FLORIDA

Therapy Services, Inc.

Helping **People**

Healing **Lives**

Giving **Hope**

Provider Clinical Training & Reference Manual

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INTRODUCTION

This manual is designed to assist providers with their job related duties. It is not intended as all inclusive. Throughout the manual, the provider may be referred to a more in-depth description of a topic, where applicable. This manual will be an evolving document, thus as needed it will be revised and reissued. Provider feedback is strongly encouraged. If a provider would like to see a topic added to the manual, please do not hesitate to submit your request via email to the QA Department.

FTS Website - Employee and Provider Resources

On the FTS website, team members will find a link entitled, "Employee and Provider Resources." Here providers will find important and valuable tools necessary to accomplish their job. In addition to clinical and administrative forms and documents, team members will find training resources, FTS policies and procedures, Florida Statutes and codes governing our profession, the Health Insurance Portability and Accountability Act (HIPAA), the Medicaid handbook, the FTS Contractor Manual, and the ethical codes from the various disciplines.

The Quality Assurance Department is responsible for the revision and maintenance of the FTS training resources. These resources are revised as necessary. Team members must have a username and password (issued from IT) to access the resource page. An email will be sent to team members notifying them of changes made to FTS training resources.

When conducting FTS business team members are expected to utilize only the most up to date documents maintained on the FTS website. Thus, it is imperative that providers stay abreast of revisions and updates.

CONFIDENTIALITY

All team members must adhere to the rights of clients regarding the confidentiality of their treatment. Please ensure that you are knowledgeable of the clients' rights that are located on the website. A provider is encouraged to proceed cautiously before disclosing client confidential information. Seek supervision from your supervisor or the QA Department, should you have a question.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).

FTS adheres to all federal and state regulations regarding protected health information. See applicable FTS policies and procedures. Refer to the website for the complete act.

POLICIES AND PROCEDURES

FTS develops and maintains agency policies and procedures regarding all aspects of FTS operations. Each health care clinic maintains a P&P manual, which is updated annually. Providers are given access to the Florida Therapy website (flatherapy.com) which has pertinent policies and procedures regarding FTS clinical and administrative standards. Providers are expected to have a working knowledge of these standards.

PROFESSIONALISM, ETHICS, AND BOUNDARIES

FTS team members are expected to maintain the highest level of professionalism. Therapists are expected to know and adhere to the code of ethics for their discipline. On the website you will find the code of ethics for mental health counselors, social workers, and marriage and family counselors. If you have a discipline outside these three, it is your responsibility to know and adhere to the applicable code of ethics.

SCOPE OF SERVICE AREA

FTS provides mental health services in Areas 1 and 2, A & B. We are currently serving children, adolescents, and adults in sixteen counties: Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Santa Rosa, Taylor, Wakulla &Washington.

FTS SERVICES

FTS provides psychiatric services; therapeutic behavioral on-site services for children and adolescents; individual and family therapy for children, adolescents, and adults; peer support services, and targeted case management services for children, adolescents, and adults.

FTS/PROVIDER COMMUNICATION

Strong communication amongst FTS team members is truly a key element to the success of our mission. Without it, we flounder. FTS uses several mediums to communicate with our providers, that being: face-to-face supervisions between program directors and supervisors, email correspondences, telephone/webinar conferences, as well as a weekly QA messages. It is crucial that we maintain timely, accurate, and efficient communication regarding all FTS business. FTS retains the discretion to schedule training meetings in which attendance is mandatory.

DISASTER PREPAREDNESS

The FTS Disaster Preparedness manual is located on the website in the Contractor Handbook.

INFECTION CONTROL

Providers must familiarize themselves with, and adhere to, universal precautions.

1. Hand washing after direct contact with patients.
2. Use of protective barriers such as gloves, gowns, aprons, masks, and goggles for direct contact with blood and other body fluids.
3. Safe collection and disposal of needles and sharps, with required puncture- and liquid- proof boxes in each patient care area.
4. Preventing two-handed recapping of needles.
5. Covering all cuts and abrasions with a waterproof dressing.
6. Promptly and carefully cleaning up spills of blood and other body fluids.
7. Using a safe system for health care waste management and disposal.
8. Stay home and recuperate if running a fever and/or you are contagious.
9. Employ appropriate coughing protocol by coughing into the bend of your elbow versus your hands.
10. Cover mouth and nose with a Kleenex when sneezing.
11. Wash your hands with soap and water frequently.

SAFETY PRECAUTIONS

Team member safety is our number one concern. Our providers work with clients in a variety of settings to include office, home, and school; thus, it is imperative that providers take the necessary steps to protect themselves against harm. Listed are a few guidelines to follow when considering safety.

