What Should be in Your Charts–But Probably Isn't: Writing Great Progress Notes and Treatment Plans

Presented by Barbara Griswold, LMFT

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with
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CAMFT PRIVATE PRACTICE SERIES WORKSHOP

Why Are You Watching This?

- You never got training in notes
- You're not proud of your charts (if so, you are not alone)
- You've heard plans reviewing treatment
- You've received records request
- Healthcare landscape is changing
- Goal: develop new habits so that you stay on top of notes, write notes that can be more helpful to you and clients, and feel confident if reviewed

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Who Am I?

- 26 years licensed therapist in practice
- Author, *Navigating the Insurance Maze: The Therapist's Complete Guide*
- For 10 years: insurance consultations and trainings-- notes is frequent question
- But three experiences most affected notes:
  1. Serving four years on professional association's State Ethics Committee
  2. Having to turn over my charts five times to court/disability/insurance plans
  3. When client of mine killed his wife

When you think of a health plan reading your client notes, how do you feel?

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Why Don't We Keep Better Notes?

Do Any of These Sound Like You?

- "I don't have time to take good notes"
- "I hate paperwork, so take quick notes"
- "By the time I write, I don't recall details"
- "I was taught -- the less you write, the better"
- "To protect my clients, I keep notes vague"
- "I can write notes for me, since I'm the only one reading them"
- "I don't have to worry about my records – I don't work with insurance"

While understandable, in today's healthcare environment, writing vague notes or notes unreadable to others can hurt you and clients

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Why Keep Good Notes?

<u>To protect you</u>:

- Required by most state laws and ethics codes
- Required by insurance
- Detailed notes will assist in a complaint
  - "If you didn't document it, it didn't happen"
  - Licensing boards concerned about the job you did – or did not do; your only evidence may be your notes
  - Notes justifying facts, your thinking and your actions serve as your best defense

Why Keep Good Notes? (continued)

<u>To provide better care</u>:

- Aid your memory
- Provide history to inform treatment
- Returning clients

<u>To assist your client:</u>

- Coordination of care/continuity of care
- Document symptoms/impairment for disability coverage/worker's comp/legal
- Document "medical necessity" of treatment for insurance *(even out-of-network therapists can have treatment and notes reviewed)*

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Legal and Ethical Codes

- CA Law: unprofessional conduct is "[failure] to keep records consistent with sound clinical judgment, standards of the profession, and the nature of the services being rendered."[1]
- CAMFT Ethics: MFTs "create and maintain patient records…consistent with sound clinical practice."[2]
- CA law requires you to retain records:
  - For at least 7 years from termination
  - For at least 7 years from date a minor client reaches age 18

But BBS has 10 years to investigate complaints

[1] Cal Bus & Prof Code §4982(v)
[2] CAMFT Ethics Code 3.3 pg. 5

Even BBS Gives Citations for Charts

- **Most frequent citations involve failure to document:[3]**
  - sessions
  - treatment goals/plans
  - risk factors; if risk factors found, actions taken & referrals made
  - client progress
  - relevant history
  - client complaints, in client's own words
  - fee agreement
- **Failure to back up electronic records**

3 - David Jensen, JD, CAMFT attorney, 2016

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What clinical documentation should be in your chart?

- Initial evaluation
- Ongoing progress notes
- Treatment Plan

What Do Insurance Plans Require? *(A Review of 7 Major Plans' Requirements)*

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This Applies to You Out-of-Network Providers, Too

- As soon as your client turns in an invoice for services, your treatment ***and chart*** can be reviewed – and they want documented details of treatment and diagnosis
- And what follows could be seen as outline of an ideal clinical record

Common Health Plan Requirements

- Each insurance plan has own documentation requirement list: If network provider, get list
- Plans require notes to be:
  - Legible and readable (avoid abbreviations)
  - May require blue or black ink
  - Legibly signed: degree, license/credentials
- If records electronic, finish entry with words, ex. "Signed by Mary Smith, LCSW," or "Finalized by Joe Jones, MFT"

