MANAGED CARE

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"Colorful Grapes" Artist: Linda L.

IN THIS ISSUE

Wellness Recovery Action Plan (WRAP)

Fresno County supports and encourages our providers to embrace and utilize wellness and recovery principles in treatment of our mental health clients. There is actually a training program for something called a Wellness and Recovery Action Plan (WRAP). WRAP® is a self-management and recovery system developed by a group of people who had mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives. WRAP is designed to:

- Decrease and prevent intrusive or troubling feelings and behaviors
- Increase personal empowerment
- Improve quality of life
- Assist people in achieving their own life goals and dreams

WRAP is a structured system to monitor uncomfortable and distressing feelings and behaviors and, through planned responses, reducing, modifying, or eliminating them. It also includes plans for responses from others when one cannot make decisions, take care of oneself, or keep oneself safe.

The person who experiences symptoms is the one who develops their personal WRAP. The person may choose to have supporters and health care professionals help them. Here are some links we found on the internet where you can find more information about WRAP. You just may find some very helpful tools here.

WRAP Home Page

WRAP Work Sheets

WRAP Personal Workbook

If you have further questions about WRAP, please contact Joan Keenen at (559) 600-4673

What's In A Name?

Over the years we have referred to those people we serve using several different terms ranging from "Client" to "Consumer" and from "Patient" to "Partner." Have you ever wonder what our clients prefer to be called? According to research* most prefer the term "Client." For consistency and as part of Fresno County's Department of Behavioral Health on-going efforts to provide a client and family-centered environment to those we serve, we are encouraging our providers to use the term "*clients*".

Covell, N., McCorkle, B., Weissman, E., Summerfield, T., & Essock, S. (2007). What's in a Name? Terms Preferred by Service Recipients. *Springer Science+Business Media, LLC.*

Let's Face It

When you begin to see a client for mental health services, you no longer need to send us the assessment and plan of care, but we still need to get the ***Face Sheet*** from you. As soon as you begin to see a new client, FAX us the face sheet ASAP so we can open the client's account in AVATAR as your client. This will let us know that you are providing mental health services for the client and will also assure that you get paid for the services you are providing. ***Let's face it***, if you want to get paid, we need to get ***the face sheet***. See what we did there? . . . a funny little play on words to help you remember to send us the face sheet. Okay. Managed Care trying to be funny might be an oxymoron. Sorry. Just wanted to give it a try. Thanks for indulging our attempt at humor. We now return you to your regularly scheduled reading. ☺

Splitting the Assessment and POC Service Time Over Two Sessions

Can this be done? Absolutely! Sometimes two hours straight is too much for the client to endure for an assessment and POC. The question then comes into play about how to document for your time so you get paid for the work you have done. Below is an excerpt from a recent audit question and answer session about how to document the time spent facilitating an assessment over a couple of days.

Q&A Documenting Service Time

Question: "From my understanding, an assessment does not need a separate progress note. The assessment itself will provide documentation regarding the date that the assessment was completed. Does this also apply to the Plan of Care? Should the date on top of the document be the date that the plan of care was signed?"

Answer: The date the assessment is completed should be the date on the assessment. The date the POC is completed should be on the POC. Since a POC is not effective until all required parties sign it, this should also be the date on the POC and the date the POC is billed.

Question: "If it takes a clinician 2 or more attempts to complete an assessment (clinical interview, collateral data collection, observation study, etc), where would the clinician indicate the different dates of services? "

Answer: If two or more days are required to complete the assessment this should be indicated on the assessment and a separate progress note will be needed for each additional day of the assessment. Each separate progress note will need to stand alone, i.e., it will need to include the elements of an assessment and should also state that the assessment took more than one day. For example, if two days are required to complete the assessment, the first day should be noted on a progress note; the second day on the assessment itself. A separate progress note is not needed if dated the same day as the assessment. The assessment is a stand alone document. The service/travel times only need to be indicated where required on the assessment/POC/progress note. They do not need to be summarized on the assessment. It only needs to be noted that the assessment began on one day and was completed on another day.

Question: "Can the clinician include the time it takes to complete/type up the assessment as part of the units of direct service and include this time at the top of the first page of the assessment?"

Answer: Yes. This is not different from past practice. All documentation and travel time can and should be included in the total time. The only change is that the new assessment and POC have a space for this info to be noted at the top of each form.

Question: "Regarding plan development services for reauthorizations, is the policy the same as assessments (include the service time and travel time at the top of page one, and include the different dates and service/travel times on the 'summary of presenting problem' section)?"

Answer: Travel, documentation and service time should be indicated on reassessments and POCs in the same way as it is on the Assessment and progress notes, at the top of each form. If two or more days are required to complete the assessment (formerly known as authorization request) this should be noted as above.

Managed Care will be closed on Monday, February 18th in observation of the National Washington's birthday holiday. Often people celebrate this three day weekend as "President's Weekend" — also honoring Abraham Lincoln's birthday, as well. Have a great holiday. We'll be back and open for business, as usual, on Tuesday the 19th.

This monthly feature has been developed to focus on one specific documentation skill that will help you meet State documentation requirements and increase the likelihood of passing your Managed Care audits with flying colors. This month's spotlight is on . . .

Documenting Interventions

When writing about interventions in your progress notes, the documentation needs to accurately reflect the types of interventions you originally identified in the consumer's individualized Plan of Care. Documentation must also demonstrate ***specific*** treatment interventions (rather than generic intervention information) that you used while providing that billable service.

The documentation must demonstrate that your treatment interventions are something that requires a trained professional to facilitate that an untrained person would not know how to do. For example, if you identify that your intervention was to listen to the client and that is all you identify as an intervention, that is something that could be disallowed because it does not take a trained professional to listen to someone talk. Anyone could do that.

Interventions need to accurately reflect what the clinician did to facilitate treatment rather than what the client talked about. It is important to document the client's content of the session, but that is a separate issue from documenting what ***you*** did in the session to help the client move towards their treatment goals. It does not mean that you have to write an epic novel in each note to describe your treatment interventions. Give a brief, non-generic, report of what ***you*** did that was therapeutic base on what you said you would do in the Plan of Care. The State is paying you to provide therapeutic services to the client you are writing about. Think of your intervention section as telling the State that you provided services only a trained professional could provide.