

Processes that Support Clinicians' Memory and Skills to Ensure Proper Documentation

Bill Schmelter PhD.

Senior Clinical Consultant MTM
Services

mtmwilliam@aol.com

Bill.schmelter@mtmservices.org

What Do We Want Our Form Processes To Help Clinician's With?

- Forms samples used in today's presentation are from the NYS Clinical Record Initiative (Standardized Form Set)
- Only Sample sections of the forms are presented
- The forms can be found at:

http://www.mtmservices.org/NYSCRI_2010F/2010-Forms.html

Important Note! The form samples used in this slide set are for demonstration purposes only. They are not intended to be used in the State of Illinois as they were not designed to meet specific Illinois Regulations or Standards.

Clinical Forms Under Discussion

- Assessment
- Assessment Updates
- Service (Treatment) Plans
- Service (Treatment Plan) Updates
- Progress Notes (Individual & Group)
- Progress Notes (Specialized)

Compliance and Quality

What's Our Compliance Focus?

- “Compliant Looking Paper” ?
- “Quality Service Processes” that meet the “Spirit of Standards” ?

Compliance and Quality

When We Focus on Paper Compliance

Clinical Staff come to not just devalue documentation but also to de-value the clinical processes they represent:

- The Assessment Process
- The Service Planning Process
- The Value of the Service Plan for their Work with Clients

Don't let the Compliance "Tail" Wag the Quality "Dog"

What Do We Want Our Form Processes To Help Clinician's With?

1. Addressing Required Content Elements
2. Support for Medical Necessity (The Golden Thread)
3. Support for Person Centered & Driven Services
4. Relevant Clinical Content

What Do We Want Our Form Processes To Help Clinician's With?

1. Addressing Required Content Elements
 - Areas that Regulations and Standards Require to be “Addressed”
 - What is the best approach?
 - Prompts?
 - Structured Form Areas?
 - Checkboxes?
 - Tables
 - Checkboxes with Narrative?
 - Specialized forms and addenda

Prompts

- To remind clinicians to include specific content in narrative fields
- Best used when a narrative format is needed
- Useful for insuring that areas required by regulation or standards are addressed
- Caution – prompts are often overlooked or ignored and so should only be used when other formats are inappropriate

Adult Comprehensive Assessment

Presenting Concerns

Reason for Referral: (Note Symptoms, Presenting Problem, Behavioral and Functional Needs):

Family Information

Does the individual have Children: Yes No, if Yes complete the grid below:

Name	Age	Who do they live with	Identify Custody Issues
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Family History and Relationships:

Pertinent Family Medical, MH and Substance Use History including Adult Child of Alcoholic(ACOA)/Child of Substance Abuser(COSA) status:

Comments:

Development History

Developmental History (include motor development and functioning, sensory, speech problems, hearing and language problems)

Has Individual Been Previously Diagnosed With a Developmental Disability?: **No** **Yes** (If Yes, provide the following information as it pertains to treatment and services to be provided- particular disability, needs as a result of disability, impact on family and causes, if known):

Social Supports

Friendships/Social/Pets/Peer Support Relationships:

Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests):

Community Supports/Self Help Groups (AA, NA, NAMI, Double Trouble, Peer Support, etc.):

Structured Form Areas

- To ensure that content areas are addressed
- Organizes forms into logical and easy to find areas
- These areas can be formatted in various ways (e.g. narrative, checkbox, etc.)

Initial Individualized Action Plan

Transition/ Discharge Criteria	For COA Only: Estimated length of treatment and stay: <input type="text"/>
<p>How will the provider/individual/guardian know that level of care change is warranted? <input type="text"/></p>	
<p>Discharge Plan - <i>Indicate the anticipated plan for discharge, including Tx., support services, community resources. For OASAS programs, include a description of a substance abuse relapse prevention plan.</i> <input type="text"/></p>	

Individual Counseling/Psychotherapy Progress Note

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan:

Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>
Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Checkboxes

- Best for categorical data
- Ensures that data is collected in a consistent format
- Allows for reporting of categorical elements – not possible with narrative information