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INITIAL EVALUATION: Common Health Plan Requirements

- Symptoms, problem and problem history
- Psychiatric history, including hospitalizations
- Current medications, including over-the-counter meds, prescribing doc, contact info
- Psychosocial information
- Medical issues / relevant history, allergies
- Mental status exam
- Document risk factors danger self/others; alcohol/drug/cigarette
- Diagnosis
- Support system / emergency contact info
- Medical necessity / impairment

ONGOING PROGRESS NOTES: Common Health Plan Requirements

1. **Start and end times (ex. 1:05-1:55 pm)**
2. Date and client's name on each page
3. Service type, ex. individual, couples, group
4. Problem statement, description/quotes
5. Interventions/homework assigned
6. Client strengths/limitations or barriers
7. Functional impairments
8. Client in-session behavior/mood
9. Progress/lack of progress
10. Date of next appointment
11. Support for diagnosis/**medical necessity**

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Medical Necessity: The Key to Treatment Approvals

An increase in chart reviews?

Treatment reviews have always been a part of managed care, but have increased since

Federal Parity Act and Affordable Care Act

- Most clients now have unlimited sessions regardless of diagnosis (some exceptions)
- **BUT:** Plans can still refuse to cover visits they feel are not "medically necessary"
- Plans rely on "medical necessity reviews" to limit sessions, even for out-of-network folks
- Notes must defend medical necessity of care

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What Are Plan Looking For? Medical Necessity Criteria

We must document how treatment meets Criteria. Varies with each plan, but usually:

- DSM diagnosis is present/suspected
  - Z code can't be sole or primary diagnosis
- Treatment is necessary, not just desired or supportive
- Treatment goals can't be just personal growth, self-esteem, feeling awareness; must be reduction of symptoms/impairment
- Document functional impairment/distress
- Most appropriate, cost-effective level of care
- Document client improvement, but…

SAMPLE Progress Notes

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Just like there is no single recipe for apple pie,
there is no single way to do progress notes, but…

Barb's Key Ingredients of a Great Progress Note

- ✓ **Generous helping of specific DETAILS** of symptoms/diagnosis
- ✓ **A dash of client QUOTES** (optional)
- ✓ **A heaping serving of YOU!** What did you do? What will you do?

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Example 1: How Good Is This Note?

Explored client thoughts and feelings about divorce.

Example 1: Better Note

8/29/17, 2:07-2:54 pm: Ct. reports experiencing grief and moderate depression since divorce was finalized last week, "when I got the paperwork the sadness really hit me." Ct. says "I'm not sure what my future holds." Ct. reports "I have vague thoughts about dying" but no suicide plan, "I would never do that -- my aunt killed herself and it really upset me." Helped ct. identify stages of grief related to end of marriage. Helped him identify negative self-talk that is adding to depression ("I feel since marriage failed, I'll never be happy") and used CBT to combat distorted thoughts. Created depression/safety plan with ct for coping; Ct. agreed to contact therapist if thoughts of dying worsened. Next appt. 9/4/2017.

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Example 2: How About This One?

Ct. discussed wk stress. Validated ct. feelings.

Example 2: A Better Note

8/3/17, 3:04-3:56 pm: Ct. discussed anxiety related to high-stress job and 12+ daily work hours. Says "I work 6 days a week, and worry about keeping up. There don't seem to be enough hours a day to do all I need to do." When asked, client admitted she was getting less sleep and waking in the middle of night worrying about job-related tasks. Explored realistic boundaries she could set with work, in an effort to improve self care, ex. leaving desk to take breaks and for lunch, and asking boss to help prioritize tasks. Gave insomnia handout. Next appt. 8/10/17.

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How About a Couples Note Example?

