a service may be medically necessary, it may still not be reimbursable. Criteria that Medicaid uses to determine whether medically necessary services can be paid include:

- Outpatient services are voluntary and initiated by the individual, or the individual's family/guardian (*Note: Payers believe with some justification that people who come freely to services and are actively involved in developing their individualized action/service plans are more likely to participate actively in their treatment and to comply with their treatment regimen.*) In some cases, inpatient admissions can be involuntary and these criteria would not need to be met.
- The individual's right to select both the provider agency and the specific providers of their choice. Again, this promotes the active participation of the individual served in his/her own care and is a fundamental right addressed in the State Medicaid Manual. In some cases, as in New York, federal Medicaid waives the requirement for absolute choice by allowing managed care entities to limit their provider pools.
- The services are provided by an eligible provider. In addition to ordering the service, an eligible provider must also render the service. (*Note: Most payers list the credentials they require for the provider of each service covered under their benefit plans. For most payers credentials include a combination of licensure (if required), education, and experience. Providers are expected to comply with these credentialing requirements as a condition of payment.*)
- The service must be provided in compliance with the Medicaid definition for the service as defined by the eligible service codes in the CPT or HCPCS code books. Although some states have been quite liberal in their use of a code and expanded on some definitions, providers should be careful to maintain internal coding integrity.

- The service must be the lowest cost service that effectively addresses the problem of the individual served.

## **Medical Necessity in Mental Health and Substance Use Disorder Services**

In operational terms Medical Necessity requires that:

1. The individual must have one or more diagnoses – either the ICD or the DSM and the diagnosis must currently “endanger life, cause suffering or pain, interfere with life functioning, threaten to cause or to aggravate a handicap, or result in illness or infirmity”. In other words, a diagnosis is not enough. There must be negative manifestations of the diagnosis in the clinical picture of the individual for services to be medically necessary.
2. The services provided must be the lowest cost and least intensive which are appropriate, potentially effective, and available.
3. The services or help provided by the mental health or substance use disorder systems of care can be directed towards:
  - a. Diagnosing mental illness and/or substance use disorders.
  - b. Preventing the worsening of the diagnosed illness.
  - c. Alleviating the symptoms, functional deficits, or other manifestations of the diagnosed illness.
  - d. Correct or cure the diagnosed illness.
4. The service must be documented in a medical record that is available for review.

## **Medical Necessity and Recovery**

Recovery-based, rehabilitative service models must also meet medical necessity criteria if they are going to be billed to a third-party payer who covers rehabilitative services. Federal Medicaid law defines a rehabilitative service as *“any medical or remedial services (provided in the facility, a home, or other setting), recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”*<sup>1</sup> Medical necessity, therefore, is not just based on diagnosis (with its attendant signs and symptoms) but also on functional criteria.

This federal definition is very compatible with the description of the Rehabilitation Model found in the IAPRS<sup>2</sup> publication, *Best Practices in Psychosocial Rehabilitation*. This rehab model *“focuses on the functioning of the individual in the normal, day-to-day environment, and looks at the strengths and skills people bring to the rehabilitation process and supports in the community. Although an individual may still be symptomatic, the rehabilitation process helps an individual learn ways to compensate for the effects of the mental illness through environmental supports and coping skills. The individual with the mental illness becomes the expert in managing the disability.”*<sup>3</sup>

<sup>1</sup> Social Security Act, Section 1905(a)(13)

<sup>2</sup> International Association of Psychosocial Rehabilitative Services

<sup>3</sup> Hughes, R. and Weinstein, D. editors, *Best Practices in Psychosocial Rehabilitation*, IAPRS, 2000, p. 42.

Both the federal and IAPRS definitions focus on improving the functioning of the individual. Both also make it clear that the services are directed toward keeping the individual served in community settings and, therefore, contemplate the necessity for services to be provided in multiple settings in order to maximize benefit to the individual. In addition, the IAPRS definition stresses the active participation of the individual served. The individual served must actively participate in the development of their individualized action/service plan and they must become the experts in their own recovery. IAPRS is also specific about their expectations of benefit to the individual served, using a strengths-based model to promote:

- Greater functionality.
- Independence.
- Integration into their community and support network.

The rehabilitation option model, therefore, uses a functional test as the basis for a *medical necessity* determination for covered services, and then adds the generally accepted criteria of benefit, participation, and individual planning.

What is clearly very important about the rehabilitation option and its coverage by Medicaid is the difference in the approach to services and the impact this has on the overall model of care.

Recovery is a holistic treatment process that deals with all aspects of an individual's life. Under this model, the individual served becomes knowledgeable about his/her mental illness/substance use, works with other community and environmental supports toward self-defined realistic goals, and eventually manages his/her mental health/substance use disorder. Community providers support the individual's efforts using their training, research, and knowledge.

Some of the services included in a recovery model are not reimbursable under the Medicaid program's rehabilitation option, or under most third-party payers' benefit plans. Providers must be clear about which services:

- Do meet Medicaid and other payer criteria and can be appropriately billed.
- Do not meet Medicaid and other payer criteria and, therefore, must be funded by alternative sources. In particular, providers should pay attention to state and federal regulations and service definitions about educational, vocational, recreational, social, and peer services.

The New York State Office of Mental Health has been a vocal advocate of recovery models of care and has used its array of resources to support the development of these models. Medicaid is one of these resources that, with judicious use, can assist individuals served and providers in making recovery/resiliency programs possible.

### **Medical Necessity and Provider Documentation**

One of the primary means for determining *medical necessity* is the review of the provider's documentation. The "big three" areas of documentation that support medical necessity are:

1. The diagnostic assessment and any updates or additional diagnostic testing done at the outset or during the treatment episode.
2. The individualized action plan and any reviews, updates, or modifications.

3. Each and every billable progress note. These must describe an ordered, covered service that is necessary to realize the clinical outcomes of treatment.

Together, all of these documents make the initial and continuing case for the medical necessity of the services being delivered and billed. Documentation is a requirement of all payers, and in particular, all Medicaid/Medicare providers are required to keep such records as are necessary to establish medical necessity and to fully disclose the basis for the type, extent, and level of the services provided.

In reviewing documentation for medical necessity, the reviewer looks for key elements in the documentation, such as the following:

1. Is there a diagnosis that meets payer criteria? Is there sufficient documentation in the initial assessment or additional diagnostic work that provides evidence that this is the correct diagnosis?
2. Is there an assessment of functioning for the individual served? Are there sufficient symptoms, behaviors, and functional deficits or the threat of developing deficits to support the level of care ordered?
3. Is there an individualized action plan, signed by the appropriate provider, for an array of services that are generally accepted as being appropriate for the diagnosis, functional level, and assessed needs of the individual served?
4. Are the services rendered in accordance with the individualized action plan and with payer definitions? This is called “active treatment” and includes the requirement that services are “skilled interventions” rendered by appropriately credentialed providers.
5. Is there evidence of participation by the individual served? There are two issues here. First, the individual must have the cognitive ability to be able to participate in treatment and to benefit from it. And, second, the individual served must be willing to participate in treatment and, therefore, benefit from it. For example, individuals with early Alzheimer’s may be able to benefit from talking therapies for depression and other mental illnesses until their disease has progressed to the point where there is no potential for therapeutic progress. Individuals with severe or profound mental retardation are generally not covered for talking therapies but can be covered for medication management if warranted and medically necessary to control behaviors. In any case, where services that are not “generally accepted” as beneficial to an individual with certain diagnoses are being provided the practitioner should expect that auditors and payers will expect an explanation and will look for it in the clinical documentation.
6. Is the individual “committed” to outpatient treatment? This is very different than a situation where a judge tells an individual that they can choose between jail and treatment and are effectively being coerced into treatment. In these cases, medical necessity must be determined independent of any court decision or recommendation for a third party payer to be billed. A commitment to outpatient treatment is different than the choice between jail and treatment. In these cases the Individual chooses one form of treatment over the other and there must be sufficient evidence of the need for mental health services.
7. Is there evidence that the individual being served is actually benefiting from treatment? This is a critical issue in medical necessity. Most services are directed towards improving the health status of an individual. Medicaid and other third party payers want to see that improvement recorded in the medical record or want to know why they should be continuing to pay for services that do not appear to be effective. There is also a concept in medical necessity that considers situations, especially those with significant chronic conditions, where services may be primarily directed towards the prevention or the slowing down of further deterioration and the need for higher levels of care. However, again there must be evidence in the medical record that these “maintenance”

services are necessary and that they constitute the lowest cost effective service for this individual and their particular clinical picture.