1. Be aware of your surroundings at all times.
2. When entering a home or building familiarize yourself with all exits.

3. To the extent possible, strategically place yourself close to an exit, with nothing or no one blocking your immediate exit.
4. Trust your instincts, if something appears amiss, check it out.
5. Keep a schedule that is accessible to others in case of an emergency.
6. Have a working cell phone with you at all times. Keep a cellular car charger in the car.
7. Prior to going into homes query owners about pets. This precaution is twofold, 1) to protect against allergies, and 2) to protect against aggressive or temperamental animals.
8. Avoid domestic violence situations. If a situation escalates, leave immediately and contact authorities, if necessary.
9. Prior to going into homes, query clients regarding the security of any weapons (guns) they may possess.
10. Keep a personal first aid kit in your vehicle.
11. It is against FTS policy to transport clients. This is a safety precaution that is strictly enforced.
12. In the case of an emergency, notify proper authorities immediately.
13. If injured, seek medical treatment accordingly.
14. Notify your supervisor as soon as possible regarding all adverse situations.

FTS POLICY ON SECLUSION AND RESTRAINT

1. It is the policy of Florida Therapy Services, Inc. (FTS) **not** to engage in the use of seclusion or restraint.

2. All direct care providers will participate in an approved aggression control training course within six months of date of hire. A certificate of completion will be placed in the provider's personnel file.

3. If a provider is physically confronted by a client the provider will make effort to verbally deescalate the client. If the provider believes himself/herself to be in imminent danger, the provider will immediately remove himself/herself from the area and notify appropriate authorities.

4. Should a provider be physically attacked by a client, the provider will make every effort to protect himself/herself in order to stop the attack and get away from the attacker. Again, appropriate authorities will be immediately notified.

5. All incidents involving threat of harm or actual harm will be reported in written format utilizing a FTS Incident Report Form which will be submitted to the Corporate Office located at 459 Grace Ave. within 24 hours of the incident.

6. The provider will report the incident to his/her supervisor, as soon as possible.

FTS REQUIREMENT FOR AGGRESSION AND CONTROL TRAINING - Nonviolent Crisis Intervention

Within the first six months of hire, all direct care providers are required to complete an approved aggression control training class. A certificate of completion must be submitted to the HR Manager WITHIN the first six months. Please contact the HR Manager for assistance and/or questions regarding this requirement. New providers that have current and valid certificates of aggression control may submit them at the time of hire.

REFERRAL PROCESS

Referrals are generated from a variety of sources, to include community agencies, doctor offices, schools, family members and individuals seeking help. The FTS Referral Coordinators located at the corporate office are responsible for disseminating referrals to the appropriate office locations. The completed FTS referral form must go in the client file upon opening.

CLIENT ELIGIBILITY

The client eligibility statement is part of the initial referral process that specifies what insurance benefits a client possesses, whereby specifying the payer source that will be billed for services rendered. The initial eligibility statement is run at the time of the referral and monthly thereafter, throughout the course of treatment. Eligibility can be reviewed on the biweekly database. Intake counselors must remember to recheck the client's eligibility at the time of opening, should the opening take place the next month after the initial referral was generated.

The importance of having the client's eligibility rechecked at the time of opening, as well as every month cannot be underestimated, as benefits terminate and/or the carrier changes. Every month thereafter, after the eligibility has been run by the billing department, a database is sent to providers that informs them of the current status of client eligibility. When an insurance carrier changes or terminates, the eligibility statement reflecting the change must be printed and placed in the client chart.

Supervisors and/or program directors are responsible for training and educating new providers as to how to read an eligibility statement.

The identified payer source (insurance benefit) will determine the billing codes and documentation used by the provider. For example, for Medicaid and Managed Care recipients, Medicaid established codes are used. For any other commercial insurance, CPT codes are used. Thus, providers must be familiar with payer source prior to seeing the client.

CLIENT DATABASES

The purpose of the client databases is to keep providers informed regarding client eligibility, unit authorization, caseload assignments and documentation compliance due dates. The databases are simply tools to assist providers. Providers must not rely on the databases to manage their caseloads. Providers are responsible to keep up with their assigned cases, eligibility, authorizations, unit useage, and documentation requirements.

1. Client Databases – FTS maintains several databases regarding client information: The Eligibility/Compliance database (combined for convenience purposes),targeted case management database, commercial database, and the prior authorization database.
2. The eligibility/compliance database is made available to the providers via password protected emails. The purpose of the eligibility database is to inform providers as to the type of insurance held by the client, as well as to the status (active versus inactive) of the client's insurance benefits. The billing department checks eligibility status on all FTS clients twice at the beginning of the month. The eligibility is run on the 1st of the month and again on the 10th of the month. The second run is to double check the inactive list, as there is often a delay between Medicaid (AHCA). This information is then disseminated to the providers.
3. All of the FTS databases contain PHI and are password protected. The password is "fts" and then the 4 digit date. A database from 12/25/1996 would be "fts1225."