Adult Comprehensive Assessment

Living Situation

Where is the individual currently living? (check one)

- House/Apartment Friend's Home Relative Parent/Immediate Family Guardian
 Foster Care Home Respite Care Jail/Prison Homeless living with friend
 Homeless in shelter/No residence Other: _____

- Residential Care/Treatment Facility:** Hospital Temporary Housing Residential Program Nursing Home
 Supportive Housing Supported Housing Other: _____

At Risk of Losing Current Housing? No Yes

Comments: _____

Satisfied with Current Living Situation? No Yes

Comments: _____

- Race:** Black/African American American Indian/Alaskan Asian Hispanic Multiracial
 Native Hawaiian/Pacific Islander Caucasian Not Known Other: _____

Comment: _____

Individual Counseling/Psychotherapy Progress Note

Modality	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Couple <input type="checkbox"/> Phone
Individuals Present	<input type="checkbox"/> Individual Present / Contact Type: <input type="checkbox"/> Onsite <input type="checkbox"/> Offsite <input type="checkbox"/> Phone Conversation <input type="checkbox"/> Others Present (please identify name(s) and relationship(s) to individual): <input type="text"/> <input type="checkbox"/> No Show <input type="checkbox"/> Person Canceled <input type="checkbox"/> Provider Canceled Explanation: <input type="text"/>

Tables

- To organize data into a logical format
- Allows for combination of various formats within table
- Ensures that data is collected in a consistent format

Adult Comprehensive Assessment

Employment History		
Type of Job/Name of Employer	How Long	Reason for Leaving
■	■ Months / ■ Years	■
■	■ Months / ■ Years	■
■	■ Months / ■ Years	■
■	■ Months / ■ Years	■

Mental Health and Addiction Treatment Service History					
Treatment Services History Within the Past 5 years <input type="checkbox"/> None Reported					
Type of Services	Dates of Service	Reason	Name of Provider/Agency:	Inpatient / Outpatient	Completed
■	■ / ■	■	■	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> No <input type="checkbox"/> Yes
■	■ / ■	■	■	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> No <input type="checkbox"/> Yes
■	■ / ■	■	■	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> No <input type="checkbox"/> Yes
■	■ / ■	■	■	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> No <input type="checkbox"/> Yes
■	■ / ■	■	■	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> No <input type="checkbox"/> Yes
■	■ / ■	■	■	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> No <input type="checkbox"/> Yes
■	■ / ■	■	■	<input type="checkbox"/> In <input type="checkbox"/> Out	<input type="checkbox"/> No <input type="checkbox"/> Yes

Outpatient: MA



Initial Individualized Action Plan

GOAL # <input type="text"/> OBJECTIVE <input type="text"/> : <input type="text"/>			
Start Date: <input type="text"/>	Target Completion Date: <input type="text"/>	Adjusted Target Date: <input type="text"/> as per IAP Review Form Dated: <input type="text"/>	
Intervention(s) / Method(s) / Action(s)	Service Description/ Modality	Frequency	Responsible: (Type of Provider)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Individual Counseling/Psychotherapy Progress Note

Individual's Condition	No Significant Changes Reported or Observed	Notable	If Notable, List the Changes in Individual's Condition
Mood/Affect:	<input type="checkbox"/>	<input type="checkbox"/>	
Thought Process/ Orientation:	<input type="checkbox"/>	<input type="checkbox"/>	
Motor Activity and Speech:	<input type="checkbox"/>	<input type="checkbox"/>	
Behavior/Functioning:	<input type="checkbox"/>	<input type="checkbox"/>	
Medical Condition:	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Use / Addictive Behaviors: <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	
Risk Assessment			
Danger To: <input type="checkbox"/> None OR Check all that apply below and record action taken in Therapeutic Interventions section below			
<input type="checkbox"/> Self: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt - Comments: 			
<input type="checkbox"/> Others: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt / <input type="checkbox"/> Property: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt			

Checkboxes with Narrative

- Ensures that required areas are “Addressed”
- Allows for minimal unnecessary documentation
- Allows for detail when a pertinent area applies to a particular client