The forms developed by NYSCRI have been designed to encourage the complete and accurate documentation of the diagnosis/condition, functional level and/or deficits, identified assessed needs, treatment goals, and level of care decision-making for the individual served. There are cues to remind providers to document the individual's participation and benefit from treatment. And, there are places for providers to sign, date, code, and time the interventions so they may be appropriately and accurately billed. As with all forms, they cannot make up for sloppy or inadequate content, but they do help the writer organize their information in ways that make it easier for reviewers to locate and to determine medical necessity.

### **C. NYSCRI Forms Support Medical Necessity**

The NYSCRI forms are an integrated documentation toolset that is designed to:

- Facilitate the complete and accurate documentation of the condition, functional level and/or deficits, assessed needs, treatment goals and objectives, and level of care decision-making for the individual served.
- Provide linkage between the Comprehensive Assessment, the Individualized Action Plan and the Progress Notes, as well as the Comprehensive Assessment Update and Individualized Action Plan Review/Revision to demonstrate on-going progress and medical necessity.
- Contain cues to remind providers to document the participation in and benefit from treatment for each individual served.
- Contain fields for providers to date, code, and time stamp the interventions so they may be appropriately and accurately billed.
- Contain fields for all required signatures and credentials of individuals authorizing/recommending treatment and action plans.

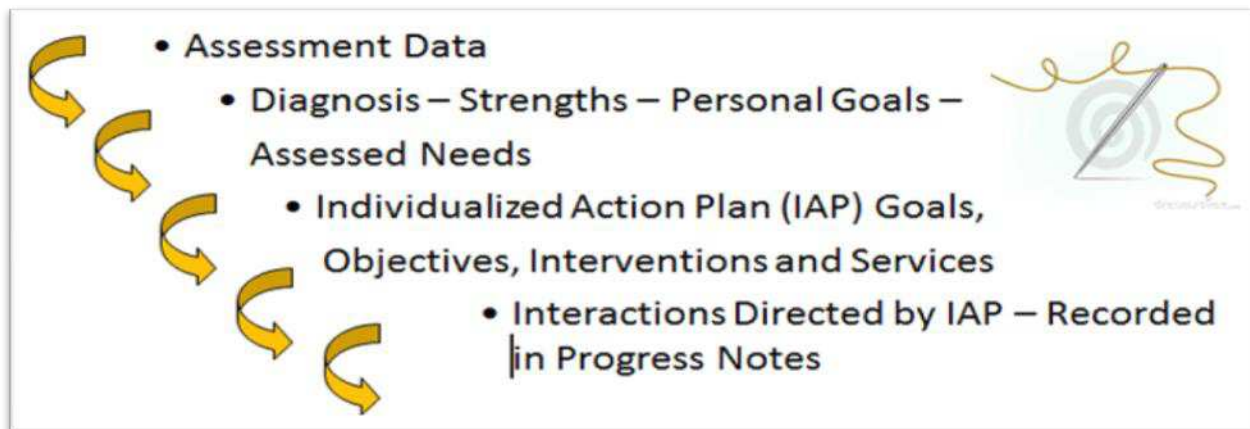
### **D. Medical Necessity Documentation Linkage Requirements**

(Note: Reprinted with permission from Chapter Seven of *How to Deliver Accountable Care* written by David Lloyd and published by the National Council of Community Behavioral Healthcare)

The common thread of concern and findings within qualitative audits is that the documentation model utilized does not continuously support the need for the intensity, frequency, and duration of the service(s) being provided to the Medicaid and/or Medicare eligible individual.

A key issue in the audit findings is the lack of a link (Golden Thread of Necessity) between the assessed therapeutic needs that results in specific goals supported by measurable objectives with specific therapeutic interventions ordered to be provided by specific clinicians within specific service modalities/locations (outpatient individual, group, IOP, Residential, Psychopharmacology, etc.) within the provider organization.

The Five major linkage processes that are designed into the NYSCRI form documentation system to support compliance with qualitative reviews are identified below. (MTM Services Diagram (updated by NYSCRI))



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).

Each of these primary documentation processes should be designed and implemented at the same time within the community provider organization in order for each of them to serve as very important support for medical necessity linkage requirements. Outlined below are the primary linkage and support functions for each process:

#### **Purpose of Comprehensive Assessment in Medical Necessity Linkage Requirements**

1. Establishes a baseline measurement for the **Symptoms, Behaviors, and Skills/Needs Deficits of the individual served** and documents how each of these areas impact the individual's ability to **function, which is the basis for developing the individualized action plan.**
2. The more specific/objective the information gathering process during the assessment, the easier it is to demonstrate the necessity for treatment.
3. Use of standardized assessment tools in conjunction with the initial assessment can help support the assessed functioning baseline and help justify continued necessity.
4. The assessment contains an integrative summary of prioritized therapeutic treatment needs of the individual served that can be the only supportive medical necessity basis of goals in the action/service plan.

Figure below shows the Treatment Recommendations/Assessed Needs section of the NYSCRI Comprehensive Assessment:

Individual's Name (First MI Last): <input type="text"/>		Record #: <input type="text"/>		DOB: <input type="text"/>		
<b>Prioritized Assessed Needs:</b> <i>OASAS providers must provide clinical conclusions on each of the Eight Functional Areas:</i> <i>1 Chemical dependence/abuse; 2 Physical health; 3 Mental health; 4 Vocational/educational/employment;</i> <i>5 Social/leisure; 6 Family; 7 Legal; 8 Problem Gambling</i>				A-Active, IFD-Individual or Family/Guardian Declined, D-Deferred, N/A-Not Applicable, R-Referred Out		
				A	IFD*	D*
1.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Individual Declined/Deferred/Referred Out-Rationale(s) (Explain why the Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out/NA; Offer time frame for deferment below). <input type="checkbox"/> None						
1.	<input type="text"/>					

### Purpose of Comprehensive Assessment Updates In Medical Necessity Linkage Requirements

The key “dis-link” observed in the typical chart is the lack of current, continuous updates of newly assessed therapeutic needs identified by the individual served and/or direct care staff after the initial comprehensive assessment is completed. In many cases the Progress Note has been used to record any additional assessed needs after the initial assessment is completed which makes it the “primacy” documentation in the chart.

The challenge with the Progress Note being the primacy documentation tool in the chart is that it is very difficult to demonstrate to reviewers the qualitative assessed basis for the services ordered in the IAP if the additional assessed needs are buried in hundreds of Progress Notes. The Progress Note is not designed to support the qualitative weight and data elements needed to provide an updated assessment of treatment needs/recommendations, diagnostic changes and a prioritized summary of assessed therapeutic needs and justification for treatment that can be linked to Goals in the Individualized Action Plan. The standardized CA Update is an appropriate assessment form to record additional assessed information after the treatment process has begun that will provide a direct link between the assessed therapeutic need and the goal(s) in the Individualized Action Plan.

Figure below shows the section of the Comprehensive Assessment Update which would be used to update the Assessment.