4. The Compliance database is combined with the Eligibility database and is available for providers as a way to stay abreast of documentation due dates. The Compliance database is updated daily and disseminated weekly.
5. The significance of color indicators on the Compliance database:
    A. Red means out of compliance.
    B. Yellow means compliance item approaching due date.
    C. Blue means client is inactive.
    D. Green means that the client has a share of cost which means they are responsible for a specific cost of their coverage.
    E. Brown mean the client has an insurance that requires prior authorization.
6. Provider responsibility regarding the databases – it is imperative that providers review the databases regularly. As databases are only as good as the information entered, it is of vital importance that documentation is completed in full and submitted in a timely manner.
7. Notifying the billing department regarding updates and errors found on the database ten (10) business days after completion of clinical encounters in IOS – if a provider discovers an error on the database, the provider should notify the database specialist at the corporate office.

LIMITATIONS TO CONFIDENTIALITY

Limitations to confidentiality apply in the following circumstances, where the law requires disclosure:

- if a client presents as an imminent threat of harm to self or to others,
- to report a crime committed on FTS premises or against FTS personnel,
- when there is a suspicion or indication of abuse, abandonment, or neglect of a child, vulnerable adult, or an elderly adult.
- to medical personnel in a medical emergency, and
- by a court order from a judge under specific circumstances.

Remember that it is very important to review these limitations with all clients very early in the rapport building stage of therapy. From the very first session (including intake) these issues must be discussed.

INTAKE PROCESS

The intake process is a vitally important component of treatment. This is the opportunity for the client to be introduced to FTS. The intake counselor will introduce to the client the services available at FTS, such as psychiatric services, therapy services, and case management.

Required encounters and documents necessary for the intake process consist of the Informed Consent, Assignment of Benefits, Client Rights, Consumer Handbook, the assessment encounter (BPSA or In-depth), FARS/CFARS, and confidential releases of information. If the intake is completed by a non-licensed master level provider, then a **face-to-face** with the client must be done by a licensed provider. In that case, a Brief Behavioral Health Status Exam (BBHSE) encounter must be completed in IOS. The BBHSE encounter must be completed prior to the development of the treatment plan.

Importance of providing Clients/Guardians with Consumer Handbook – Every client MUST receive a Consumer Handbook. Therapists, please ensure that your clients received a handbook at intake. If not, please provide him or her with one.

Intake counselors are expected to review with clients:

1. All intake encounters and documents.
2. Their rights and responsibilities. Clients must be afforded the opportunity to ask questions and seek clarification.
3. The FTS discharge policy, i.e. what constitutes a successful discharge versus noncompliance or abandonment.
4. The limitations to confidentiality.
5. Mandated reporting laws.

Intake counselors that receive collaborating documentation from an outside source, such as discharge paperwork from a recent inpatient stay, must ensure that the documentation is turned in with the completed intake packet.

The intake counselor and the assigned therapist must staff the case. Staffing new cases can be accomplished over the phone, if necessary. It is counterproductive for the client and/or guardian to have to repeat their history. Furthermore, the intake counselor has valuable information regarding the new client and guardian that should be imparted to the assigned therapist.

CONSENT FOR TREATMENT

The Consent for Treatment is an essential form, as it outlines the expectations for treatment for the client. As is the case with all of our forms, it is our expectation that providers will have a full understanding of all FTS forms that they utilize. In addition to understanding the content of the form, the provider must ensure that:

1. only the client and or legal guardian signs the consent to treat;
2. FTS has a copy of guardianship papers, if the guardian is someone other than a parent. Copy of court documentation must be scanned into the IOS chart.

AUTHORIZATION TO RELEASE INFORMATION

Releases are obtained at intake, as well as throughout the episode of care, as needed. Compliance items to remember and adhere to regarding releases include:

1. Releases must be filled in completely BEFORE asking the client to sign the release. Do not ask client to sign blank releases.
2. The scope of the release must be defined. Be specific about documents and information requested. Do not include progress notes on a release.
3. Fill in expiration date correctly – three years from date signed.
4. It is the provider's responsibility to fill in releases – not the file clerk's. When records are needed, provider can ask file clerk to mail/fax release. Refer to FTS policy regarding releases.
5. Providers are not authorized to release or give out documents from the file. That is the responsibility of the file clerk.
6. All releases must include address and phone number of organization from which records are being requested.
7. If there are family members or others living in the home or involved in the life of the client and will be included in the therapy process, there must be a signed release. This includes spouses, paramours, grandparents etc.