Addictive Behaviors

✓		CN - Current Need Area NI – Not Clinically Indicated	As evidenced by:	Individual/Family Served Desires Change Now?:
CN	NI			
<input type="checkbox"/>	<input type="checkbox"/>	Substance Use/Addiction:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Other Addictive Behaviors (food, gambling, exercise, sex, etc.):	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Behavior Management

✓		CN - Current Need Area NI – Not Clinically Indicated	As evidenced by:	Individual/Family Served Desires Change Now?:
CN	NI			
<input type="checkbox"/>	<input type="checkbox"/>	Anger/Aggression:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Antisocial Behaviors:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Lack of Assertiveness:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family and Social Support

✓		CN - Current Need Area NI – Not Clinically Indicated	As evidenced by:	Individual/Family Served Desires Change Now?:
CN	NI			
<input type="checkbox"/>	<input type="checkbox"/>	Communication Skills:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Dependency Issues:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Family Education: (Family education must be directed to the exclusive well being of the individual served)	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Family Relationships:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Peer/Interpersonal Support Network:	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Adult Comprehensive Assessment

Trauma History None Reported

Does individual report a history of, or current experience of:

Physical Abuse/Neglect Domestic Violence Elder Abuse Community Violence Verbal/Emotional Abuse Sexual Abuse/Molestation Immigration Trauma Witness to Violence Other:

Provide Relevant Details:

Specialized Forms and Addenda

- Keeps overall form length to a minimum
- Ensures that there is support for:
 - Specific Types of Services
 - Areas of clinical interest that only apply to some clients/circumstances

Group Progress Note

DOCUMENTATION OF PARTICIPATION AND RESPONSE OF INDIVIDUAL TO GROUP TREATMENT

Behavior in Group (*Check All that Apply*):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Showed insight | <input type="checkbox"/> Active in discussion | <input type="checkbox"/> Offered constructive input | <input type="checkbox"/> No apparent interest |
| <input type="checkbox"/> Showed interest | <input type="checkbox"/> Non-verbal but engaged | <input type="checkbox"/> Supportive to others | <input type="checkbox"/> Appeared distracted |
| <input type="checkbox"/> Showed leadership | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Not supportive to others | <input type="checkbox"/> Disruptive |

Individual's Mood: Stable Depressed/Sad Anxious Angry Other:

Psychopharmacology-Psychotherapy Progress Note

Takes meds as prescribed: yes no n/a - Comments:

Side effects reported: yes no - if Yes, Please comment on review:

Allergic reactions: yes no - Comments:

Changes in Medical Status: yes no - If yes, please comment on plan:

Other meds: Over the counter herbal none other - Comments:

Therapeutic Interventions Delivered in Session

Psychopharmacology Only: Medication Education/Counseling Symptom/Illness Management Injections

Counseling Provided with Client/Family/Caregiver (For each counseling topic checked, describe specific details below):

- | | |
|--|---|
| <input type="checkbox"/> Diagnostic results/impressions and or recommended studies | <input type="checkbox"/> Risks and benefits of treatment options |
| <input type="checkbox"/> Instruction for management/treatment and/or follow-up | <input type="checkbox"/> Importance of compliance with chosen treatment |
| <input type="checkbox"/> Risk factor reduction | <input type="checkbox"/> Client/Family/Caregiver Education |
| | <input type="checkbox"/> Prognosis |

Response to Intervention / Progress Toward Goals and Objectives:

Coordination of Care Provided (Must be with person present and involves coordination of care with staff outside of our Agency) Check off as appropriate and describe below-include name, phone # of person with whom coordinating care.)