<input type="checkbox"/> Update of New Information <input type="checkbox"/> Re-Admission <input type="checkbox"/> Annual Update – Date of Admission: _____	
<b>Reason for Update:</b> _____ <b>Date of Most Recent Comprehensive Assessment:</b> _____	
<b>Comprehensive Assessment Sections for Update</b> Check the box(es) next to the section(s) of the assessment (including addendums), which you are updating. Be sure to label all additional/updated information in your narrative with the number of the section of the Assessment or Addendum being updated.	
<input type="checkbox"/> 1. Reason for Referral and Chief Complaint/Presenting Problem	<input type="checkbox"/> 11. Trauma History
<input type="checkbox"/> 2. Psychiatric Illness/Substance Use/Addictive Behavior History	<input type="checkbox"/> 12. Social/Leisure
<input type="checkbox"/> 3. Mental Health and Addiction Service Treatment History	<input type="checkbox"/> 13. Physical Health History
<input type="checkbox"/> 4. Social and Developmental Status	<input type="checkbox"/> 14. Mental Status, Suicide, Violence
<input type="checkbox"/> 5. Sexual History	<input type="checkbox"/> 15. Life Goals, Strengths, Abilities and Barriers
<input type="checkbox"/> 6. Vocation/Education/Employment	<input type="checkbox"/> 16. Diagnosis (Case Management Only)
<input type="checkbox"/> 7. Military Service	<input type="checkbox"/> 17. Prioritized Assessed Needs
<input type="checkbox"/> 8. Legal	<input type="checkbox"/> 18. Other: _____
<input type="checkbox"/> 9. Living Situation	<input type="checkbox"/> 19. Other: _____
<input type="checkbox"/> 10. Family History and Relationships	<input type="checkbox"/> 20. Other: _____
<b>Update Narrative:</b> List each assessment section being updated with narrative explanation below it.	

### Purpose of Individualized Action Plan and IAP Review/Revisions in Medical Necessity Linkage Requirements

1. **Goals:** Utilizes assessed prioritized therapeutic needs from the comprehensive assessment (or subsequently dated CA Updates) to link to a corresponding goal in the IAP. The Goal linkage section from the NYSCRI Individualized Action Plan is shown below. As indicated, each numbered Goal in the IAP can be specifically linked to a numbered Treatment Recommendation/Assessed Need/Prioritized Assessed Need from one of the core Assessment forms / Updates. The *linkage occurs* by entering the Treatment Recommendation number, form date and checking the specific NYSCRI form type adjacent to the specifically numbered Goal.  
For programs accredited/regulated by CARF and OMH Parts 594/595 (Residential Care), the desired outcomes of treatment in the individual's own words are required. For other programs this is an optional data element.

Figure below shows the section of the IAP where the linkage is documented.

<b>Goal #</b>			
Linked to Prioritized Assessed Need # _____ from form dated _____: <input type="checkbox"/> CA <input type="checkbox"/> CA Update <input type="checkbox"/> RFA <input type="checkbox"/> Psych Eval. <input type="checkbox"/> Other: _____			
Start Date:	Target Completion Date:	Adjusted Target Date:	as per IAP Review Form Dated:
<b>Desired Outcomes in Individual's Words (Required for CARF &amp; OMH Parts 594/595):</b> _____ _____ _____			
<b>Goal</b> (State Goal for this Assessed Need in Collaboration with the Individual Served): _____ _____ _____			

By establishing this link to the Treatment Recommendations/Assessed Needs from one of these Assessments/Updates, the IAP fully supports an integrated clinical formulation



that effectively addresses the assessed symptoms, behaviors and functional needs of the individual served.

2. **Objectives:** Develops measurable Objectives that support step-by-step attainment of each goal. Objectives that end in “ing” (i.e., “increasing”, “decreasing”, or “improving”, etc.) usually do not have the ability to specifically measure attainment. Perhaps the best and most humorous example of the need to develop very specific and measurable objectives was a handwritten notation from an auditor that read “Improving client’s relationships”. The auditor’s note read “With NATO? With Mexico?” Difficult to know if and when the objective was achieved. In training staff, the concept of writing very specific objectives produces a level of anxiety in that in many cases objectives have historically been more general/non-measurable, which has provided a lower goal/objective attainment rate. The more the Goal in the plan is formulated to be a broad long term achievement effort, the more objective and measurable the objectives supporting that goal need to be in order to show attainment and benefit to the individual served from the services provided to support ongoing Medical Necessity determination. The figure below provides the NYSCRI IAP Objective Section that includes the measurable/attainable objective, the start date and duration, efforts the individual served will take, his/her family/others, if clinically appropriate, the intervention methods (see item three following), the service description/modality, frequency and providers responsible.

<b>GOAL # ____ OBJECTIVE ____:</b>				
<b>Start Date:</b>	<b>Target Completion Date:</b>	<b>Adjusted Target Date:</b>	<b>as per IAP Review Form Dated:</b>	
<b>Intervention(s) / Method(s) / Action(s)</b>		<b>Service Description/ Modality</b>	<b>Frequency</b>	<b>Responsible: (Type of Provider)</b>

3. **Intervention(s) / Method(s) / Action(s):**  
The concept of documenting specific interventions, methods, or actions that will be used to support attainment of each Objective seems to create a significant change in practice. In many cases, Interventions and Services have been used interchangeably. The service such as individual therapy is not the intervention, method, or action but rather the service location/modality that is being ordered in the plan where the therapeutic interventions will be provided. The ability to order specific interventions in the clinical formulation of the Individualized Action Plan provides needed support/clinical guidance to provide and document the specific therapeutic interventions provided in the structured Progress Notes. This linkage from the progress note to the IAP is a critical Medical Necessity documentation linkage requirement. (i.e., If the assessed need is Anger Management as evidenced by..., and the corresponding Goal in the plan is, “Like to stop losing my cool all the time”, and the measurable Objective is “Reduction of anger episodes per week from 10 to 7 based on individual’s self report”, then the intervention could be, “Help individual identify anger triggers”. The ordered service (location) could be Outpatient Therapy or Anger Management Group, etc.
4. **Services:** The IAP will serve as the order for interventions and services if the following elements are incorporated
  - a. Goals and Objectives with start date and target date of completion.

- b. Service Code or Descriptor link to specific therapeutic interventions for each Objective.
- c. Disposition to specific Clinical staff with appropriate credentials to deliver the ordered interventions in the service location/type ordered.
- d. Indication of Frequency and Duration of Services ordered.

### **Purpose of IAP Review/Revision in Medical Necessity Linkage Requirements**

In many cases the Progress Note has been considered an adequate IAP Update. When the need to utilize an IAP Review/Revision is presented, numerous times staff will respond, "It's in the Progress Note and, therefore, it is in the Chart which has been good enough in the past!" Typical historical quantitative audit standards perhaps allowed the practice of "if the documentation is in the chart, that is adequate"; however, qualitatively if the intervention being provided is not linkable to a specific objective and goal in an Individualized Action Plan (or subsequently dated IAP Review/Revision) then it is not ordered and not reimbursable. Therefore, the use of an IAP Review/Revision is essential with the usual reasons for use being:

- 1. Attainment of Goal and/or Objective that requires the development of an additional Goal(s) or Objective(s).
- 2. Need to increase the Frequency and/or Duration of an ordered intervention.
- 3. Need to modify or add interventions in number or intensity.
- 4. Need to modify or add an ordered service/modality.

The standardized IAP Review/Revision form is a critical part of maintaining a Medical Necessity Linkage between the assessed need and the documentation of the interventions provided that are appropriately linked to a specific goal(s)/objective(s).

### **Purpose of Structured Progress Notes in Medical Necessity Linkage Requirements**

The Progress Note provides an opportunity to provide specific linkages between the interventions provided in the service to the IAP (IAP Review/Revisions) by requiring that the Goal(s) and Objective(s) being addressed in the service session be clearly identified within the note. In many cases, staffs have indicated their inability to record the specific Goal(s)/Objective(s) they are addressing in the Progress Note as a result of not having the IAP available or completed. Again the practice of providing services without a plan and/or without the ability to link the interventions provided in the session to specific Goal(s) and Objective(s) in the IAP seemed to meet most quantitative review requirements. However, in most cases this practice does not meet current qualitative reviews criteria. The NYSCRI standardized structured progress notes for individual psychotherapy, group psychotherapy, psychopharmacology services, nursing services, intensive service activities, etc. have been designed to address the need for specific elements of information to be recorded on each note.

