Boosting UR Outcomes and Quality of Care: Capturing Client Quotes

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Author: Elizabeth Irias, M.S., LMFT (https://www.recoveryview.com/Topic/TabId/107/PID/100/authorid/232/Default.aspx?AuthorName=Elizabeth-Irias,-M.S.,-LMFT)

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As any Utilization Review (UR) clinician will tell you that pleading a client's case with a managed care company can be an exhaustive, disconcerting process. Those of us in this field were likely drawn to the work due to our desire to help others; we explore, we nurture, and we advocate. It's a rare day to come across a clinician who enjoys paperwork or delights in the UR process… it is tedious. Utilization Review occurs behind the curtain, often with clients and families unaware of the importance this process plays in their care, though an enormous amount of the client's treatment depends on this procedure. Behavioral health providers want the best outcomes for their clients, and the documentation process can sometimes seem daunting; cutting corners in this area may negatively affect your client care, your overhead, and auditing results. There are a few simple changes that can help you improve this process, both to better the outcomes for your clients and help the financial stability of your organization. I like to call them 'UR gold': Direct client quotes and straightforward descriptions.

Let's start by taking a look at a couple of examples picked straight from progress notes, both of which chronicle the same clinical information. Example one: "Client reports symptoms of depression, including suicidal thoughts, tearfulness, and anhedonia." Example two: "Client reports, 'I've been thinking about suicide constantly, and I stood there holding the knife to my wrist two days ago while cutting up onions for dinner, just thinking about how nice it would be to put a stop to the pain. I only stopped because I heard my wife coming down the stairs… I don't know what would've happened if she hadn't walked in. I've been written up at work a few times for crying during meetings… I just can't seem to keep it together, and I'm afraid that I might get fired. I'm a regional manager, and my income supports our family. I feel so bad now that I actually hid in the bedroom during my daughter's birthday party last week… I just couldn't fake it anymore and put on a happy face. I hate this."

Both of these illustrations are describing the same information in very different ways. The first uses broad strokes and clinical interpretation and gives the reader a brief overview of the client's symptoms. It satisfies Quality Assurance needs, and lays the groundwork for why the client was admitted to treatment. The other, alternatively, gives the reader a front-row seat to the client's actual process and explanation about his or her experience. From a Utilization Review standpoint, there is no contest: The second example is clearly more illustrative and would be far more effective when opening a case with the insurance company. Managed care companies seek detailed, individualized information to justify the proposed level of care and treatment plan. The second quote patently shows what is at risk: The client's life, the client's job, the financial stability of the family, and his or her emotional connections with others. These components are critical to understanding how all of the pieces fit together, more than just the clinical label attached to the symptoms.

I know what you're thinking: "This is all well and good, but we can't write novels in order to capture all of these quotes." You're right. You can't, and you shouldn't. There are simple strategies that you could employ that may make this transition easier, and would actually save your staff time in the long-run. In my experience, when the details in the chart are lacking, time is lost when the UR personnel are hounding the clinical staff, asking for more clarity and description. The clinician then needs to re-open the chart, add in additional information, and reconvene with the UR staff, who then in-turn need to again review the client's chart to find the gems of information. That cycle is a time-suck and the system and structure can be modified to help them run more smoothly.

Initial Client Contact

Clients and families generally have a number of options when they are choosing behavioral health treatment. They are frequently in a particularly vulnerable state when they reach out, and are seeking a rapid exchange of information because they know that their time is precious in this stage. They need you to understand their needs and concerns, and they need to know if your treatment is the right treatment. Chances are some extremely important details are discussed during this initial call or visit… how and when the client's problem began, how it has been affecting his or her life and the lives of others around him or her, and what's at risk. These words are the client's or family's first way of painting a picture for you. They also may be the first facts and figures that go into the client's chart, laying the groundwork for opening the case with the managed care company. So much information will be based on these details… if the client is appropriate for your treatment center, which level of care will be recommended, whether the initial authorization call with the managed care company will go smoothly or start off faltering. How is your organization capturing this data? Are trained professionals conducting the interview, and then documenting the client's words? Take a look at your documentation processes surrounding the initial client contact, and challenge your intake personnel to integrate client quotes. Additionally, does your Electronic Medical Record offer a 'patient portal' feature which would allow you to have the client and families fill out background information before they even set foot in your facility? This data could be make-or-break during the Initial Authorization contact with the insurance company, and requesting it from prospective clients (and particularly from their family members) and then integrating it into the treatment may contribute to them to feeling heard and supported during those tenuous first days of treatment. It also would help save time when writing the initial assessment, since clear examples are outlined for clinicians and can be easily included in the intake notes.

Progress Notes

The purpose of a progress note is to record the gist of what happened in the session: The client's symptoms and mental state, the interventions that took place, the client's response to the session, his or her progress, the clinician's clinical interpretation, and the plan for the next session. Of these different progress note components, only two involve the client's presentation or response (the symptoms/mental status section and the client response section), and simple changes can be made to your progress note structure to improve these segments. What

would happen if you required your clinicians to record at least one client quote in every single progress note? What if your treatment staff (floor staff, receptionists, etc.) were instructed to write a few-sentence note during each shift for each client with whom they interacted, also requiring at least one quote or direct observation (ie- “Client appeared sullen during dinner and said few words, and excused herself early. Ten minutes later, writer observed client writing in her journal while in her bedroom, crying.”) These small changes could be game-changers.

Weekly Treatment Team Meetings

Having attended many treatment team meetings, I have witnessed first-hand how much client data is exchanged during these gatherings. In a perfect world, these meetings involve a number of professionals collaborating about the client’s care, updating one another, all the while integrating and revising the treatment plan. Though the treatment plan is one of the critical components of this meeting, so are the episodic updates that may not have made their way into the chart: The phone calls from the family, the client incidents that happened in the hallway, the commotion during the community outing. Do you have a designated staff person who is recording this information during the treatment team meeting, and adding it to a note in the chart? The treatment team meeting ought to be a time for clinical reflection, treatment plan modifications, and record-keeping; all of these components contribute to sound behavioral health care.

These are just a few ways that you can alter your documentation practices, which may both improve the quality of the care your clients receive, as well as enhance your UR processes, simultaneously affecting the client and the financial stability of your treatment center. Few clinicians and treatment staff enjoy the documentation requirements of being a behavioral health treatment provider, but the process can be streamlined and improved for the betterment of your clinicians, your clients, and your company... these are all worthy investments.

About Elizabeth Irias, LMFT:

Elizabeth is a warm, tenacious, and detailoriented licensed Marriage & Family Therapist, with specializations in Utilization Review, Clinical Management, and Quality Assurance. She serves as a spokesperson for behavioral health clients with their insurance companies, advocating for appropriate and necessary treatment. As a consultant, Elizabeth works closely with clinical teams to improve their quality of care and documentation practices. Her highlevel clinical work comes from her passion to improve the quality of care for mental health patients, and she feels strongly that streamlining administrative processes can lead to an improvement in the patient’s treatment experience and the resulting outcome. She also operates a private practice in Westlake Village where she provides adolescent/young adult therapy, family therapy, and addictive disorder treatment. In addition, Elizabeth conducts personalized, targeted presentations for educational institutions and area mental health and legal providers, and is a professor at Pepperdine University in Malibu, California.

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