"Homeless Children" Artist Credit: Cynthia M.

MANAGED CARE

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The New DSM 5— Oh My!

In May 2013, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was released. There are many documented changes to commonly used diagnostic criteria, including widely discussed changes in the psychotic, developmental, anxiety and mood disorder categories.

Despite the fact that the book was available in May 2013, the State's Medi-Cal claims system will not be ready to implement any changes for several months. At this time, the State has not set a date when Medi-Cal claims will be accepted in the DSM-5 format. We will continue to use the existing DSM-IV codes and criteria until the State is able to accept billing transactions using the new codes. In the meantime, we will keep you posted on training opportunities as they are developed in the near future!

Pathways to Recovery

Originally, the PATHS program was for pregnant and parenting women and infants experiencing alcohol and other drug challenges. It expanded a few years ago to include the Department of Social Services Welfare to Work Mental Health program, and started serving women and men with Mental Illness and/or Co-Occurring MH and Substance Use Issues in the same facility.

Given the broader nature of the services, PATHS changed its name to Pathways to Recovery Services. As noted above, there is a Substance Abuse track for pregnant/ parenting women as well as women without children. This track has two 90 day phases. Phase I focuses on stopping alcohol and other drug use, and developing a wellness and recovery plan while learning parenting and other life skills. Phase II builds on this, adding services addressing trauma issues in these women's lives. This program will take any referral from voluntary to mandated treatment.

The CORE (Co-Occurring disorder REcovery) track is for those women and men living with substance use and other thinking, feeling, and behavior challenges at the same time. Participants from either the Substance Abuse or Mental Health tracks work towards a stable recovery for these complex disorders while also doing the education classes with participants from those tracks. This track also has two 90 day phases. Completion of the two phases is considered a program completion.

The Mental Health track is for Department of Social Services Welfare to Work recipients who cannot go to work/school or are having difficulty parenting due to their thinking, feeling and/or behavior challenges. Due to funding, this track can only accept those with a Welfare to Work plan who are referred by DSS staff. This co-ed track has two 90 day phases. Phase I focuses on reducing or eliminating their symptoms, developing a wellness and recovery plan to use at work/school or home and learning other life skills. Phase II starts focusing on re-entering school and/ or work. We have DSS staff teaching courses on job seeking, resume development, etc. We also assist these participants in finding work or entering school. For more information on Pathways to Recovery, call (559) 600-6068 or visit the Fresno County Substance Abuse Services Webpage.

Fourth of July

Managed Care will be closed on Thursday, July 4th in observance of Independence Day.

Progress Notes

Progress Notes are the primary place where mental health services and interventions are described. This is necessary for Medi-Cal billing. When an auditor looks at the client's chart, he will spend most of his time reading the progress notes. It is especially important that the mental health intervention is clearly documented and is directly related to the goals as identified on the POC.

Termination activities with the client would also be included in the progress notes. At the end of treatment, a discharge summary would be added to the chart providing additional documentation as to the client's status at the time of discharge, areas for follow up treatment and referrals to other providers.

Medical necessity is an essential part of the Mental Health Assessment but it is also important to document medical necessity or the ongoing need for treatment through out the client record. It is a good idea to periodically document how the client continues to meet these criteria as it relates to the identified behavior or symptoms.

Each note has to be signed and dated by the writer of the note. This is different than the "date of service" as identified on the Note. The dated signature indicates when the note was signed or completed. The practitioner must put his/her printed name and educational designation below each signature line. In most cases Progress Notes, Assessments and Plans of Care will be typed. It is important that the signature line has license designations (for example, LMFT, LCSW, MFT intern) instead of the job title. This is so that auditors can easy monitor issues related to scope of practice. Progress Notes must be legible. Auditors have disallowed notes due to illegibility.

The format of the Progress Note needs to follow a simple four part outline

Because a reviewer is going to match up the invoice date and the date written on the progress note, the date of service must be clearly identified as such. The auditor will not assume that the signature date is in fact the date the service was provided.

The format of the Progress Note needs to follow a simple four part outline. These four parts can be called different things or can be in different forms.

The first part is the current behavioral goals as written on the Plan of Care. The goals serve as a reminder to the practitioner and the client of what issues are being worked on. A specific and focused description of the problem followed by clear goals will lead to an increased clinical focus and better outcomes.

The general goals of treatment must be symptom reduction and reduction of impairments to life functioning

The second part is a description of the mental health intervention(s). The general goals of treatment must be symptom reduction and reduction of impairments to life functioning. Describe specific interventions used and provide justification for their selection. This is one of many places documentation should be specific. For example, if one of the Plan of Care goals is to reduce the client's depressive symptom of crying by helping the client gain insight into the triggers that bring up the negative memories that cause her to cry through journaling about her triggers, this is where the intervention is described, the justification for the intervention is presented and the expected outcome of the intervention is given.

The third part is describing the client's reaction and response to the interventions given in session. Is the client doing the journaling? Is the journaling helping? Record the clinical observations and reactions to how the client is responding to the intervention. This is also the place to write other clinical issues such as referrals or impediments to treatment.

The fourth and final part of the Progress Note is to write the plan for the next phase of treatment. Because of the client's refusal to journal, is a new intervention going to be implemented? Document homework assignment or between session activities the client is supposed to participate in. This is also the place to document if there is follow up needed with a particular person or agency. If major changes in client presentation or if the plan of care needs modification, this is the place to begin documenting those changes. Major changes in treatment direction need to be documented on the Plan of Care or if significant changes are occurring, a new Plan of Care may need to be developed, with the client, that better reflects what the client is needing at that time. This part of the progress note is also the place to write about the desire of the client to continue treatment and the decision to do it or not and why.

Here are some final reminders:

- Tie the service into the identified symptoms and behaviors on the Plan of Care.
- Include the specific interventions that were used and why.
- Document the focus on symptoms reduction.
- Document the client's response to the mental health interventions and their general progress.
- Then document the plan for future services and treatment or complete a discharge summary with referrals.

Doing this will show the clear link between the Plan of Care and the interventions provided in session.