

# Clinical Decision Support Tools in Risk Management

by Center for Behavioral Health

**Winner: Chairman's Award, 2007 Negley Awards for Excellence in Risk Management**

Perhaps more than at any other time, behavioral healthcare, particularly community behavioral healthcare, is under attack by payers seeking fiscal recoupment. The Health and Human Services Office of the Inspector General (OIG) has set aggressive goals for paybacks. The Deficit Reduction Act alone is estimated to accrue \$350 million in recoupment from behavioral healthcare providers<sup>1</sup>. The State of Iowa has experienced a 65% payback in all Medicaid claims because they were found to be erroneous during an OIG audit in that State<sup>2</sup>. Much of the providers' risk in these initiatives is related to the inaccurate documentation of services. We identified two areas that needed to be addressed if we were to decrease our risk of payback.

The first problem cited in these audits is that providers had not shown a clear link between 1) an assessed need that is 2) related to a diagnosable condition which 3) leads to specified outcomes by 4) way of appropriate interventions. This is a difficult standard to reach technologically made worse by the sheer volume of clinical transactions done by provider organizations. For example, here at Center for Behavioral Health (CBH) we did over 250,000 clinical transactions in FY06 of which approximately 90% were Medicaid. Nonetheless, we believed that if we could find a way to document this "golden thread" (assessed need - diagnosis - outcome - intervention), our risk of payback in an audit would be substantially decreased.

The second problem that contributes to the documentation errors might best be called "clinical drift". This manifests itself when even excellent clinicians begin addressing needs that are not identified on the client's approved treatment plan. These

services may be clinically helpful or necessary but they are usually not defensible when audited. Clinicians are at even higher risk for this today because of increased productivity requirements. We believed we could both improve quality of care and mitigate our payback risk if we could help clinicians focus their documentation on the services approved on the treatment plan.

We addressed these problems by developing an entirely new kind of treatment plan and progress note to integrate into our existing Electronic Health Record (EHR). Though CBH has been paperless since 2003, we were unable to address this problem using our existing treatment plan and progress note. The new documents included sophisticated Clinical Decision Support (CDS) functionality that, to our knowledge, does not exist in any commercial behavioral healthcare EHR soft-ware. We named these products PsychRemix™ and are applying to patent it.

CDS is defined as ". . . active knowledge systems which use two or more items of patient data to generate case-specific advice".<sup>3</sup> CDS is well established in medical-surgical electronic medical records partly because medical practitioners have an abundance of quantifiable data available to them in the form of measurements and lab values. Consequently, it is easy to see how software could be written that would review two lab values and make a suggestion for further care. On the other hand, behavioral healthcare does not use quantifiable indicators as much as medical care, relying instead on textural descriptions of services rendered. While such notes might be more understandable (though even this is often arguable) they do not lend themselves to CDS.

One of the challenges posed by external auditors is a preference for an assessed need or problem as the driving force in treatment planning. Though not all assessments need to be objective and quantifiable, those that are, are less easily challenged in an audit. Because of this we integrated into our system an objective functional measure that would assess the needs of clients, automatically calculate a DSM-IV Axis V GAF score with high inter-rater reliability, and have those assessed needs pre-populate the treatment plan. The clinicians would then link each need with a diagnosis, identify what outcomes the client would likely expect, and identify what interventions would yield those outcomes.

All of this is done in the treatment plan, but it was our goal not just to ask the clinicians to do these tasks but rather to build CDS logic into the treatment plan to assist them. For example, when the clinician chooses an outcome to link with a problem, PsychREMIX™ has a library of outcomes that we created based on internal practice patterns and best practices in the industry. All include the behavioral descriptors "as evidenced by" so that outcomes can be measured. PsychREMIX™ preselects a list of the most likely outcomes for the client based on his functional level. The clinician can pick one of the pre-selected outcomes or expand the list to choose another outcome or create a new one. Groups of commonly associated outcomes can be combined into outcome groups.