Coordination with: Medical Staff Residential Staff School staff Probation Family Caregiver Other

Lab Tests Ordered Yes No - **Labs Reviewed** Yes No, **Results:**

If Labs not received, describe action to be taken:



Psychopharmacology-Psychotherapy Progress Note with Evaluation & Management

Goal(s)/Objective(s) Addressed As Per Psychopharmacology/Individualized Action Plan:

Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>
Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>

Therapeutic Interventions Delivered in Session

Psychopharmacology Only: Medication Education/Counseling Symptom/Illness Management Injections

Counseling Provided with Client/Family/Caregiver (For each counseling topic checked, describe specific details below):

- Diagnostic results/impressions and or recommended studies
- Instruction for management/treatment and/or follow-up
- Risk factor reduction
- Client/Family/Caregiver Education
- Risks and benefits of treatment options
- Importance of compliance with chosen treatment
- Prognosis

Response to Intervention / Progress Toward Goals and Objectives:

Coordination of Care Provided (Must be with person present and involves coordination of care with staff outside of our Agency) Check off as appropriate and describe below-include name, phone # of person with whom coordinating care.)

Coordination with: Medical Staff Residential Staff School staff Probation Family Caregiver Other

Psychopharmacology-Psychotherapy Progress Note with Evaluation & Management

Medicare "Incident to" Services Only

Name and Credentials of Medicare Supervising Professional on Site

Greater than 50% of face to face time spent providing counseling and/or coordination of care:

Coordination of Care Progress Note

Type of Scheduled Contact: <input type="checkbox"/> In-Person Meeting: <input type="checkbox"/> Onsite / <input type="checkbox"/> Offsite – Location: <input type="text"/> <input type="checkbox"/> Telephone		
Service <i>(check ONE service only)</i>	Purpose <i>(check purpose(s) for the indicated service)</i>	
<input type="checkbox"/> Case Consultation <input type="checkbox"/> Family Consultation <input type="checkbox"/> Collateral Contact <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Assessment of the appropriateness of current services <input type="checkbox"/> Coordination/Planning <input type="checkbox"/> Discharge/Transition/Aftercare planning <input type="checkbox"/> Clinical consultation <input type="checkbox"/> Other: <input type="text"/>	
List of Participants	Name:	Agency/Relationship to person served:
	<input type="text"/>	<input type="text"/>
Summary of discussion with this contact:(for ex: IAP goals/objectives/ interventions) <input type="text"/>		
Actions that will occur as a result of this contact:	Responsible Party:	
1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>	1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>	

Adult Comprehensive Assessment

Legal Status

Does Individual Served have a Legal Guardian, Rep Payee or Conservatorship? No Yes

If yes, complete and attach the Legal Status Addendum

Is there a need for a Legal Guardian, Rep Payee, Conservatorship or Special Needs trust? No Yes

If yes, explain:

Legal Status Addendum

Legal Status Addendum (Check all that apply)

Representative Payee:

Phone #:

Name/Agency:

Relationship to Individual:

Legal Guardian:

Phone #:

Name:

Relationship to Individual:

Comment:

Permanent Temporary (Explain):

Conservatorship:

Phone #:

Name/Agency:

Relationship to Individual:

Special Needs Trust

Phone #:

Name of Trustee:

Relationship to Individual:

Completed by - Print Name and Credential:

Signature:

Date:



Adult Comprehensive Assessment

Substance Use / Addictive Behavior History None Reported

Does individual report current use or a history of any of the following?

Illegal drug Prescription drug Non-prescription (OTC) Alcohol Gambling Tobacco

**If Yes to any of the above, complete and attach Substance Use/Addictive Behavior Addendum.
(OASAS Programs must have individual complete Communicable Disease Assessment)**