The figure below shows the critical linkage portion of the standardized Progress Notes which is the section entitled "New Issues Presented Today". If the individual served shares totally new information with the worker that was not included in the original assessment and the worker assesses that the information shared constitutes an ongoing need then one of two actions is required:

**New Issues / Stressors / Extraordinary Events Presented Today:** ☐ New Issue Resolved, No Update Required

☐ New Issue, CA/IAP Update Required ☐ None Reported

**Explanation:**

This section of the Progress Note provides three check box indicators - “None Reported”, “New Issues Resolved, no updates required”, and “New Issue, CA/IAP Update Required”, that are to be used as follows:

1. If the individual served *does not* share any *new information/issues* at the session being documented, check “None Reported”.
2. If the individual served *shares new information/issues* during the meeting that are assessed by the worker to **not** constitute a continuing treatment need, check “New issues resolved, no updates required” and record the information in this section of the note.
3. If the individual served *shares new information/issues* during the meeting that *were not included in the original Assessment, (or an earlier Update)*, and the clinician determines that the information *shared does constitute a continuing treatment need*, the linkage requirements are:
  - a. Check “New issue, CA/IAP updates required?” and record the new information in this section of the note. Indicate on the Progress Note that the individual has self-reported new information and it will be recorded on an Update. The new information provided by the individual served should be recorded on the Update form by checking the appropriate element of the Assessment that is being updated, then writing the element and the information in the open narrative section of the form. As noted above, this figure below provides this section of the CA Update as an example.

<input type="checkbox"/> Update of New Information <input type="checkbox"/> Re-Admission <input type="checkbox"/> Annual Update – Date of Admission:	
<b>Reason for Update:</b> _____	
<b>Date of Most Recent Comprehensive Assessment:</b> _____	
<b>Comprehensive Assessment Sections for Update</b>	
Check the box(es) next to the section(s) of the assessment (including addendums), which you are updating. Be sure to label all additional/updated information in your narrative with the number of the section of the Assessment or Addendum being updated.	
<input type="checkbox"/> 1. Reason for Referral and Chief Complaint/Presenting Problem	<input type="checkbox"/> 11. Trauma History
<input type="checkbox"/> 2. Psychiatric Illness/Substance Use/Addictive Behavior History	<input type="checkbox"/> 12. Social/Leisure
<input type="checkbox"/> 3. Mental Health and Addiction Service Treatment History	<input type="checkbox"/> 13. Physical Health History
<input type="checkbox"/> 4. Social and Developmental Status	<input type="checkbox"/> 14. Mental Status, Suicide, Violence
<input type="checkbox"/> 5. Sexual History	<input type="checkbox"/> 15. Life Goals, Strengths, Abilities and Barriers
<input type="checkbox"/> 6. Vocation/Education/Employment	<input type="checkbox"/> 16. Diagnosis (Case Management Only)
<input type="checkbox"/> 7. Military Service	<input type="checkbox"/> 17. Prioritized Assessed Needs
<input type="checkbox"/> 8. Legal	<input type="checkbox"/> 18. Other:
<input type="checkbox"/> 9. Living Situation	<input type="checkbox"/> 19. Other:
<input type="checkbox"/> 10. Family History and Relationships	<input type="checkbox"/> 20. Other:
<b>Update Narrative:</b> List each assessment section being updated with narrative explanation below it.	

The figure below provides the important linkage element on the second page of the CA Update which provides a place to record the Prioritized Assessed Needs with justification for treatment or indicate that there are no additional recommendations clinically indicated.

Treatment Recommendations / Assessed Needs: <input type="checkbox"/> No Additional Recommendations Clinically Indicated				
A-Active, ID-Individual Declined, D-Deferred, R-Referred Out (If declined/deferred/referred out, please provide rationale)				
1. <input type="text"/>	A	ID*	D*	R*
2. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Individual Declined/Deferred/Referred Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred or Referred Out below). <input type="checkbox"/> None				
1. <input type="text"/>				
2. <input type="text"/>				
3. <input type="text"/>				

The figure below demonstrates a linkage section to cue the clinician to determine if existing Goal(s) and Objective(s), therapeutic interventions, services/modalities, provider type, duration and frequency address the newly identified assessed therapeutic needs. If yes, then the clinician should go back to the Progress Note and check the appropriate Goal and Objective and provide interventions ordered.

Change In IAP Required: <input type="checkbox"/> No <input type="checkbox"/> 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)
--

- b. If there is not an existing Goal and Objective that meets the newly assessed needs or if an existing Goal and Objective needs to be changed/revised to add new interventions, service/modalities, frequency, responsible staff, duration, etc. then worker can complete an IAP Review/Revision. The newly created Goal and Objective(s) in the IAP Review/Revision can be noted on the Progress Note as interventions are delivered for the newly created Goal/Objective(s).

## **Section 4 – NYSCRI Integrated Documentation Approach**

In addition to the primary link based clinical documentation processes, there are several others that were simultaneously developed by the NYSCRI Standardized Documentation Team to ensure that appropriate linkages are designed into the total documentation process. Each process is supportive of another and the total clinical documentation process is utilized to continuously document support and an update of Medical Necessity.

### **A. Signature Requirements for NYSCRI Documentation Process**

Each provider agency must independently determine its own policy and procedures regarding signature requirements for each of the NYSCRI forms. Most of the forms provide for multiple provider and/or supervisory signatures to accommodate provider agencies' internal policies/procedures. The development of each form was guided by state and federal regulations as well as the standards of the major accrediting bodies in allowing for provider, individual served, and supervisory signature lines.

### **B. Signature Instructions**

Signature instructions for all forms universally require a legible signature. This is critically important. Federal and state auditors will throw out perfectly good claims on an audit if they cannot determine who provided the service. Additionally, day-to-day practice requires an understanding of who had an interaction with an individual served, and subsequently entered information into the medical record. The Joint Commission standards require that provider agencies develop a register of provider names and their signatures in order to be able to identify particularly obscure or sloppy signatures. (This is good practice regardless of your accrediting body.) Additionally, signature instructions universally require that a provider's or supervisor's signature be accompanied by their credentials and the date of the signature. This is both a payer/payment issue, as well as a risk management issue.

- Most states have laws regarding the licensure of professionals and the services or service array they are eligible to provide as a result of their licensure.
- Some states may issue certification requirements or licensing requirements for facilities that also are concerned with the credentials of providers and the services they are allowed to provide.
- Most payers have very specific standards for the type of provider credentials they will reimburse for specific services.
- In many cases, both the state and the payers have similar requirements. In some cases, payer standards are more stringent than state law or may cover providers who are not the subject of state laws, such as paraprofessionals. In those cases, payer rules must be followed in order to bill for a service.
- Provider agencies may issue their own requirements that exceed state and payer requirements, but cannot allow for lesser credentials.

Signature instructions also require that each provider date their signature. This may or may not be the date of service. Providers should not, under any circumstances, back-date their signature to match the date of service.

## C. Credentials Instructions

In listing the credentials of the provider, it is recommended that the following generally accepted conventions apply:

1. If the provider is licensed, he/she should list next to his/her name the highest level of licensure achieved that is related to the service being recording. For example, if an individual who is an RN and also an independently licensed social worker is providing psychotherapy, then social work credentials would be recorded. If a medical-somatic service is being provided, the RN credentials would accompany the signature.
2. If the provider is not licensed and the service requires a certain educational degree, record the degree, e.g. B.A.S.W., B.S.R.N., B.S.
3. If the provider is not licensed and the service requires specialized training and certification, record the certification, e.g. CASAC.
4. If the Provider is not licensed and the service requires that the provider have a certain amount of educational or specialized training or experience that is not easily recorded as credentials, then agency policy/procedure should be followed regarding the credentials that should accompany the signature. For example: *"The provider must have 2 years of experience in providing services to the seriously mentally ill population."* In many cases, the provider should also list or abbreviate his/her job title, such as CM or case manager. Providers are encouraged to consult state laws, regulations and certification standards to define internal policy for signatures and credentials required to authorize services. In **all** cases where licensure, training, education, and/or experience are required, the documentation that provides proof of this should be kept in the Provider Agency's personnel files and available to auditors.

## D. NYSCRI Billing Strip Instructions

Below are the instructions for completing the Billing Strip on all NYSCRI forms. Individual sections of the Training Manual will not repeat these instructions.