For each outcome the clinician has chosen, she must associate one or more interventions from a library of all the treatment interventions offered here at CBH. Again, we wanted to assist the clinicians by pre-selecting a list of the most likely used interventions for this

problem. However, in this case a more sophisticated algorithm that uses the unique combination of age, diagnostic related group, and functional level of the client generates the pre-selected list. The clinician can choose one or more of the pre-selected interventions, but she may not define one because all the interventions we offer are listed, including the 20+ Evidence Based Treatments we have implemented. It should be noted that the choices of outcomes and interventions are easily done collaboratively with the client's input. The result is a treatment plan like the one shown in Figure 1. Note that the golden thread is clearly documented to include assessed need, diagnosis, outcome and intervention.

Similar CDS functionality was designed into the progress note and it was then integrated with the treatment

impairments germane to this service.

For example, if the service rendered was to observe the client taking his medications, PsychREMIX™ would not allow the provider to choose "Grooming" as the problem addressed by this billable service. Rather, something like "Medication Non-compliance" would be offered for the clinician to choose. The only problems available for this progress note are those that were originally identified on the treatment plan, and the only outcomes available are those originally identified on the treatment plan. However, newly identified needs/problems can be easily added to the treatment plan from the PsychREMIX™ progress note.

The clinician must then rate the client's progress on each problem addressed in this session using a seven point scale that ranges from "Complete"

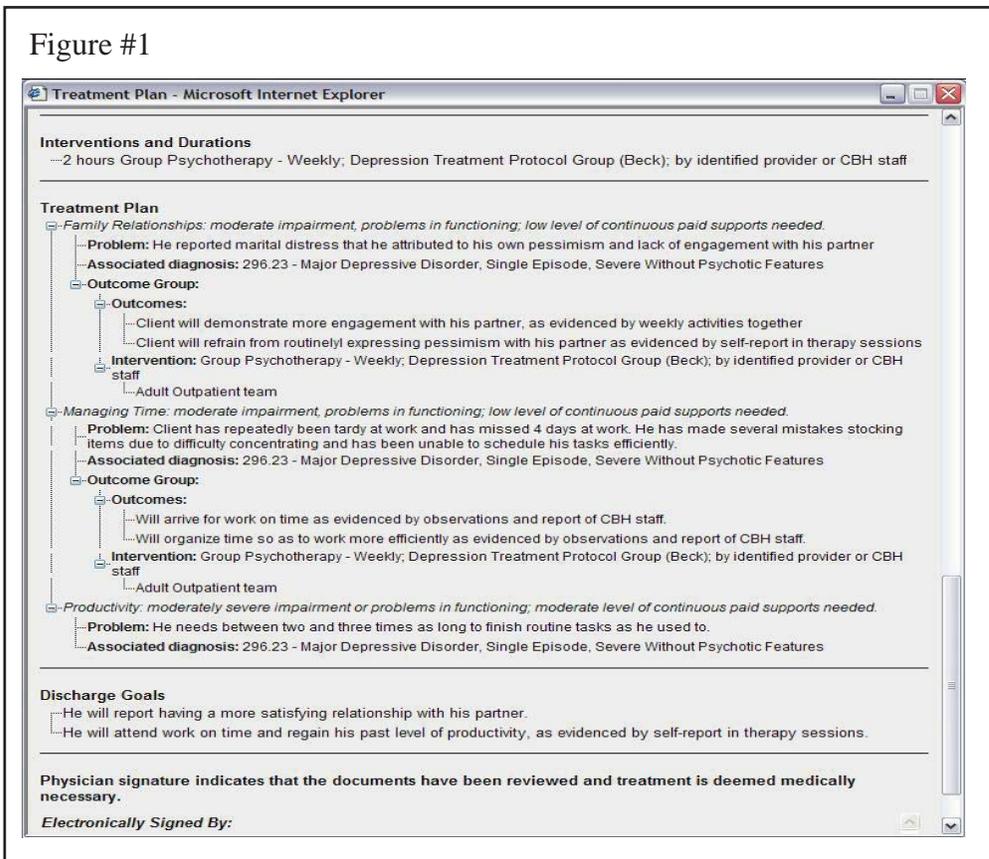
assessment. If the clinician indicates "Yes", PsychREMIX™ asks for a disposition or plan. If the client is not at risk, the clinician simply clicks "No" and completes the note as usual. Our goal is not to dictate practice to clinicians but to remind them to assess for risk when clients' progress toward goals takes a turn for the worse in any area of their lives.