How clients/guardians revoke a release. Ideally a revocation of a release should be provided in writing by the client. Each release has a section at the bottom which is to be completed for revocation.

Remember however, that a verbal revocation is valid in Florida and must be honored. Once a provider is aware of a verbal revocation, it should be annotated in the file on a Client Contact encounter. Additionally, the original release located in the client chart must be documented citing the client's request for revocation.

New and/or resigned releases are required at the annual date, upon expiration of a release (if still needed), upon every new episode of care (regardless of date), when a client turns eighteen and the previous releases were signed by the parent/guardian, as needed throughout the course of treatment.

BIOPSYCHOSOCIAL ASSESSMENTS (BPSA)

BPSA encounters are completed at intake. All sections of the assessment must be completed. If an item is not applicable, annotate as N/A. Do not leave a section blank. Select the appropriate BPSA as it corresponds to the client's age (adult, child, in depth - five and under.) The narrative section of the BPSA encounter must be completed addressing all of the cues identified.

IN-DEPTH ASSESSMENTS

An in-depth assessment is a diagnostic tool for gathering information to establish or support a diagnosis, to provide the basis for the development of or modification to the treatment plan and development of discharge criteria. The in-depth assessment must include an integrated summary as described below.

Assessment components

The in-depth assessment must provide detailed information on the components below.

- Chief complaint – client's perception of problem or prominent symptoms;
- Personal history – identifying information, legal involvement, educational analysis, and resources and strengths;
- History of treatment (as applicable):
    - Psychiatric to include previous and current psychotropic medication;
    - Inpatient behavioral health treatment;
    - Medical;
    - Alcohol and other drug use;
    - Therapy and counseling;
- Current behavioral and mental status; and
- Desired services and goals from the client's viewpoint.

Integrated Summary Component

The integrated summary is developed after the in-depth assessment has been completed. The integrated summary is documented to evaluate, integrate, and interpret from a broad perspective, history and assessment information collected. The summary identifies and prioritizes the client's service needs, establishes a diagnosis, provides an evaluation of the efficacy of past interventions, and helps to establish discharge criteria.

Clients Eligible to Receive an In-Depth Assessment

Clients who meet one of the following criteria are eligible to receive an in-depth assessment;

- Clients with a documented need for a level of treatment beyond outpatient individual or group therapy or medication management (i.e., outpatient services have been tried and failed);
- Clients who have been identified as high risk (i.e., stepped down from or denied admission to an inpatient setting);
- Clients who have been receiving intensive services for 6 months or longer and for whom the documentation supports lack of significant progress; or
- Clients who have been identified through the utilization management process as being high risk or high utilizers.
- Infants 0-5 who are exhibiting symptoms of an emotional or behavioral nature that are atypical for the child's age and development. Remember that an assessment of a child five and under must include an observation period assessing the interaction of the parent/caregiver and the child.

Who Must Provide
The in-depth assessment and integrated summary must be provided by a master's level practitioner.

Reimbursement Limitations
Medicaid reimburses one in-depth assessment, per client, per state fiscal year (July 1 through June 30). An in-depth assessment is not reimbursable on the same day for the same client as a bio-psychosocial evaluation.

CLIENT CLINICAL RECORD
The clinical record must contain:

- An evaluation or assessment conducted by a licensed provider for diagnostic and treatment planning purposes. For new admissions, the evaluation or assessment by a licensed provider for treatment planning purposes must have been completed within the past six months.
- Copies of relevant assessments, reports and tests must be scanned into the IOS chart;
- Service notes (progress toward treatment plans and goals);
- Documentation of service eligibility, if applicable;
- Current (within last 6 months) treatment plans, reviews and addenda;
- A description, including clinical findings of the face-to-face interview with the client that is signed and dated by a psychiatrist, physician, treating practitioner, master's level certified addiction professional (only for clients with a substance abuse diagnosis), or licensed provider who conducted the interview;
- Copies of all certification forms (e.g., comprehensive behavioral health assessment); and
- The physician's orders, results of diagnostic and laboratory tests, medication assessment, prescriptions and medication management.

DOCUMENTATION REQUIREMENTS
A provider must maintain a medical record for each client treated. Documentation must be maintained to support each service for which Medicaid reimbursement is requested. Documentation must clearly distinguish and reference each separate service billed.