Substance Use/Addictive Behaviors Addendum

Addictive Behavior History Addendum

Have you ever used:	Age of First Use	Date of Last Use	Frequency	Amount	Method
<input type="checkbox"/> Alcohol	[]	[]	<input type="checkbox"/> No use past 30 days <input type="checkbox"/> 1-3x past 30 days <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-6x/week <input type="checkbox"/> Daily/Multiple times/day	[]	<input type="checkbox"/> Oral
<input type="checkbox"/> Amphetamines/Stimulants Please specify: []	[]	[]	<input type="checkbox"/> No use past 30 days <input type="checkbox"/> 1-3x past 30 days <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-6x/week <input type="checkbox"/> Daily/Multiple times/day	[]	<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled <input type="checkbox"/> Injected
<input type="checkbox"/> Barbiturates/Sedatives/ Benzodiazepine Please specify: []	[]	[]	<input type="checkbox"/> No use past 30 days <input type="checkbox"/> 1-3x past 30 days <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-6x/week <input type="checkbox"/> Daily/Multiple times/day	[]	<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled <input type="checkbox"/> Injected
<input type="checkbox"/> Crack/Cocaine Please specify: []	[]	[]	<input type="checkbox"/> No use past 30 days <input type="checkbox"/> 1-3x past 30 days <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-6x/week <input type="checkbox"/> Daily/Multiple times/day	[]	<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled <input type="checkbox"/> Injected
<input type="checkbox"/> Hallucinogens Please specify: []	[]	[]	<input type="checkbox"/> No use past 30 days <input type="checkbox"/> 1-3x past 30 days <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-6x/week <input type="checkbox"/> Daily/Multiple times/day	[]	<input type="checkbox"/> Oral <input type="checkbox"/> Smoked

Individual Counseling/Psychotherapy Progress Note

<input type="checkbox"/> Medicare "Incident to" Services Only	Name and Credentials of Medicare Supervising Professional on Site [Redacted]									
Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

What Do We Want Our Form Processes To Help Clinician's With?

2. Medical Necessity - Linkage Requirements
 - Support for Medical Necessity (The Golden Thread)
 - Critical to Reducing Audit Risk Exposure

Medical Necessity

Medical Necessity Phase 1:

- Establish that an individual seeking behavioral health services is qualified to receive specific services at a particular level of care and/or intensity.
 - Qualifying DSM-IV diagnosis of a mental, behavioral, or emotional disorder
 - Diagnosed within the past year by a qualified practitioner
 - **Results in functional impairment which substantially interferes with or limits the person's daily life activities.**

Medical Necessity

Medical Necessity Phase 2:

- Establish that all services and interventions provided are necessary and potentially sufficient to:
 - Address assessed needs in the areas of symptoms, behaviors, functional deficits, and/or other deficits/barriers directly related to or resulting from the diagnosed behavioral health disorder
 - Produce improvements or prevent worsening

Medical Necessity and the Golden Thread



Medical Necessity Linkage Requirements

1. **Comprehensive Assessment (CA)** – Identifies Treatment Recommendations/ Assessed Needs
2. **CA Updates** – Identifies New Treatment Recommendations/ Assessed Needs
3. **Individualized Action Plan (IAP)** – Links goals to specifically numbered Treatment Recommendations/Assessed Needs
4. **IAP Review/Revision** - Links goals to specifically numbered Treatment Recommendations/Assessed Needs and/or changes in Objectives, Therapeutic Interventions, Frequency, Duration and/or Responsible Type of Provider.
5. **Progress Notes** – Links interventions being delivered to specific Goal(s)/Objective(s) and identified client response and outcomes/progress towards Goal(s)/Objective(s).

Assessment

- Clinical Data
- Diagnosis
- Strengths
- Personal Goals
- Assessed Needs

Assessment

Individual's Name (First MI Last): <input type="text"/>			DOB: <input type="text"/>	
<i>Mental Health/Illness Management</i>				
✓		CN - Current Need Area NI – Not Clinically Indicated	As evidenced by:	Individual/Family Served Desires Change Now?:
CN	NI			
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Coping/ Symptom Management Skills:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Cognitive Problems:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Compulsive Behavior:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Dissociation:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Gender Identity:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Grief/Bereavement:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Mood Instability:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Obsessions:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Somatic Problems:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Thought/Perceptual Disorder:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Trauma:	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Assessment