8/3/17, 3:00 – 3:45 pm: Couples session with ct. Beth and fiance Jill, who report increase in tense arguments (3 this week), mostly around wedding plans. Both shout, but deny abuse/violence. Ct. says "J. is pressing me to come out to my father. I rely on him financially and can't risk he'll cut me off." Ct says relationship conflict is leading to reduced work productivity, daily stomach distress, and difficulty concentrating. J. admits impatience, "we've been together 3 years and I'm tired of B. introducing me as her friend." Taught anger de-escalation and active listening skills, facilitated calm conversation using these. Pointed out how both tend to interrupt, causing escalation of anger. Clients will practice active listening. Referred both to LGBT Coming Out group. Next appt. 8/14/17

Two Progress Note Templates…

SOAP

DAP

(But first, a word about templates)

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SOAP Notes

Subjective: Client's subjective report of problem; what ct. says, use their words when possible

Objective: Your direct observations of client

Assessment: Diagnosis, assessment of what's going on, thoughts on medical necessity, progress (or lack of)

Plan: Referrals, in-session interventions, homework, changes to treatment plan

Case Example

Your Client,
Snow White

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Sample Snow White SOAP Note #1

Subjective: S. admitted "the dwarfs are at the mine all day, I feel so lonely, I've been smoking a pack of cigarettes daily for last month." Says smoked before came to live with dwarfs, "Doc made me stop." Reports fatigue, lack of appetite ("but I'm eating better"), lack of interest in berry picking, denied self-harm thoughts.
Objective: Ct. wears same stained gown to each session. Made little eye contact, cried quietly.
Assessment: Ct. reports better eating; needs help to build support system, and to combat smoking triggers.
Plan: Gave Disney Depression Scale to get baseline, she scored 24. With ct., created list of how to deal with lonliness without smoking. Referred to Princess Support Group and Enchanted Forest Smoking Cessation Class. Ct agreed to add goal of smoking cessation to Treatment Plan. Next appt. 8/9/17

Sample Snow White SOAP Note #2

Subjective: Reports sadder this week (average 8 on scale of 10), says "I feel ugly and alone, I don't feel things are getting better. On Monday I cut myself." Made 3 superficial cuts to thigh with scissor, says "it hardly bled, but I felt more alive." Denies history of this behavior, denies suicidal thoughts.
Objective: S. brought up cutting at the end of session.
Assessment: Depression seems worse. Continues to need help dealing with hopelessness and isolation.
Plan: I pointed out progress since therapy began, she said she had trouble seeing it. Helped make list of coping strategies she could use when felt like cutting. Added tx. goal of eliminating cutting. Next time explore possible secondary gains of cutting, discuss medication evaluation if depression not improved.
Next appt. 8/9/17

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DAP Template

DATA -- what client says AND what you observe in session (content and process)

Assessment – your understanding of problem, medical necessity for therapy, client's response

Plan – what are you going to do about it? Does treatment plan need revision? When is next session date?

Case Example

Your Client,
The Evil Queen

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Sample Queen DAP Notes

Data – Reports daily anxiety and insomnia (average 4 hrs. sleep/night last week), "I can't stop obsessing about S. being more beautiful than me. I can't focus on royal duties. I'm so worried others think I'm ugly, I don't allow townsfolk to visit." Ct. cried when asked history of beauty-anxiety: "Dad left Mom because Mom lost looks with age." Denied she would act on vague thoughts of hurting S. Taught progressive relaxation exercise to quiet anxiety; she reported difficulty relaxing. Referred to Mindfulness Class.
Assessment: Obsessing impairs daily functioning, work
Plan: Client will practice relaxation daily and will enroll in Mindfulness class. Therapist will monitor risk related to thoughts of hurting S. Continue to work on insomnia/obsessions. Next appt: 8/4/17

DAP Case Example

Grumpy

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Sample DAP Note #2: Grumpy

Data: Ct. reports "I love S., but since she moved in to the cabin it has been stressful. She cooks and cleans up after us dwarfs, then complains! I'm resentful—we were fine before she came!" Says feels constantly irritable, lost temper at boss last week, and avoids coming home after work. "She hogs the TV watching cooking shows, so I go to the bar." Admits 3 drinks average daily. Taught ct. assertive communication, role played talking to S. directly about resentment.