Service documentation must contain all of the following:

- Client's name;

- Date the service was rendered;
- Start and end times for procedures with specified minimum time frames and procedures billed on a per unit basis;
- Identification of the setting in which the service was rendered;
- Identification of the specific problem, behavior, or skill deficit for which the service is being provided;
- Identification of the service rendered, including the specific intervention;
- Updates regarding the client's progress toward meeting goals and objectives identified in the treatment plan; and

FARS AND CFARS

For quality assurance purposes FTS uses the FARS/CFARS as its outcome measurement tool. . Although the tool was not originally designed for the domains to be totaled, when asked by DCF, the creators of the tool acquiesced whereby agreeing that the totaled domains could be used as an outcome measure. Thus, FTS captures not only the individual domains, but the total of all of the domains, as well.

1. All providers must successfully complete the FARS/CFARS training and obtain a rater number.
2. FARS/CFARS are completed at opening, six months intervals, and/or discharge
3. Required fields to be completed by provider.
4. Ratings must be totaled and placed in the text field at the bottom of the encounter. Please add the domains columns and total.
5. Discharge FARS/CFARS must include face to face interaction within 21 days. If not, then the encounter is still completed, however the ratings are not completed.

THERAPIST ASSIGNMENTS – cases are assigned considering several factors, to include: therapist specialty, geographic location, and client request. Every effort is made to provide a "good therapeutic fit." Clients are afforded the right to know the credentials and qualifications of their providers. Thus, it is important that therapists discuss these factors with all of their clients.

When a therapist agrees to take on a new case, it is imperative that the therapist and the intake counselor staff the case. This can be done in person or over the phone. The Intake counselor will have important information to share with the assigned therapist. Furthermore, nothing is more frustrating to a client than to have to repeat their enter history with the assigned counselor when they have just done so with the intake counselor.

Assigned therapists are expected to make initial contact with the client and/or guardian no later than 72 hours or three business days of receipt of case. Attempts (successful or not) to reach a client must be documented using a no bill note.

Therapists must take responsibility to ensure that assigned clients are eligible for services. With regard to newly assigned cases, if a client was open for services in May, however the provider is seeing the client for the first time in June, the provider will want to ensure that the client is still eligible for services. Refer to client database for further information regarding client eligibility. If the updated eligibility is not available on the database regarding an assigned client, call the billing department. Therapists are asked to closely monitor the database to ensure that clients are assigned to the correct provider.

FTS tracks provider case loads, thus it is important that providers keep their program directors informed as to the amount of cases they are carrying and the approximate average of hours they bill weekly. Additionally, providers are asked to keep supervisors informed regarding caseload limitations

Therapists that receive previously established clients from other counselors must follow the transfer guidelines. Refer to Case Transfers.

TREATMENT PLANNING

A well developed and user friendly treatment plan is essential for the successful outcome of treatment. The treatment plan is considered the road map and is what drives the course of therapy. Without a treatment plan, therapy would wander about aimlessly. A therapist and client can develop a great treatment plan, all to no avail if it is not referenced frequently. Without the treatment plan, therapy can quickly go awry, whereby the therapist and client get caught up in the day to day happenings of the client's life, versus working on the pre-established goals of therapy.

Treatment planning must involve client and guardian(s). FTS allows for 45 days from the opening date for the provider and client to develop the treatment plan and have it signed by all involved treatment team members, as well as the Clinical Review Specialist in QA.

The success of treatment is in large part based on the "buy-in" of the client. Thus, it is imperative that the client and guardian(s) assist in the development of the goals and objectives that will be the focus in treatment. Accordingly, the plan must be written using language the client can comprehend. The finished document must be reviewed with the client and client guardian(s) and must be signed by the client (where age appropriate) and/or legal guardian(s). Clients must receive a copy of their treatment plan. This is required.

The presenting problem section of the plan must justify the diagnostics and must reflect the client's specific symptoms. Do not just copy diagnostic criteria verbatim out of the DSM. It must also include the onset of treatment issues. The presenting problem must note whether or not the client is currently taking psychotropic medications, as well as who prescribes the medications, i.e. psychiatrist or primary care physician.

The treatment plan goals represent the big picture of what the client would like to achieve in treatment. They typically reflect the alleviation of symptoms and/or the addition of new coping skills.

The objectives represent the steps to be taken to achieve the goals. They must be specific, measureable, and realistic. By measurable we mean, how is the progress (or lack of progress) towards objectives to be evaluated? How will the client, parent/guardian (if applicable) and the therapist know what is working and what isn't. The following statements reflect several thoughts to keep in mind when creating treatment plan objectives.

