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

with Barbara Griswold, LMFT

Webinar handout and CE test for CA BBS licensees at www.theinsurancemaze.com/greatnotes

Why Watching This?
- You never got much training in notes
- You’re not too proud of your documentation (if so, you are in good company)
- But: You may have heard insurance plans now more often reviewing treatment and charts, or have 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

Who Am I?
- 26 years licensed therapist in practice
- For 10 years: consultations and trainings for therapists nationwide on insurance and practice-building – 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

What We’ll Be Talking About
- Why we don’t take good notes – and why we should
- What insurance plans require in notes
- How to write great progress notes
- Sample notes, tips, and templates
- How to save time writing notes
- The secret to getting more sessions approved: documenting “medical necessity”
- When to take extra-detailed notes
- How to write a 5-minute treatment plan
- Why records are being reviewed more often
- Why a plan might ask to see your charts

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

Why Don’t We Keep Better Notes?
Do Any of These Sound Like You?
- "I don’t have time to take good notes" (when busy, notes may be first thing to go)
- "I hate paperwork, so take quick notes"
- "I procrastinate, and by the time I do notes, I don’t remember details"
- "I was taught -- the less you write, the better"
- "To protect my clients, I keep notes vague"
- "I’ve never been audited -- I can write notes for me, since I’m the only one reading them"

While all of these are understandable, in today’s healthcare environment particularly, writing vague notes (or notes that are not readable to others) can hurt you and clients.

Why Keep Good Notes? (continued)
To provide better care:
- Aid your memory
- Provide history to inform treatment or if client returns

To assist your client:
- 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)

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

Why Should You Keep Good Notes?
To protect you:
- Required by most state laws and ethics codes
- Definitely required by insurance plans
- Detailed notes will assist in a complaint
  - The licensing board will be 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
- "If you didn’t document it, it didn’t happen"

What clinical documentation should be in your chart?
- Initial evaluation
- Ongoing progress notes
- Treatment Plan

This Applies to You Out-of-Network Providers, Too
- As soon as your client turns in an invoice or superbill for services, your treatment and your chart can be reviewed – and they will want documented details of treatment and diagnosis
- And for all of us, what follows could be seen as outline of an ideal clinical record
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

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 now rely on “medical necessity reviews” to limit sessions, even for out-of-network folks
- So notes must defend medical necessity of care

Barbara Griswold, LMFT
Author, “Navigating the Insurance Maze”
www.theinsurancemaze.com
408.985.0846 barbgris@aol.com
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 purely personal growth or self-esteem or feeling awareness; must be reduction of symptoms/impairment
- Document functional impairment/distress
- Most appropriate, cost-effective level of care
- Document client improvement

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?

Example 1: How Good Is This Note?

Explored client thoughts and feelings about divorce.

Example 1: Better Note

11/29/16, 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. 12/4/2016.
Example 2: A Better Note

12/3/16, 3:04-2:56 pm: Client 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 just don’t seem to be enough hours in 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 her prioritize tasks. Gave insomnia handout. Next appt: 12/10/16.

How About a Couples Note Example

11/3/16, 3:00 – 3:45 pm: Couples session with ct. Beth and girlfriend Julie. Couple reports increase in conflict as holiday approaches (3 arguments this week), where both shout, but deny abuse/violence. Ct. says "I am pressing me to 'come out' to my father. I rely on him financially and can't risk he'll cut me off." Ct says she is so tense due to conflict, she hasn't been as productive at work, and reports difficulty concentrating and stomach distress. J. admits she is impatient, "we've been together 3 years and I'm tired of B. introducing me as her friend." Taught anger management 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 to LGBT Coming Out group. Next appt 11/7/16

Two Progress Note Templates...

SOAP

DAP

(But first, a word about templates)

SOAP Notes

Subjective: What client says. Use their words when possible
Objective: Your direct client observations of client in session
Assessment: Your diagnosis and assessment of what is going on — your thoughts about the medical necessity for therapy, progress (or lack of progress)
Plan: Referrals, in-session interventions, homework, changes to treatment plan

Case Example

Your Client, Snow White
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 loneliness 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. 12/9/16

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 even cut myself." Says 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. While I pointed out progress since therapy began, she reported it didn't make her feel better.

Objective: S. brought up cutting at the end of session.

Assessment: Depression seems worse. Continues to need help dealing with hopelessness and isolation.

Plan: Helped make list of coping strategies she could use when she felt like cutting. In next session explore possible secondary gains related to cutting. Add goal of eliminating cutting. Discuss med. evaluation if depression has not improved. Next appt. 12/9/16

DAP Template

- DATA -- what client says (subjective), and what you observe (objective) in the session, both content and process
- ASSESSMENT -- your understanding of problem, medical necessity for treatment, client's response to treatment
- PLAN -- what are you going to do about it? Anything in the plan that needs revision? When is next session date?