Standard Billing Strip Sample:

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes

### Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
<b>Date of Service</b>	Date of session/service provided
<b>Staff ID</b>	Specify the individual staff member's ID as defined by the individual agency.
<b>Location Code</b>	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
<b>Procedure Code</b>	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.
<b>Modifier 1, 2, 3 and 4</b>	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
<b>Start Time</b>	Indicate actual time the session started. <b>Example: 3:00 PM</b>
<b>Stop Time</b>	Indicate actual time the session stopped. <b>Example: 3:34 PM</b>

Data Field	Billing Strip Completion Instructions
<b>Total Time</b>	Indicate the total time of the session. <b>Example: 34 minutes</b>
<b>Diagnostic Code</b>	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD or DSM code as determined by their agency's billing policies and procedures.

## **E. General Medicare “Incident to” Services Information**

Medicare provides for payment for certain services that are provided “incident to” the services of a physician or “certain non-physician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants”.

Incident to services are those that are integral to the services of the professional but are not provided directly by them. This allows in certain cases for providers not eligible to bill Medicare directly to bill for their services provided under the direct supervision of an eligible supervising professional.

There are a number of rules that must be followed in order to bill services “incident to” and the Medicare Carrier for New York should be contacted in order to make sure all requirements can be met.

One of the most important of the “incident to” rules is that each and every service must be provided under the “direct” supervision of a Medicare eligible professional. These professionals can only supervise services they can either provide or supervise under their scope of practice under state law. They must also be available and in the office suite at the time the service is provided.

The NYSCRI forms allow for the provider to document compliance with the direct supervision rule with a checkbox to alert billing that the service was provided “incident to” and the name and credentials of the supervising professional. Medicare will be easily able to audit compliance with this requirement and providers will have sufficient back up for the claim. Below are the NYSCRI forms that contain the Medicare “Incident to” checkbox:

1. Group Progress Note
2. Session Progress Note
3. Psychopharmacology – Psychotherapy Progress Notes
4. Partial Hospitalization Progress Note
5. Nursing Progress Notes

**Standard “Medicare “Incident to” Services Only” box:**

<input type="checkbox"/> Medicare “Incident to” Services Only		Name and Credentials of Medicare Supervising Professional on Site								
E & M Only		<input type="checkbox"/> Greater than 50% of face to face time spent providing counseling and/or coordination of care.								
Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes

**Instructions for Completing the Medicare “Incident to” Services Only Box**

Data Field	Billing Strip Completion Instructions
Medicare “Incident To” Services Only	Check the box when service is to be billed using the “incident to” billing rules.
Name and credentials of Medicare Provider on Site:	<p>Enter the name of the supervising professional who provided the on-site supervision of the “incident to” service.</p> <p><b>Note:</b> The presence of an appropriate licensed supervising professional is one of the key requirements for an “<i>incident to</i>” 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.</p>



## Section 5 – NYSCRI Compliance Grids

### A. The Reasons for the Compliance Grids

Compliance Grids contain the documentation requirements set forth by the major regulatory/accrediting and payer bodies affecting outpatient and residential treatment providers. Although every private payer was not consulted, the original Long Island Pilot Compliance Team believed that the standards reflected in the compliance grid fairly represented the documentation requirements of most commercial payers.

These grids look only at the actual standards or regulations; they do not consider quality of the documentation or other indicators that might also create audit risk for agencies and providers. Accrediting bodies are generally looking at clinical documentation for evidence that provider agency policies and procedures related to documentation and clinical care are being followed and are resulting in quality care and positive clinical outcomes.

The [Compliance Grid](http://www.omh.ny.gov/omhweb/nyscri/docs/compliance-grid.xlsx) can be found on the NYSCRI web site <http://www.omh.ny.gov/omhweb/nyscri/docs/compliance-grid.xlsx>. The grids cite the most recent standards available to NYSCRI from payers, regulators, and accrediting bodies at the time of the publication of the grids.

### B. How to Interpret and Use the Compliance Grid

The Compliance Grid itemizes each area of information required for core NYSCRI form types, and cites, as applicable, the particular regulation, rule, or standard requiring the information.

The **NYSCRI Compliance Grid** is designed as follows:

- Column A: The number given to the element identified by the Compliance Team.
- Column B: The Focus Area - name or description of the element and/or required information
- Additional Columns:
  - NYS Regulations (OMH, NYS DOH, OMH-PROS, OMH Standards of Care (SOC), OASAS).
  - Accreditation Standards – The Joint Commission (TJC); CARF International; and Council on Accreditation (COA).
  - Federal Payer Requirements: Medicaid and Medicare.

To use the grid, locate within each major section (i.e. Assessments, IAPs, Progress Notes and Assessment Addendums) the particular area of interest via the tabs (i.e. Assessment, Additional Children Items, Psychiatry, etc.). Find the particular focus area of interest and read across to find citations in the applicable state regulations, accreditation standards, and federal payer's standards. Finally, read any comments relating to that area.

In addition, a [Regulations and Standards Reference Guide](http://www.omh.ny.gov/omhweb/nyscri/docs/regulation-standards-reference-guide.xls) is available at: <http://www.omh.ny.gov/omhweb/nyscri/docs/regulation-standards-reference-guide.xls>. This spreadsheet references the sections under each regulatory and accrediting authority consulted when formulating the NYSCRI documentation system.

## Section 6 – NYSCRI Documentation Supporting Quality Treatment

### A. The Value of NYSCRI Standardized Forms and Processes

By: Bill Schmelter, Ph.D., M.T.M. Services and National Council on Behavioral Healthcare Consultant

The NYSCRI standardized forms and processes were designed to improve the “value” of clinical documentation for individuals served, the staff that provide services, and the organizations that support service provision.

Understanding the intended value of various aspects of the NYSCRI standardized forms and processes is an important step in their optimal implementation for several reasons.

**First**, an understanding of, “what’s in it for us and the people we serve” is necessary if staff are going to make the effort to fully learn and take advantage of the forms and processes as intended.

**Second**, understanding the ‘why’ of the forms and processes design can improve the value that results from their implementation. There are many examples of well designed forms and processes that are misused, thus neutralizing their intended value.

Well designed standardized clinical forms and processes can do much more than simply provide a format for recording information. This section discusses the potential *value* of the NYSCRI standardized forms and processes in the following three areas:

1. Improved service quality and compliance.
2. Support for ‘person centered, recovery/resiliency oriented services’.
3. Improved system learning and responsiveness.

#### 1. Improved Service Quality and Compliance

Documentation compliance efforts are often viewed by direct provider staff as independent of or even obstacles to, clinical quality. For example, staff frequently report that documentation requirements interfere with their ability to interact with the individuals they serve. A well designed set of forms and processes should assist and support staff and individuals served as they navigate the recovery process together, not get in their way.

The purpose of compliance standards is to ensure baseline levels of service quality and accountability. Any effort to improve compliance should maintain a focus on how those efforts will improve the quality of care provided. The NYSCRI standardized forms and processes were designed to provide the most current support for compliance, to guide good practice, and to improve service quality and outcomes in the most efficient manner possible.

All forms in the NYSCRI standardized forms set were cross referenced with applicable standards and regulations to insure compliance. In addition the structure and content of forms were designed to efficiently support core clinical and recovery processes.

The **Comprehensive Assessment** promotes participation by the individual being served and encourages an interactive dialogue. Through a carefully planned sequence of assessment focus areas and prompts, the Assessment supports the efficient collection and analysis of information to:

- Accurately determine and support diagnoses.
- Identify individual strengths, preferences, and personal goals.

- Identify social, environmental, and other barriers to recovery.
- Identify available supports and resources.
- Establish baselines for symptoms, domains of functioning, skills, and abilities.
- Articulate and prioritize needs and recommended services.
- Justify the medical necessity for the types and intensity of services to be provided.
- Lay the groundwork for development of a meaningful Individualized Action Plan.