- Do no use percentages when assigning a measurement.
- Gaining the "buy-in" by the client is crucial. Creating objectives that the client is not going to implement or practice is pointless.
- Providers are encouraged to utilize positive approaches to behavioral interventions when applicable to include:
    - Strength focused

    - Goal Oriented
    - Solution enhancement
- Access the client's primary learning modality (visual, auditory, or kinesthetic) when creating goals.
- Make objectives cognitively appropriate.
- Objective due dates must be individualized and appropriate, i.e., it does not take six months to establish rapport.
- Providers may want to invest in treatment planners, however avoid using objectives that are not measurable.

FORMAL TREATMENT PLAN REVIEW (FTPR)

FTPRs are required a minimum of every six months after the effective date of the initial treatment plan. The effective date of a treatment plan is the date the type seven licensed provider signed the document. The purpose of the FTPR is to document progress or the lack of progress regarding the agreed upon goals and objectives. Additionally, a FTPR must be completed when something significant occurs in treatment, such as a diagnostic change, the addition of revised or new goals and objectives, or when it becomes evident that the current plan is not working. Medicaid /Managed Care will reimburse for four FTPRs a fiscal year.

TREATMENT PLAN ADDENDUM

An addendum may be used to make minor changes to the treatment plan such as a step down in services or the discontinuation of a service. If a change occurs such as a diagnostic change, then a review would be completed. The development of an addendum is not a billable service.

TREATMENT PLAN PROCESS

Treatment plans will be developed with client and guardian (if applicable) in the IOS system. The provider starts the encounter in IOS with the provider as the "rendering provider" and the "billing provider" will be Jacqueline Emond

- Provider communicates with QA indicating TX plan is ready for review in IOS by sending an email to: ***User group: QA*** with the client name attached in the "Patient" field.
    - Initial TX plans will be reviewed in three (3) days
    - TX plan reviews and addendums will be reviewed in five (5) days
    - TX plans that have been modified or are complete will be addressed in one (1) day
- QA will then review the plan
    - If approved, QA signs plan and notifies the provider to acquire the required signatures and dates. Provider signs and dates, client signs and dates, guardian (if applicable) signs and dates. Provider emails User group: QA with the subject line "Please complete encounter." QA will close the encounter. Only QA is approved to close treatment plan encounters. QA submits the superbill and stamps TX plan with effective date. QA emails provider. Provider prints plan and gives copy to client.
    - If not approved QA emails provider with required modifications. If modifications are required, provider makes changes and sends email to: User group: QA.
- The following are the only acceptable subject lines for treatment planning emails in IOS.
    - Initial Tx Plan
    - Tx Plan Review
    - Tx Plan Addendum

    - Modifications
    - Please Complete Encounter
- Any other information must be included in the body of the treatment planning email.

DISCHARGE PLANNING

Discharge planning always begins at intake. Discussing the duration of treatment with a client and/or guardian(s) is crucial. Outpatient therapy is designed to successfully integrate new coping skills to achieve identified goals. It is meant to be time limited with a reasonable estimation of successful discharge. Simply asking the client and/or guardian what their expectations are regarding the duration of treatment can go along way with the discharge planning process.

Clients and their families need to know what constitutes a successful discharge. In other words, how will they know when they have successfully achieved their goals? What will that look like in terms of new cognitions and behaviors? Although this initial discussion begins at intake, it must be revisited during the development of the treatment plan, as well as throughout treatment. Clients must be aware of what comes after treatment. Part of a transition plan, which is built into treatment planning, consists of identifying how clients will step down the level of services they need AND what, if any, resources may be pursued after their treatment is complete at FTS.

CLIENTS WISHING TO RETURN TO TREATMENT AFTER DISCHARGE

It is not unusual for a previous client to return to FTS requesting to re-initiate treatment. When a client is ready for discharge, it is important for him or her to realize that should the need exist, that he or she can return for additional counseling. Obviously, we would like to see the client implement and use the skills and tools learned in therapy.

PROGRESS NOTES

Please remember to individualize the note. Cookie cutter or canned notes are prohibited. Follow the cues on the note – progress note must reflect the focus of the session:

1. Client's presentation regarding clinical symptoms and treatment issues – This section is where the clinician notes the report made by the client about what is going on with him/her regarding the treatment issues. For example, the client may be struggling with depression. The client reports on the decrease or exacerbation of his/her symptoms. The clinician queries the client to note these observations. This section is intended to discuss the client's perception of what is going on with him/her CLINICALLY. It is not intended to discuss what they are doing in the immediate moment, like "just sitting here watching TV." Another example might be if the client is oppositional, the clinician would query the client on behavioral issues at home and school and/or about how he/she got along with peers and family members. Again, it is the clinician's opportunity to report on the subjective opinion of the client regarding what is going on with the issues that brought them to treatment.