Assessment: Ct. is having trouble adjusting to new addition to home, it is affecting work. Needs help with anger management without being passive-aggressive.

Plan: Assess alcohol use for problem use. Continue to help client identify barriers to assertiveness. Ct. will practice assertive communication between sessions and get book *Your Assertive Right*. Next appt. 9/6/17

10 Situations When You Should Take Extra-Detailed Notes

1. Crisis cases, esp. those that may need more than once weekly sessions, or may need to breach confidentiality or make report
2. Changing diagnosis or treatment plan
3. Changing the unit being treated, or seeing multiple family members
4. Clients with personality disorders, or clients that want to restrict practice style (ex. asks you not to take notes or talk to doc)

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10 Situations When You Should Take Extra-Detailed Notes (continued)

5. Clients involved in lawsuits, litigious history
6. Extended boundary situations (ex. visit client in hospital, attend client wedding)
7. Providing non-traditional therapy
8. Payment issue/unusual payment agreement
9. Supervising interns/assistants
10. Absence/termination/transfer/referrals

BOTTOM LINE: DOCUMENT YOUR THINKING AND CONVERSATIONS WITH CLIENTS

It's Easy to Fall Behind..

Have policies for late notes; some plans have late entry rules

- ex. UBH/OPTUM says: *"if an entry is made more than 24 hours after the service was rendered, entry should include date of service, date of the entry, and notation that this is a late entry…"*[4]
- If you fall behind, don't avoid. Get consultation, and make action plan

4 – From Optum/UBH Provider Guidelines, 2016

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Tips for Better Notes

Tips for Better Notes

- Write as if a reviewer will be reading
- Imagine client might read it
- Document consultations
- Have error policy
  - OPTUM:"*Errors should be lined through so that it can still be read, then dated and initialed"*[5]

5 -- from Optum/UBH Provider Guidelines, 2016

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Treatment Plans

Treatment Plans

- Required by most health plans
- May be legally and/or ethically required
- Don't write formal plans? You're not alone…

The 3 Main Parts of a Treatment Plan

1. **Treatment goals** (should be objective and measurable)
2. **Planned interventions**
   a) Treatment modality/frequency
   b) Interventions
   c) Homework/referrals
3. **Approximate deadlines for goals**

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Thoughts on Treatment Plans

ACA Ethics Code: *"Counselors and their clients work jointly in devising counseling plans…. Counselors and clients regularly review and revise counseling plans to assess their continued viability and effectiveness…"*[6]

- Separate from notes?
- Signable by therapist/client; updateable
- Should be able to articulate treatment plan and goals at any time

6 – American Counseling Association, 2014 Code of Ethics

5-Minute Treatment Plan

THERAPY GOALS	PLANNED INTERVENTIONS	DATE
1.	1. 2.	
2.	1. 2.	
3.	1. 2.	
4.	1. 2.	

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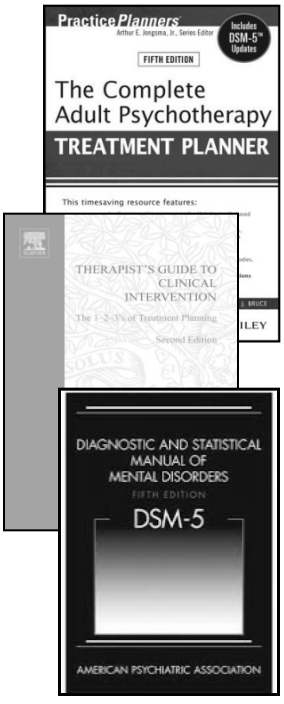
How Do I Choose Therapy Goals?