The **Comprehensive Assessment Update** is designed to ensure that:

- Relevant new or updated information is incorporated into the Assessment.
- Current Assessment data and conclusions directly support the current Individualized Action Plan.
- 

The **Individualized Action Plan** is designed to efficiently:

- Ensure active linkage to the findings and recommendations of the current Assessment.
- Encourage collaboration between the provider and the individual served.
- Encourage the meaningful consideration of strengths, preferences, and personal goals in the development of goals and objectives.
- Support the development of meaningful goals.
- Support the development of realistic, relevant, and measurable objectives that are changes to the baselines established in the Comprehensive Assessment.
- Support the clear articulation of interventions (methods), and service strategies that are expected to help achieve stated objectives and can meaningfully direct staff activities.

**Progress Notes** are designed to efficiently:

- Ensure that interventions/methods remain focused on the goals and objectives developed in the Individualized Action Plan.
- Encourage description of interventions provided, the response/reaction to the interventions by the individual served, and progress toward goals/ objectives.
- Articulate plans for activities recommended prior to the next session as well as the focus for the next session.
- Document pertinent new information that may trigger a Comprehensive Assessment Update and potentially require a change in the Individualized Action Plan

All other forms in the NYSCRI Standardized Forms set were similarly designed to support the underlying processes they reflect.

## **2. Support for Person Centered, Recovery Oriented Services**

The NYSCRI standardized forms and processes were designed to help move efforts to provide person centered, recovery/ resiliency oriented services from theory to practice.

### **Person Centered Approach:**

A person centered approach involves a genuine partnership between a provider and the individual being served throughout all aspects of the service process including assessment,

action planning, and service interactions. Person centeredness is not just about ‘respect’ or good ‘customer relations’. These should be core elements of any responsible service orientation. Rather, person centeredness is about improving outcomes!

Engaging in the recovery process takes significant and prolonged effort on the part of the recovering individual. Unless individuals believe that providers fully understand their personal goals, strengths, obstacles, and what they hope to gain from services, motivation and engagement will suffer.

Motivation and engagement are enhanced when individuals have real input into the development of goals and objectives that reflect personally desired change and can be easily related to the achievement of personal goals. Finally, ongoing service engagement will only occur if individuals understand how the services they receive are helping them reach the objectives they and their service providers committed to work on.

Person centered services ensure that Assessment and Action Planning are considered more than just paperwork, and that services provided are focused and of value to the individual served. The NYSCRI standardized forms set provides significant support for Person Centered Services.

### **Recovery Orientation:**

Recovery is another concept that has been difficult for many service providers to implement in a practical sense. One nationally accepted definition of recovery is, “A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.”

For obvious reasons the person centered approach discussed above is central to supporting recovery. In addition, a Recovery orientation requires a shift from a primary focus on symptom reduction to a focus on improvement in functioning, resilience, and adaptation.

The NYSCRI standardized forms and processes are designed to support a person centered, recovery oriented approach. It is up to service providers to take advantage of that support.

The Comprehensive Assessment is designed to efficiently prompt exploration of a wide range of issues. The focus is not limited to symptoms and diagnoses, but includes functioning domains, skills, strengths, preferences, available and needed supports, and personal goals. It is important to encourage the individuals being served to offer their perspectives in areas of importance to them and to ensure that they understand the purpose and value of the assessment. This is particularly important when developing identified needs that will form the basis for the Individualized Action Plan.

The Individualized Action Plan is also designed to encourage the active participation of the individual being served and to allow a focus on functioning. This is particularly important in the development of goals and objectives, which should be achievable, realistic and of value to the individual. The opportunity to identify individual strengths and how they can be brought to bear to help achieve goals and objectives is also provided.

Individual Action Plans should not be overly complex. It is difficult for most people (including provider staff) to maintain a focus on more than a few goals and a few objectives at a time. By focusing on a few, relevant objectives, success is easier to achieve and measure thus further building motivation and engagement.

The Progress Note is also designed to support this approach. It is important to maintain “Action Plan Awareness” when providing services. This means that it should be clear to the provider as

well as the individual served what the current intervention session has to do with the achievement of a particular objective(s) in their Action Plan. It is all too common to find progress notes that document conversations about current 'mini crises' or other 'topics of the day' with no obvious connection to the Action Plan. As providers, we have a responsibility to help maintain Action Plan Awareness and provide interventions that help the individual achieve the agreed upon objectives or, based on changing conditions, modify the Action Plan in collaboration with the individual served.

For many of the people we serve, past experience with services has left them with low expectations. In their experience, Assessment and Action Planning may have been primarily paperwork exercises with little connection to the service interactions they have had with provider staff. For these individuals, involvement in person centered, recovery/resiliency oriented services will involve some relearning. This involves extra effort on the part of provider staff to help instill a sense of hope and engagement.

### **3. Improved System Learning and Responsiveness**

The uncontrolled proliferation of forms is a common problem in behavioral health service settings. Frequently no single person or entity is even aware of all the forms used within their organization.

This situation, in addition to putting an unnecessary strain on an organization's ability to train new staff or retrain existing staff for new assignments, makes responding to change a daunting task. Conforming to new regulations or accreditation standards can mean analyzing and making changes in dozens of forms.

Similarly, any planning process for programmatic, quality improvement or other rapid cycle change initiatives will frequently identify the need to undertake complex and costly changes in documentation as a significant obstacle. Just the proposition of needing to make changes in numerous forms can sometimes derail an otherwise worthy undertaking.

A standardized set of forms and processes that have been specifically designed to meet applicable regulatory and accrediting body standards, as well as to support clinical practice, makes staff training easier, more consistent, and more effective. In addition, responding to changing conditions can be accomplished in a more efficient and coordinated fashion.

Documentation standardization at the system (e.g. statewide) level greatly increases the benefits discussed above. While all behavioral health organizations have similar core missions and similar documentation change requirements to address evolving regulations and accreditation standards, they have historically been left to their own devices in terms of developing responses. Organizations have not been able to take full advantage of the experiences of other providers (e.g. audit findings) because their core documentation forms and processes are significantly different.

Supervision and monitoring systems also benefit from the adoption of standardized forms and processes. Because forms are consistent, supervisory, medical records, utilization review, and quality improvement staff can use more standardized approaches to supervision and documentation review and can benefit from the experience of others. Standardized monitoring tools can be developed so that benchmarking both within and among provider organizations becomes more practical.

Another benefit of a collaboratively developed standardized form set is its value as a critical step for the potential conversion to an Electronic Health Record (EMR) format. The biggest challenge organizations face when preparing for this transition is identifying and piloting the form elements

and processes they want represented. The development of the NYSCRI standardized forms and processes are a major step in preparing for EMR conversion for interested organizations. In addition, statewide system adoption of a common set of standardized forms and processes can create an economy of scale that greatly reduces the cost of EMR conversion and ongoing support for any particular organization.

Adoption of the NYSCRI standardized forms and processes will make it possible for all organizations to take advantage of the experience of other providers and to participate in and benefit from coordinated responses to change, training, and support.

## **B. Additional Background on Recovery Oriented Documentation**

Based on work by the NYSCRI Consumer, Family Advisory Committee CFAAC; Updated 10/13

Studies show that orienting health care around the preferences and needs of people using medical treatment has the potential to improve patient's satisfaction with their care, as well as their ... outcomes.<sup>4</sup>

Historically, the nation's mental health system was not guided by individuals' life goals and ambitions. In July of 2003, The President's New Freedom Commission on Mental Health reported the following state of affairs:

- "... [Individuals] and their families do not control their own care."<sup>5</sup>
- "Currently, adults with serious mental illness [diagnoses] ... have limited influence over the care they receive ..."<sup>6</sup>

Promotion of person-driven, person-centered and recovery oriented approaches, seen throughout NYSCRI, comes from a variety of leaders within the healthcare arena.

The Institute of Medicine defines patient-centered care as:

*"Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care... [Patient-centered care is] respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions."<sup>7</sup>*

Moreover, in 2006, The Institute issued ten rules to guide the redesign of health care. The first four of these expressly embrace the core values of person-driven care:<sup>8</sup>

1. Care should be based on continuous healing relationships.
2. Care should be customized based on the individual's needs and values.
3. The [individual] is the source of control.
4. There should be shared knowledge and a free flow of information.

<sup>4</sup> Agency for Healthcare Research and Quality, *National Healthcare Quality Report*, Dec. 2005.