2. Therapist's observations and findings regarding the client's presentation (Mental Status) – This is where the clinician notes a mental status of the client. The clinician also notes congruence or incongruence with what the client is reporting. Let's go back to our first example where the client is struggling with depression. The client might report that she is feeling very sad, yet is very giggly and chatty throughout the session. Or she may report that she has been sleeping very well and feels energetic, however is falling asleep in the session. In our second example

with the oppositional client, the client may report that he is behaving very well at school; however the teacher states that the client has been sent to the office every day that week. This would also be where you make observations about the client's current mental status.

3. Specific therapeutic techniques and interventions used – This section calls for what the therapist and the client worked on during the session. The clinician must cite the therapeutic modality used and what the specific intervention entailed. For example, let's say that the clinician is trained in Transactional Analysis and introduced the client to the ego states. That is what the clinician would annotate. Simply citing the modality is not sufficient.

4. What treatment plan goal/objective does intervention(s) address? (In narrative form) – Remember, the point of the treatment plan is to drive the course of treatment. In this section the clinician must annotate the goal and objective targeted in the session. The goal and objective must be in narrative format.

5. Client's response to intervention & level of participation – In this section, the provider must address how the client responded to the intervention utilized. For example, if role play was used, was it successful and did the client glean something from the exercise? Did the client appear to benefit from and understand the intervention? Furthermore, what was the client's level of participation?

6. Follow up date & plan – This is where the provider and client discuss when they will meet again and what they will address.

7. Encounters for progress notes must be started the day of interaction with the client and closed within 72 hours of the interaction.

8. If a client no shows or cancels the provider must cancel that encounter and complete a no bill encounter explaining the reason for the note.

Client contact (NO Bill) & Admin Information Note- Must be used when interaction on behalf of client is not billable or the client cancels or "no shows" for a session. Documenting the "no show" and cancellations, provides an explanation for any gap in service provision. This is important, as the treatment plan stipulates an agreed upon frequency of sessions. Additionally, providers often make or receive pertinent treatment related phone calls with, or on behalf of, the clients that should be recorded in the client file. No Bill notes are used for this purpose.

TEAM CONSULT FORM

Located in the IOS system is an encounter entitled, *Team Consult Form*. This encounter was created in order to increase communication between providers and the treating FTS medical professionals (Psychiatrist or ARNP).

This document, to be completed by providers to provide information to all interested parties about:

- Diagnostics
- Therapy
- Case Management
- Medication
- Intake

- Discharge notification and approval
- Compliance issues
- Treatment team documentation
- Other purposes.

This encounter will be initiated by one party to inform other parties about any issues. In most instances this form will be used by one provider (varied discipline) to communicate with the assigned qualified medical professional (Psychiatrist or ARNP) about a treatment issue, discharge plan, or compliance issue. Once the encounter has been started, the psychiatrist will be notified of the review using the note system in IOS. The psychiatrist will respond in the appropriate section. Then an outcome or plan of action will be developed by the requesting party

ANNUAL DOCUMENTATION REQUIREMENTS – It is imperative that those cases that reach the annual date are staffed with a supervisor in order to determine the continued need of services. If continued treatment is deemed medically necessary, the following forms must be completed.

1. Assignment of Benefits
2. Client Rights
3. BPSA update – The update is used to document the continued need for services, as well as pertinent changes that have occurred throughout the course of the year. It must reflect progress, as well as barriers to treatment.
4. FARS OR CFARS, if necessary, based on previous review date. FARS or CFARS are required at a minimum of every six months. We are allowed to bill three (3) assessments a year.
5. Treatment Plan Review, <u>if necessary</u>, based on previous review date. Treatment Plan Review required at a minimum of every six months.

FILE MAINTENANCE AND FILE REVIEW

Providers must regularly review online chart for accuracy. The therapist is considered the lead provider for each case and must be aware of different components of treatment, such as medication management and Targeted Case Management (TCM).

CLIENT CHART AUDITING

Providers are expected to perform ongoing self audits on all of their assigned clients' charts. As the Master level practitioner assigned to the case is the lead treatment provider on the case, it is that clinician's responsibility to review the contents of the complete chart. The peer review form is a paper document available from the program director.

PEER FILE REVIEW PROCESS

The Peer File Review Forms are used to audit a client chart. The Peer File Review Form is generated from the QA Department. When a file is audited using this form, a copy will be disseminated to providers through the inter-agency mailboxes. Additionally, providers are notified via email that one of their charts has been audited. Program Directors receive a cc: concerning peer review forms. It is the responsibility of the provider to make noted corrections within two weeks of receipt of the completed audit tool. The provider must return the signed copy, documenting the corrections to the QA Department.