Case Example

Your Client,
The Evil Queen

Sample Queen DAP Notes

Data -- Reports daily anxiety and insomnia (average 4 hrs. sleep/night for last week), "I can't stop obsessing about S. being more beautiful than me. I can't focus at work. I'm so worried others think this. I don't allow townsfolk to visit." Ct. cried when discussing history of beauty-anxiety; "Dad left Mom because Mom lost her looks with age." Denies substance use, threat of violence, self-harm. Taught relaxation exercises she could use to quiet anxiety; she reported difficulty relaxing. Referred to Mindfulness Meditation Class.

Assessment: Obsessions impair daily functioning/work. Changed subject quickly when I asked about husband, ct. may be avoiding dealing with marital problems.

Plan: Client will practice relaxation daily and will enroll in Mindfulness class. Continue to work with client on insomnia and obsessions. Next appt: Nov. 30, 2016
Barbara Griswold, LMFT
Author, “Navigating the Insurance Maze”
www.theinsurancemaze.com
408.985.0846 barbgris@aol.com

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. 9/6/16

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, not to talk to doc

It’s Easy to Fall Behind...

- Develop 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...”1
- If you’ve fallen behind, don’t be embarrassed/get avoidant—get consultation, make action plan

Tips for Better Notes

1 – from Optum/UBH Provider Guidelines, 2016
Tips for Better Notes

- Write as if a reviewer will be reading
- Imagine client might read it – avoid judgmental language
- Document consultations
- Have error policy
  - OPTUM: "Errors should be lined through so that it can still be read, then dated and initialed"
  - No white out

How To Save Time Doing Notes

- Make it a habit, at a regular time daily. Find what works best for you.
- Idea: Try ending on time/earlier and charting right after session
  - If do 25 sessions a week, ending 5 minutes earlier gives 2 extra hours weekly for notes!
  - But don’t sacrifice all breaks
- Try note taking templates

3 – Adapted from Dr. Maelisa Hall’s blog, www.qaprep.com

How To Save Time Doing Notes (cont.)

- Dictation software (ex. Dragon NaturallySpeaking) or Smartphone dictation Apps
- Go Electronic: Practice Management Programs
  - ex. SimplePractice, customizable templates
- Collaborative documentation
  - In session
  - “Let’s sum up what we discussed.” Ask: “What did you feel was the main focus? Progress made? What insight surprised or motivated you? What will you work on in the next week?” etc.
- Like writing therapy journal together

4 – Adapted from Dr. Maelisa Hall’s blog, www.qaprep.com

Treatment Plans

- Required by most health plans
- May be legally and/or ethically required
- Most of us don’t seem to write formal plans

The 3 Parts of a Treatment Plan

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

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.”

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

5 – American Counseling Association, 2014 Code of Ethics
How Do I Choose Therapy Goals?
- In first session, ask client therapy goals
- Rewrite client goals 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” → “ct. will report decreased anxiety when spouse leaves home”
- Suggest additional goals
- Goals should be tied to diagnosis, aimed at reducing impairment

---

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 (give example)
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. Development/use of support system

So What Are Some Possible INTERVENTIONS for Snow White?
Some Possible Snow Interventions:
1. Weekly individual insight-oriented 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
9. Assign daily exercise in woods to tire body
10. Teach assertiveness/ability to ask for help
11. Monitor substance use and danger to self

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 friends due to obsessions
6. better concentration, better work functioning, less impairment

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

Some Possible Queen Interventions:
1. Weekly individual insight-oriented therapy
2. CBT aimed at cognitive restructuring
3. Help identify catastrophizing about aging
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/Family Treatment Plan
- For insurance to cover session, one treatment plan focused around identified client with a diagnosis other than a Z-code
- can't be solely to improve relationship, communication, sex, trust
- couples/family treatment plan 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

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
   a) If Adjustment Disorder w/Depression, see criteria for Depression for target symptoms
   b) 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 and challenge cognitive distortions
- Educated clients about (grief, insomnia, etc)
- Helped identify progress or barriers to progress
- Coordinated care with...
- Gave questionnaire
- Taught assertiveness
- Helped identify strengths
- Assign reading
- 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 and discussed fears to improve compliance

Why Charts Are Requested: Administrative Reviews and Treatment Reviews

Why Plans Might Come A Knocking...

1. Chart Reviews
   - Administrative Review
   - How to prepare now
   - Billing Patterns (ex. 90837 CPT Review)
   - Risk Management Review
2. Treatment Reviews
   - Medical Necessity

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

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

- Ask plan for Medical Necessity Criteria and expected questions
- Don't try to wing it - your answers can hurt clients
- Contact me for consultation - I have a list of common treatment review questions and will help you rehearse how to speak the language of medical necessity

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

How can I help you with your notes, insurance issues, or to build your dream practice?

- Get handouts at www.theinsurancemaze.com/greatnotes
- California BBS Licensees: Get 2 CE Credits for viewing this!
  Get post-test at www.theinsurancemaze.com/greatnotes
- Get one-on-one support around your notes, insurance and ongoing private practice building
- Visit www.theinsurancemaze.com
  - Buy book "Navigating the Insurance Maze"
  - Buy Claim Forms
  - ICD-10 webinar /CPT Report
  - View articles/Workshops

Barbara Griswold, LMFT
barbgris@aol.com  408-985-0846