To assist the clinician writing the note, PsychREMIX™ presents context-appropriate keywords that are specific to the particular service being rendered. These words are verbs that auditors and consultants have told us best describe what actually occurred in this type of service. For example, billing Life Skills Training would present verbs such as "Aided", "Coached" and "Trained" while billing for Medication Monitoring might present such words as "Observed" or "Monitored". If a clinician clicks on the word "Coached", that word is then automatically inserted into the text field that describes the billable service and the clinician can type in the remainder of the sentence around that word. An example of a completed progress note can be seen in Figure 2 (shown on page 8).

There is much more functionality available in the PsychREMIX™ product that can not be described in the space available, however, the reader can see that the documentation trail is substantially enhanced with PsychREMIX™. Lethality assessments are now automatically prompted based on the functional status of the client in real time; clinician "drift" is mitigated by requiring them to associate billable services with assessed needs and outcomes and to document progress towards goals for every outcome at every session; and hotlinked, context-sensitive keywords remind them how to accurately document this particular service.

The impact of PsychREMIX™ on our organization has been very positive. Both the treatment plan and

Figure #1



plan. To complete a progress note and bill for a service, the provider must select which problems were addressed in this treatment session from a pre-selected list that only displays those

to "Much Worse". To further mitigate potential risk, any goal the clinician rates as "Much Worse" triggers an alert asking whether this change in status warrants a suicide or homicide risk

See CDS on page 8

Figure #2

progress note were uniformly well received but of the two, the progress note received the most accolades by clinical staff. Both were developed with the clinician work flow in mind which they appreciated. It takes 30-50% less time to do a treatment plan now than in the past, and progress notes require very little typing compared to old free-form text blocks. Quality of care is enhanced because the system focuses the attention of the clinician on the assessed need of the client, not on the “problem *du jour*”. We have not been audited since implementing these products, but they have been reviewed by a well known consultant in the area of Medicaid compliance and she not only approved of them but asked if she could share what we have done with her other clients.

Having an EHR admittedly makes this easier to implement but this technology is portable to any organization willing to put the time and energy into it. The assessment tool we use is commercially available, and the outcomes, interventions and risk assessments were all developed in-house. The primary impetus for moving in this direction was to realign the organization before we were audited

based both on the OJG’s expressed recoupment goals and on the advice of some respected consultants in our industry. The enhancements described herein are fully implemented in our agency. This is how we do business and as a result, we believe our risk is significantly reduced. ❖

**References**

1. Thornton, Mary, *Issue Brief New Medicaid Compliance Issues from the Deficit Reduction Act*. National Council for Community Behavioral Healthcare: <http://www.nccbh.org/POLICY/ThorntonDRAandMedicaidCompliance.pdf>
2. *Audit of Iowa’s Adult Rehabilitation Services Program*, (A-O7-O3-03041) March 28, 2005 <http://oig.hhs.gov/oas/reports/region7/70303041.htm>
3. Wyatt J, Spiegehalter D, 1991 *Field trials of medical decision-aids: potential problems and solutions*. Proc Annu Symp Comput Appl Med Care 3-7.

**About Center for Behavioral Health:** Incorporated in 1967, CBH now serves 9000 clients annually. JCAHO accredited. Member of both MHCA and the National Council (NCCBH). Located in Bloomington, Indiana. CEO is Dennis P. Morrison, PhD. Phone 812-337-2302.