Diagnosis: <input type="checkbox"/> DSM Codes (or successor) <input type="checkbox"/> ICD Codes (or successor)				
Check Primary	Axis	Code	Narrative Description	
<input type="checkbox"/>	Axis I	_____	_____	
<input type="checkbox"/>		_____	_____	
<input type="checkbox"/>		_____	_____	
<input type="checkbox"/>		_____	_____	
<input type="checkbox"/>	Axis II	_____	_____	
<input type="checkbox"/>		_____	_____	
	Axis III	_____	_____	
		_____	_____	
		_____	_____	
	Axis IV	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with primary support group: If yes, describe: _____	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems related to the social environment: If yes, describe: _____	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Educational problems: If yes, describe: _____	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Occupational problems: If yes, describe: _____	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Housing problems: If yes, describe: _____	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Economic problems: If yes, describe: _____	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with access to health care services: If yes, describe: _____	
<input type="checkbox"/> No <input type="checkbox"/> Yes		Problems with interaction with the legal system/crime: If yes, describe: _____		
<input type="checkbox"/> No <input type="checkbox"/> Yes	Other psychosocial and environmental problems: If yes, describe: _____			
Axis V	Current GAF: _____	Highest GAF in Past Year (if known): _____		

Assessment

Life Goals, Strengths, Abilities, and Barriers

Life Goals:

Strengths (skills, talents, interests, protective factors):

Barriers (environmental and personal):

Barriers to care and existing gaps:

Past and Present Successes in Achieving Desired Goals:

Assessment

Individual's Name (First MI Last): <input type="text"/>			DOB: <input type="text"/>			
Prioritized Assessed Needs: A-Active, ID-Individual Declined, D-Deferred, R-Referred Out			A	ID*	D*	R*
1.	<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Individual Declined/Deferred/Referred Out-Provide Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred/Referred Out below) <input type="checkbox"/> None						
1.	<input type="text"/>					
2.	<input type="text"/>					
3.	<input type="text"/>					
Level of Care/Indicated Service Recommendations: <input type="text"/>						

Treatment Plan

- Link to Assessed Needs
 - Goals
 - Objectives (Measurable or Observable Outcomes)
 - Interventions
 - Modalities/Services
 - Frequency/Duration
 - Target Dates
 - Responsible Clinician Credentials

Treatment Plan

Goal # []		
Linked to Assessed Need # [] from form dated []: <input type="checkbox"/> CA <input type="checkbox"/> CA Update <input type="checkbox"/> RFA <input type="checkbox"/> Psych Eval. <input type="checkbox"/> Other: []		
Start Date: []	Target Completion Date: []	Adjusted Target Date: [] as per IAP Review Form Dated: []
Desired Outcomes for this Assessed Need in Individual's Words: []		
Goal (State Goal Below in Collaboration with the Individual Served/Reframe Desired Outcomes): []		
Individual's Strengths and Skills that will be Utilized to Meet This Goal: []		
Supports, Resources, Organizations, & Individuals Needed to Meet this Goal: []		
Potential Barriers to Meeting This Goal: []		

Treatment Plan

GOAL # [] OBJECTIVE []:				
Start Date: []	Target Completion Date: []	Adjusted Target Date: [] as per IAP Review Form Dated: []		
Intervention(s) / Method(s) / Action(s)		Service Description/ Modality	Frequency	Responsible: (Type of Provider)
[]		[]	[]	[]
[]		[]	[]	[]
[]		[]	[]	[]
[]		[]	[]	[]

Progress Notes

- New Salient Information Provided by the Client
- Linked to Goal(s)/ Objectives(s)
- Intervention(s) Provided
- Client Response
- Client Progress toward Goal(s) / Objective(s)
- Plan/ Additional Information

Progress Notes

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan:

Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Goal <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>
Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>	Objective <input type="checkbox"/>

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Progress Notes

New Issues / Stressors / Extraordinary Events Presented Today: New Issue Resolved, No Update Required

New Issue, CA/IAP Update Required None Reported

Explanation:

Assessment Update

- Used to Easily Update Pertinent Assessment Information
- Especially Important for Information that will Impact the Treatment Plan

Assessment Update

Reason for Update: Update of New Information Re-Admission Annual Update – Date of Admission:
 Date of Most Recent Comprehensive Assessment:

Adult Comprehensive Assessment Sections for Update

Check the box(es) next to the section(s) of the assessment (including addendums), which you are updating. Be sure to label all additional/updated information in your narrative with the number of the section of the Assessment or Addendum being updated.