- In first session, ask client therapy goals
- Help restate it to be symptom-focused, achievable, observable, measurable, ex:
  - ex: "I want to feel better" ⟶ "decrease in depression: client will no longer dread getting up when alarm goes off"
  - ex: "I want to trust spouse again after the affair" ⟶ "client will report decreased anxiety when spouse leaves home"
- Suggest additional goals
- Goals should be tied to diagnosis, aimed at reducing impairment

Treatment Plan Resources

1. Use Treatment Planners, ex:
- "*The Complete Adult Psychotherapy Treatment Planner, Ed. 5*" (and others in PracticePlanners series; Wiley)
- *"Therapist's Guide to Clinical Intervention; The 1-2-3s of Treatment Planning, Ed. 2"* and others by Sharon Johnson
- Warning about these

2. Use DSM-5
- Use diagnostic criteria to identify goals consistent with diagnosis



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Exercise: Write Measurable, Observable Goals for a Depressed Snow White Using DSM-5

DSM-5 Major Depression Criteria:

1. Depressed mood most of the day, almost daily
2. Loss of pleasure in almost all activities
3. Weight loss/decrease in appetite/weight gain
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive guilt
8. Diminished ability to think or concentrate
9. Recurrent thoughts of death/suicide
10. Symptoms cause significant distress or impairment in social/occupational/other areas

5 Minute Treatment Planning: Possible Measureable, Observable GOALS for Snow White:

Client will report:

1. Decrease in depression frequency, severity, duration from daily to 1x weekly; will score less than 12 on Disney Depression Scale
2. Renewed pleasure in activities enjoyed in past, including berry picking and picnicing
3. Improved self-care (healthier eating habits, no meal-skipping, better grooming)
4. Insomnia no more than twice monthly
5. Reduction of fatigue/loss of energy
6. Improved ability to think or concentrate
7. Increased use of support system

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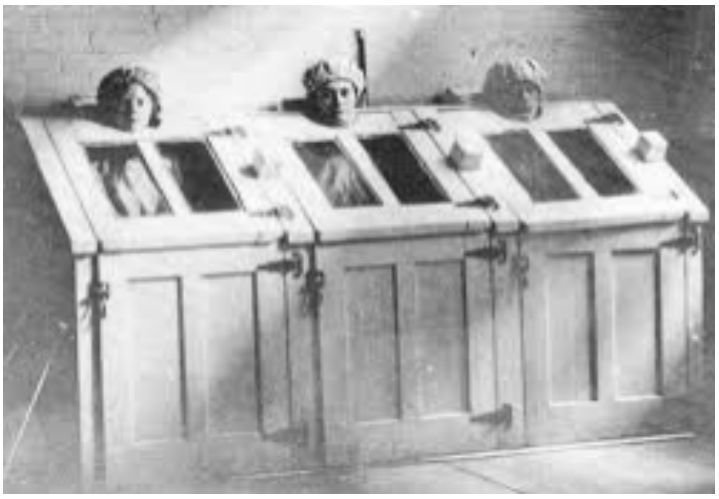

So What Are Some Possible INTERVENTIONS for Snow White?

Some Possible Snow Interventions:

1. Individual (and/or "family") therapy?
2. Assist ct. in recalling coping strategies used successfully in past
3. Assign negative thinking journal
4. Create self care plan/depression coping plan
5. Refer for med. evaluation & coordinate care; address ct. concerns to improve compliance
6. Urge development and use of support system; identify barriers to utilization
7. Educate client (and dwarfs) about depression/insomnia via written materials
8. Give insomnia CD to listen to before bed
8. Assign daily exercise in woods to tire body
9. Teach assertiveness/ability to ask for help
10. Monitor substance use and danger to self

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5 Minute Treatment Plan Example #2: Write Goals for Queen

- **DSM-5 Defines Obsessions as:**
  1. intrusive and unwanted recurrent and persistent thoughts, urges or images
  2. the individual attempts to ignore or suppress
  3. The obsessions are time-consuming
  4. The obsessions cause significant distress

So… Possible Goals for Queen with OCD

Client will report:

1. decrease in frequency and intensity of intrusive and unwanted thoughts/images
2. ability to do thought-stopping techniques and to shift thinking away from obsessions
3. reduction in time spent on daily obsessions
4. when unwanted thoughts occur, they will cause less clinically significant distress
5. will no long avoid townsfolk and advisers due to obsessions
6. better concentration, better functioning in royal tasks, less impairment