CASE CONSULTATION AND SUPERVISION REQUIREMENTS

All providers are expected to attend supervision with their assigned program directors. This is an opportunity to staff cases, conduct peer reviews, and stay informed regarding agency business. Your program director will discuss with you supervision dates and times.

CASE TRANSFERS – Cases are transferred for a variety of reasons, to include, 1) client relocates, 2) therapist relocates or transitions from FTS, or 3) therapist or client request a change. Whatever the reason, the transfer must be discussed with the provider's program director prior to taking place.

1. When the client relocates and wants to continue services with FTS, the program director will ensure that the client file is transferred to the applicable clinic. A case transfer encounter must be completed in IOS. The billing department must be notified so that appropriate databases can be updated. All compliance items and documentation should be up to date prior to the transfer being completed. Whenever possible, the previous therapist should staff the case with the newly assigned therapist.
2. When a therapist relocates or transitions from FTS, he or she must notify his or her program director as soon as possible in order to determine the outcome of assigned cases. Those cases that require ongoing care will be transferred to another FTS therapist. The goal is to minimize any delay in treatment. Again, assigned therapists, whenever possible, should assist with the transition by ensuring that all compliance items are up to date and all documentation is complete. Staffing cases with newly assigned therapists is strongly encouraged. Case transfer encounters must be completed.
3. When a therapist or client requests a change, the reason must be disclosed and staffed with the program director. Resistance to the therapeutic process can occur especially with adolescents, thus staffing the case with your supervisor prior to transferring or closing the case may provide ideas to break through the resistance. **Prior to the transfer occurring, the transferring therapist must ensure that the file is in full compliance with all documentation having been completed and submitted for billing.** Case transfer encounters must be completely filled in and completed.

Prior to accepting a transferring case, the therapist should discuss the case with the previous therapist, whenever possible. When not possible, the case should be staffed with the program director. The new therapist will want to check the file for compliance issues, eligibility, as well as to read the file. If it has not already been done, the billing department must be notified in order to update the database. The new therapist must make contact with client and/or guardian within 72 hours or three business days of receipt of case. Again, the goal is to minimize the disruption of care.

INCIDENT REPORTING

All FTS team members, regardless of position within the agency are expected to adhere to the incident reporting policy which is located on the website in the policy and procedure folder. Incident reports, also on the website, are generated when unusual or critical events occur, or the disclosure of an event occurs, that has injured or has the potential to physically and/or psychologically injure a person (client, client's family member, or FTS team member.)

There are a number of predefined categories on the incident report form. The list is not all-inclusive. There is an "other" category to capture incidents that do not have a category specified. If the "other" category is used, the team member must define the issue in the category box. An incident report form must be completed within 24-hours (or next business day) upon being informed of, or involved in, an incident.

Remember to fill in **all** the demographic information asked for on the form. Providers sometimes forget to include the birth date of the individuals involved. If the birth date is not available, at the very least put an approximate age of the individual(s) involved. This is important as it may affect the reporting and follow up requirements.

Once the circumstances of the incident are completely documented, the form is signed by the provider generating the form, as well as by the program director or supervisor. The completed form is turned into the program director or supervisor. In the essence of time, a copy may be faxed to the corporate office –however the signed original must be turned in, as well.

Incident reports are reviewed and staffed weekly at the Safety meeting. The attendees at the Safety meeting serve as the incident report committee. Each report is read out loud and the issue is discussed, as needed. The President or Clinical Quality Manager must sign the report. There may be follow up information requested by the President or Clinical Quality Manager. The QA Dept will generate a request for follow up to the provider with a "cc" sent to the applicable program director. The provider responsible for generating the report must provide the follow up, as requested.

All incidents are tracked and logged onto a spread sheet. Each Quarter, as well as year-end, the Incident Report Committee will review the quarterly and year-end status. This information is used for training purposes.

MANDATED REPORTING – providers of mental health services are mandated by Florida law to report occurrences, allegations, or suspicions of abuse and/or neglect against minors, the elderly, and impaired and/or disabled adults. Abuse, in the form of sexual, physical, and/or emotional, must be reported to the Florida Abuse Hotline. Neglect and abandonment are also mandated reporting issues. Clients and guardians have the right to know this law. During the first session with a client and/or guardian, this reporting obligation must be discussed.

I _____ acknowledge that I have read and understand the material provided in this Clinical Training and Reference Manual. Should I have any questions about the content of any item I will contact my Program Director or Quality Assurance Director (FTS Corporate Office 850-216-6007).

Staff Signature: _____ Date: _____

Please sign and date this acknowledgement and send to the FTS corporate office:
Attn: QA