<sup>5</sup> *Achieving the Promise: Transforming Mental Health Care in America*, page 28

<sup>6</sup> *Achieving the Promise: Transforming Mental Health Care in America*, page 29

<sup>7</sup> *Envisioning the National Health Care Quality Report*

<sup>8</sup> *Appendix B: Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, 10 Rules for Health Care Reform

NYSCRI supports a recovery oriented approach as well which is consistent with The Substance Abuse and Mental Health Services Administration's (SAMHSA) working definition of recovery which:

- ✓ Emerges from hope
- ✓ Is person-driven
- ✓ Occurs via many pathways
- ✓ Is holistic
- ✓ Is supported by peers and allies
- ✓ Is supported through relationship and social networks
- ✓ Is culturally-based and influenced
- ✓ Is supported by addressing trauma
- ✓ Involves individual, family and community strengths and responsibility
- ✓ Is based on respect<sup>9</sup>

In addition, in 2005, The American Psychiatric Association (APA) endorsed and affirmed the application of the concept of recovery to the comprehensive care of those with mental illness: *"The concept of recovery emphasizes an individual's capacity to have hope and lead a meaningful life, and suggests that treatment can be guided by attention to life goals and ambitions."*<sup>10</sup>

Finally, in addition to other significant information, the publication, Morbidity and Mortality in People with Serious Mental Illness<sup>11</sup> offers further support for the concepts of recovery and person-centered care.

### **C. Collaborative Documentation – A Person-Centered Process**

NYSCRI form processes support the use of this voluntary style of documenting work with an individual/family. Documenting services at the time and in the place they are provided is an excellent way to ensure a person-centered documentation process. **Collaborative Documentation** gives the provider a concrete tool for inviting the individual to *direct the description, course, and ultimate outcome of their own treatment*. At the same time, **Collaborative Documentation** employs the provider's expertise, and the form itself, to keep documentation of medical necessity on track.

**Collaborative Documentation** allows the service provider to proactively confirm:

- The goals and actions addressed during the session;
- The therapeutic interventions provided by direct care staff;
- Feedback concerning progress made and perceived benefit of the service; and
- The obstacles to progress (clinical or process) and the strategies to overcome them.

In addition, documenting at the time of service reduces stress for providers who are chronically behind in documenting their work.

For further resources on [Collaborative Documentation](#)<sup>↗</sup>, please refer to:

<http://www.thenationalcouncil.org/expert-buzz/2013/09/collaborative-documentation/><sup>↗</sup>










<sup>9</sup> <http://blog.samhsa.gov/2012/03/23/definition-of-recovery-updated/><sup>↗</sup>

<sup>10</sup> The American Psychiatric Association, Position Statement on Use of the Concept of Recovery, July 2005

<sup>11</sup> <http://www.nasmhpd.org/Publications/NASMHPDMedicalDirectorsCouncil.aspx>,<sup>↗</sup> 2006

## Section 7 – Additional Clinical Resources

The following table is included to provide an easy link to other resources such as OASAS and/or OMH screening tools, clinical guidance, and NYSCRI Frequently Asked Questions.

Focus Area (Ctrl F to hyperlink)	Internet Address
<b>OASAS</b>	
<b>Traumatic Brain Injury TBI Screening Tools</b>	<a href="http://www.oasas.ny.gov/tbi/index.cfm">http://www.oasas.ny.gov/tbi/index.cfm</a>  <a href="http://www.oasas.ny.gov/TBI/HELPS.cfm">http://www.oasas.ny.gov/TBI/HELPS.cfm</a> 
<b>SBIRT (Screening, Brief Intervention, Referral and Treatment)</b>	<a href="http://www.oasas.ny.gov/AdMed/sbirt/index.cfm">http://www.oasas.ny.gov/AdMed/sbirt/index.cfm</a> 
<b>Clinical Guidance for Part 822 Providers (October, 2012)</b>	<a href="http://www.oasas.ny.gov/treatment/documents/ClinicalGuidance-Final.pdf">http://www.oasas.ny.gov/treatment/documents/ClinicalGuidance-Final.pdf</a> 
<b>Perception of Care (access to survey and online data reporting)</b>	<a href="https://www.oasas.ny.gov/POC/index.cfm">https://www.oasas.ny.gov/POC/index.cfm</a> 
<b>Depression Screens</b>	<a href="http://phqscreeners.com/pdfs/02_PHQ-9/English.pdf">http://phqscreeners.com/pdfs/02_PHQ-9/English.pdf</a> 
<b>OMH</b>	
<b>Clinical Rating Scales</b>	<a href="http://www.omh.ny.gov/omhweb/psyckes_medicaid/resources/clinician/tools/rating_scales.html">http://www.omh.ny.gov/omhweb/psyckes_medicaid/resources/clinician/tools/rating_scales.html</a>
<b>Clinic Standards of Care (Draft Guidance – March, 2013)</b>	<a href="http://www.omh.ny.gov/omhweb/clinic_standards/">http://www.omh.ny.gov/omhweb/clinic_standards/</a>
<b>Clinic Standards of Care Anchor Element</b>	<a href="http://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html">http://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html</a>
<b>OASAS/OMH</b>	
<b>Co-Occurring Disorders</b>	<a href="http://www.oasas.ny.gov/treatment/COD/index.cfm">http://www.oasas.ny.gov/treatment/COD/index.cfm</a> 
<b>Co-Occurring Disorders - History</b>	<a href="http://www.oasas.ny.gov/treatment/COD/History.cfm">http://www.oasas.ny.gov/treatment/COD/History.cfm</a> 
<b>Co-Occurring Disorders - Resources</b>	<a href="http://www.oasas.ny.gov/treatment/COD/Resources.cfm">http://www.oasas.ny.gov/treatment/COD/Resources.cfm</a> 



## Section 8 – Accessing and Using the Forms

### A. How to Access the Forms

1. As reference, see the [Form Usage Index](#)

(<http://www.omh.ny.gov/omhweb/nyscri/docs/form-index.xls>) to locate the applicable mandated and optional forms per your program type.

2. Within an EMR format, utilize the process delivered by your vendor or organization. Within a paper format, [access the forms](#) (<http://www.omh.ny.gov/omhweb/nyscri/nyscri-forms.html>) either through an Electronic Word version (fillable forms), or a paper based PDF.

### B. How to Use the Forms – An overall clinical approach to the form set

The forms are arranged in a way to support the clinical flow with individuals and their families. However, the documentation process is not intended to direct how a provider conducts an interview/intervention or service.

### C. Further Guidance

#### [Glossary:](#)

This section (<http://www.omh.ny.gov/omhweb/nyscri/docs/form-element-glossary.xlsx>) describes how to utilize the data fields across the entire form set.

**Form Descriptions:** Accompanying each form is a brief description of the form's purpose and associated instructions/examples.

## **Section 9 – Addendum I – Project History**

### **A. NYSCRI Pilot History**

NYSCRI was initiated on Long Island by The Long Island Coalition of Behavioral Health Providers and was developed in conjunction with the New York State Offices of Mental Health (OMH) and Alcoholism and Substance Abuse Services.

In March of 2009 the Quality Management Council (QMC), Standardized Documentation Team (SDT), Compliance Review Team (CRT) and the Consumers, Families and Advocates Advisory Committee (CFAAC) of the NYSCRI initiative embarked on a lengthy and challenging journey to investigate and develop standardized clinical documentation forms.

Having completed an inquiry and review of state and federal regulations, accreditation requirements, best practice standards, and generally accepted clinical and medical documentation styles, the teams began their work in April 2009 to develop a standardized documentation forms set.

The SDT used the Ohio and Massachusetts statewide standardized form sets and training manuals as models to direct their efforts. Additionally, the SDT reviewed sample forms/processes being used in New York State by mental health and substance use disorder providers. The CRT created compliance matrices for each group of NYSCRI documentation processes (e.g. Assessments, Individualized Action Plans, Progress Notes, and Transfer/Discharge Summary and Plan). These NYSCRI Compliance Grids will be addressed later in this section of the manual.