<input type="checkbox"/> 1. Presenting Concerns	<input type="checkbox"/> 11. Mental Health and Addiction Service Treatment History
<input type="checkbox"/> 2. Living Situation	<input type="checkbox"/> 12. Psychiatric Illness History
<input type="checkbox"/> 3. Family Information	<input type="checkbox"/> 13. Medication Information
<input type="checkbox"/> 4. Development History	<input type="checkbox"/> 14. Trauma History
<input type="checkbox"/> 5. Social Supports	<input type="checkbox"/> 15. Mental Status Evaluation
<input type="checkbox"/> 6. Legal Status	<input type="checkbox"/> 16. Past Risk and Alerts
<input type="checkbox"/> 7. Legal Involvement History	<input type="checkbox"/> 17. Assessed Needs – Functional Domains
<input type="checkbox"/> 8. Education and Employment	<input type="checkbox"/> 18. Life Goals, Strengths, Abilities, and Barriers
<input type="checkbox"/> 9. Military Service	<input type="checkbox"/> 19. Prioritized Assessed Needs
<input type="checkbox"/> 10. Substance Use/Addictive Behavior History	<input type="checkbox"/> 20. Other: <input type="text"/>

Update Narrative: List each assessment section being updated with narrative explanation below it.

Assessment Update

Diagnosis: <input type="checkbox"/> No Change <input type="checkbox"/> Change in Diagnoses Listed below <input type="checkbox"/> DSM Codes (or successor) <input type="checkbox"/> ICD Codes (or successor)			
Check Primary	Axis	Code	Narrative Description
<input type="checkbox"/>	Axis I	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Axis II	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Axis III	<input type="checkbox"/>	<input type="checkbox"/>

Assessment Update

Treatment Recommendations / Assessed Needs: No Additional Recommendations Clinically Indicated
 A-Active, ID-Individual Declined, D-Deferred, R-Referred Out (If declined/deferred/referred out, please provide rationale)

	A	ID*	D*	R*
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What Do We Want Our Form Processes To Help Clinician's With?

3. Support for Person Centered and Driven Services

Person Centered Services

Person Centered Services :

- Focus on the person / family in the context of their personal/ life goals , individual strengths, unique barriers, etc.

Person Driven Services:

- Involving the individual/ family in directing the plan of care (developing, reviewing, updating service planning)

Person Centered Services

Person Centeredness is Often Inserted at the Wrong Point in the Clinical Process.

- Starting at the Service Planning Process - With Questions like “What would you like to work on?” “What Goals do you have for treatment?” (This ignores the assessed needs identified in the assessment process”)
- In therapeutic sessions where discussions routinely focus around whatever the client wants to discuss rather than working on the mutually developed service plan. (If the plan isn't relevant – change it!)

Person Centered Services

Personal Life Goals and Aspirations

Do We Ask The Question?

Personal Life Goals

When You Ask the Question!

- “Get my GED and work in medical transcription.”
- “Have less stress related to parenting”
- “Take care of my kids & get back into church.”
- “Spend time with my grandchildren unsupervised.”
- “Going back to school and working.”
- “To maintain positive relationship with parents and siblings.”
- “Be able to talk to sister without getting upset or mad”
- “Be able to socialize and make friends”
- “Be able to live on my own”

Assessment

Life Goals, Strengths, Abilities, and Barriers

Life Goals:

Strengths (skills, talents, interests, protective factors):

Barriers (environmental and personal):

Barriers to care and existing gaps:

Past and Present Successes in Achieving Desired Goals:

Service Preferences: describe individual/family/guardian/significant other perception of needs and preferences for care, including environmental supports (self-help, advocacy and empowerment activities):

Assessment

Prioritized Assessed Needs: A-Active, ID-Individual Declined, D-Deferred, R-Referred Out		A	ID*	D*	R*
1.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Individual Declined/Deferred/Referred Out-Provide Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred/Referred Out below) <input type="checkbox"/> None					
1.	<input type="text"/>				
2.	<input type="text"/>				
3.	<input type="text"/>				