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Some Possible Queen Interventions:

1. Weekly individual insight-oriented therapy
2. CBT aimed at cognitive restructuring
3. Help identify catastrophizing and cognitive distortions about aging and attractiveness
4. Refer to Mindfulness Meditation Class
5. Teach progressive relaxation and meditation exercises to use when obsessions occur
6. Create self care plan/anxiety coping plan
7. Discuss possible referral for medications
8. Urge development and use of support system; identify barriers to utilization
9. Do exercises from "OCD Workbook"
10. Listen to guided meditation
11. Bring in Lady-in-Waiting for support

Couples Treatment Plan

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Couples/Family Treatment Plan

- One Identified Patient (IP), one chart, one treatment plan, unless….
- Treatment plan focuses on identified client symptoms
- Insurance coverage requires diagnosis not just Z-code or sex therapy
- treatment goals should focus on supporting identified client
- So… goals for couples therapy with S. may look very similar to individual therapy plus possible added goals including:

Possible Acceptable Couples Goals (in addition to Snow's goals)

1. Address relationship issues, if contributing to S's symptoms or lack of functioning
2. Provide education
   a) to Prince to improve S's compliance with therapy goals
   b) assist him to understand her symptoms, to address behaviors, respond more effectively
   c) reduce negative impact on Prince of her condition
3. Assist in diagnosis/treatment planning for S.
4. To speed S's progress in treatment

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What About Adjustment Disorder Goals?

DSM defines Adjustment Disorder as:

1. "Development of emotional/behavioral symptoms in response to stressor"
2. "Marked distress out of proportion to severity or intensity of stressor"
3. "Significant impairment in functioning"

So Goals (be specific, and say how measure):

1. Reduce emotional/behavioral symptoms
2. Less distress/less reaction to the stressor
3. Less impairment and improved functioning
   - If Adjustment Disorder w/Depression, see criteria for Depression for target symptoms
   - If Adj. Dis. With Anxiety, look under Anxiety

Because it's hard to articulate what we do:
Sample Interventions

- Reframed
- Taught mindfulness
- Taught meditation
- Role played
- identified positive affirmations
- Assign journaling
- Helped identify progress or barriers to progress
- Coordinated care with…
- Gave questionnaire
- Taught assertiveness
- Helped identify strengths
- Assign reading
- Helped identify/challenge cognitive distortions
- Educated clients about (grief, insomnia, etc)
- Had client write substance use history
- Had client draw/paint/use clay to…
- Referred to community resource/group/class
- Referred to med. evaluation; educated abt. meds, discussed fears to improve compliance

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Why Charts Are Requested: Administrative Reviews and Treatment Reviews

Why Plans Might Come A Knocking…

Chart Reviews

- Administrative Review
  - How to prepare now
- Billing Patterns (ex. 90837 CPT Review)

Treatment Reviews

- Medical Necessity

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Treatment Reviews

Why You Might Be Selected

- You've done more sessions than expected by computer algorithms – may be based on diagnosis, so avoid underdiagnosing
- You've done multiple sessions per week for extended period
- Out-of-network providers included!

Responding to Treatment Reviews and Records Requests

Usually they will ask to talk by phone, less often ask for notes

- Ask plan for Medical Necessity Criteria and expected questions
- Don't wing it – your answers can hurt clients
  - Contact CAMFT lawyers if receive records request for response options
  - Invite you to contact me if asked for treatment review -- I have a list of common treatment review questions and will help you prepare

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In Summary: Is Documentation a Nuisance or Clinical Ally?

I say both. Yes, it's time consuming. It's not the part of our job that we love. We worry about confidentiality. *But in my opinion, well-written, detailed thoughtful notes are:*

- Our strongest defense in an ethical, legal or licensing board complaint
- Our best tool to help defend a client's need for treatment when insurance threatens denial, or to assist client in getting disability
- An underutilized clinical tool to help guide treatment and provide better quality care

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