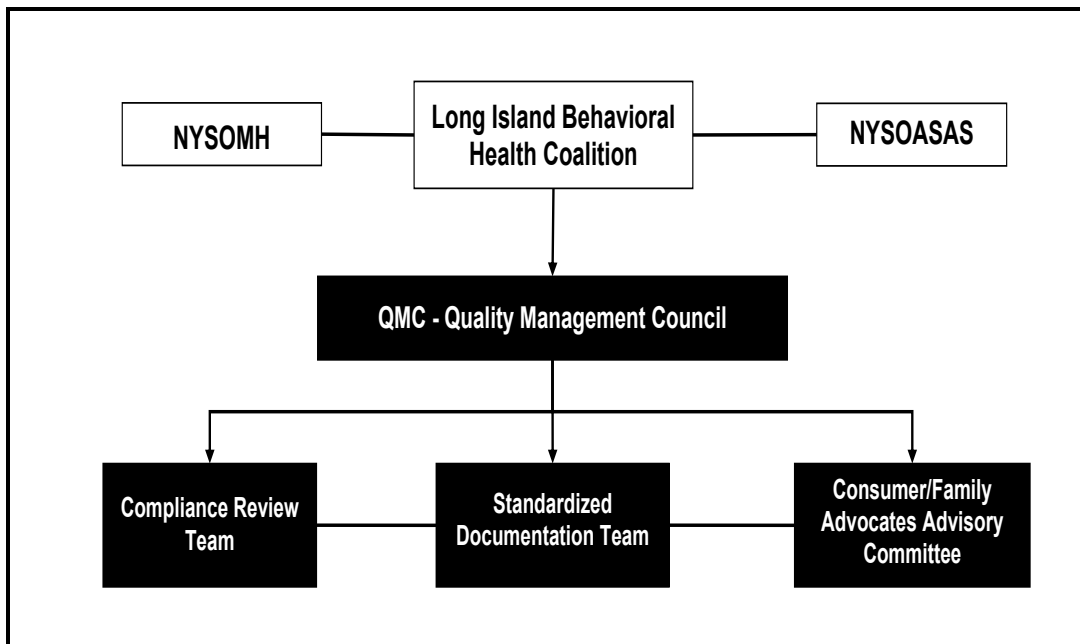
The draft Pilot Forms were reviewed by CFAAC members to provide an opportunity for their feedback and recommendations. Recommendations included names of forms/processes, the language used in form processes and manuals, support for a person-centered Individualized Action Plan approach to respond to the identified service needs in the Comprehensive Assessment, and other important recommendations.

During the spring and summer of 2010 the draft NYSCRI forms were piloted by 34 behavioral health agencies on Long Island. The piloting organizations received a full day of “train the trainer” training on the NYSCRI form development process; the concepts behind the form content, structure, and linkage support; the forms and form manuals; as well as on the pilot assessment tools. Local training was then conducted at each organization and feedback was obtained using the “NYSCRI Local Program Pilot Implementation Survey”. This instrument obtained information regarding the quality of the training and supports organizations received, as well as on the success of their local training program. The instrument also helped identify any additional information and/or supports needed to successfully implement the pilot.

The forms were then piloted by clinicians on actual cases for 6 weeks. Feedback and comments regarding the piloted forms were obtained using the following two methods:

### **NYSCRI Organizational Model:**

- The organizational model shown below was developed for the NYSCRI to provide an empowered and effective “top down” and “bottom up” support for the design, development, and implementation of the statewide initiative.



## **B. Team Descriptions**

The Pilot Project involved several different teams. Here are descriptions of each:

### **1. Quality Management Council (QMC)**

The role of the QMC was to provide leadership, vision, and statewide stakeholder involvement in the management, decision making and implementation of the NYSCRI documentation process. Members of the QMC and their stakeholder affiliation are identified below:

### **2. Compliance Review Team (CRT)**

The role of the CRT was to develop compliance grids for each clinical documentation process and review all draft forms/processes and supporting training manuals developed by the Standardized Documentation Team prior to the implementation of the Pilot Study and prior to the implementation of the final NYSCRI documentation process.

### **3. Standardized Documentation Team (SDT)**

The SDT was responsible for developing each documentation/form process and supporting training manuals, implementing the NYSCRI Pilot Study, and collecting and reviewing the evaluation feedback from participating pilot programs. The SDT operated using a three sub-group operational model that allowed simultaneous development of all NYSCRI documentation processes (Assessments, Treatment Plan, and Progress Notes).

#### 4. Consumers, Families, and Advocates Advisory Committee Membership

The CFAAC reviewed the NYSCRI documentation processes and provided valuable recommendations regarding how to support a Person-Centered Recovery/Resiliency service delivery approach. CFAAC members and their respective stakeholder affiliation are identified below:

##### C. Team Members

Below is a list of the members for each team that worked long hours to create a quality based, person-centered, recovery/resiliency focused, and compliant clinical and medical documentation form model for use statewide.

Member	Affiliation
Adams, Judy	OASAS Long Island Field Office
Arnold, Anu	FREE
Bartell, Barbara	CNGCS
Besserman, Cari	Phoenix House
Bloomberg, David	SCDCMHS
Bowling, Melena	Maryhaven
Buckley, Christine	Mercy Medical Center
Burzon, Scott	SCDCMHS
Campbell, Loren	Family & Children's Assoc.
Cassara, Joan	Pederson-Krag Center
Chelales, Joe	OASAS
Classi, Donna	Hands Across Long Island, Inc.
Cohen, Herb	Family Service League
Corbin, Ken	South Oaks
Demers, Denis (Co-Chair)	Catholic Charities
Dillon, Rosemary	Central Nassau
Dolan, Jim	NCDMHCDDDS
Dolecal, Karen	SCDCMHS
Doria, Judith	Central Nassau Guidance Center
Drew, Doug	NYS OMH Long Island Field Office
Fleishman, Anita	Pederson-Krag Center
Fogarty, Pat	Maryhaven
Gadsden, Alexis	Outreach Project
Greenfield, Steve	FREE
Hartley, Patricia	Pederson-Krag Center
Hincken, Patricia	Long Beach Medical Center
Hoffman, Michael	NYS OMH Long Island Field Office
Kaplan, Ron	FECS
Kaplan, Sherri	Central Nassau Guidance Center
Kizner, Leslie	FECS
Krajewski, Robin (Co-Chair)	NYS OMH Long Island Field Office
Lite-Rottmann, Lisa	OASAS

<b>Member</b>	<b>Affiliation</b>
Lott, Kristen	FREE
Lupo, Dora	NCDMHCDDDS
Malonowski, Maria	Hispanic Counseling Center
Manigat, Nancy	Family & Children's Association
Mayo, Deb	NAMI of Central Suffolk
McQuide, James	NYS OMH
Mickulas, Philip	Family & Children Assoc.
Newill, June	Maryhaven Center of Hope
Nye, Cynthia	Family Service League
Pandolfo, Gaylene	NYS OMH Long Island Field Office
Perez, Omayra	SSCGC
Reed, Diana	OASAS
Rice, Pam	Mental Health Association of Nassau Co.
Rinde, Lou-Ann	FECS - LIFE Program
Roth, Barbara	NAMI Long Island Regional Council
Ruben, Herb	Peninsula Guidance Center
Ruthen, Harleen	NCDMHCDDDS
Sanchez, Rosemary	Pederson-Krag Center
Santangelo, Christine	CNGCS
Savitt, Bob	North Shore University Hospital
Schmidt, Tom	SCDCMHS
Silberstein, Mary	OASAS
Smith, Jesse	Hands Across Long Island, Inc.
Steigman, Jeff	Pederson-Krag Center
Steinhardt, Susan	Options for Community Living
Tardalo, Frank	OASAS
Tedesco, Barbara	Mental Health Association of Nassau Co.
Vezer, Marge	SAIL
Weinbaum, Elizabeth	Concern for Independent Living

### **Consultation Team**

Below is a list of the M.T.M. Services consultation team members:

David Lloyd, NYSCRI Project Manager  
 Scott Lloyd, Lead SDT Consultant  
 Bill Schmelter, Ph.D., Clinical and Lead CRT Consultant