Treatment Plan

Goal # []		
Linked to Assessed Need # [] from form dated []: <input type="checkbox"/> CA <input type="checkbox"/> CA Update <input type="checkbox"/> RFA <input type="checkbox"/> Psych Eval. <input type="checkbox"/> Other: []		
Start Date: []	Target Completion Date: []	Adjusted Target Date: [] as per IAP Review Form Dated: []
Desired Outcomes for this Assessed Need in Individual's Words: []		
Goal (State Goal Below in Collaboration with the Individual Served/Reframe Desired Outcomes): []		
Individual's Strengths and Skills that will be Utilized to Meet This Goal: []		
Supports, Resources, Organizations, & Individuals Needed to Meet this Goal: []		
Potential Barriers to Meeting This Goal: []		

Treatment Plan

Individual has participated in the development of this plan Yes No, provide reason:

Other (s) participated in the development of this plan Yes No If Yes, List Names

Collaborative (Concurrent) Documentation

- There is no substitute for Collaborative Documentation as documentation support for person centered and driven services
- This is particularly true of the treatment plan
- Signatures and attestations do not necessarily provide evidence of client participation

What Do We Want Our Form Processes To Help Clinician's With?

4. Relevant Clinical Content

Relevant Clinical Content

Form Processes and Formats Can Only Go So Far!

- Organizations should define and provide consistent training on core documentation concepts – Examples:
 - Medical Necessity
 - Identified Needs (Problems) in Assessment
 - Treatment Plan Goals
 - Treatment Plan Objectives (measurable or observable outcomes)
 - Interventions vs. Services
 - Content of Progress Notes (e.g. Interventions Provided)

Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- **Clearly identified and prioritized Behavioral Health Needs (Challenge Areas) that can be used to establish Goals.**

Examples of Identified Need Areas

- Symptoms
 - Mental Health
 - Substance Abuse
- Behaviors
- Functional/ Skill Deficits (ADL/Self Care and Life Skills)
- Supports Deficits
- Service Coordination Needs
- Other Identified Needs

Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- **Clearly identified and prioritized Behavioral Health Need/ Challenge areas that can be used to establish Goals**
- **Symptoms, Behaviors, Skill and Functional Deficits stated as 'baselines' whenever possible in order to develop objectives.**

Service Planning

Goals

Definition:

A Goal is a general statement of outcome **related to an identified need in the clinical assessment.**

A goal statement takes a particular identified need and answers the question, “**What do we (clinician and client) want the outcome of our work together to be, as we address this identified need?**”

Service Planning

Examples of goals:

- “Elana states she wants to stop relapsing with alcohol and drugs”
- “Ben wants to stop getting into trouble in school and at home”
- “John states he just wants to feel normal and quiet the voices”
- “Gwen states she wants to learn how to take care of herself”
- Jordan wants to get her energy and confidence back

For an involuntary/ non-engaged client.

- “Robert will recognize the negative effects Substance Use is having on his life and voluntary participate in recovery services”

Service Planning

Goals

- Incorporate personal goals when possible with behavioral health goals

Service Planning

Examples of goals:

- “Maria wants her son Jason to be able to focus and follow directions so he can do better in school and make friends and to reduce her stress.”
- “Ben states he wants to stop getting into trouble in school and at home” so he can stop getting grounded and spend time with his friends
- “John states he wants to feel normal and quiet the voices so he can get a job and have friends”

Service Planning

Objectives

Definition:

- Objectives are observable or measurable, changes in symptoms, behaviors, functioning, skills, knowledge, support level.etc that relate to achievement of the goal, and are expected to result from planned interventions.
- **Correctly formulated objectives provide support for the ability to demonstrate “client benefit”**

Service Planning

Think of Objectives as “milestones” not as things a client will do!

Three Kinds of Changes from Baseline:

1. Changes in Level of Understanding of an Identified Need
2. Changes in Competencies, Skills, Information
3. **Changes in Behaviors, Functioning, Symptoms, Conditions (e.g. level of Supports)**

Service Planning

Examples of Objectives:

- “Steven and the clinician will understand the chief causes of Steven’s Panic Attacks”
- “Jordan will be able to articulate and demonstrate 3 strategies for reducing symptoms of depression.”
- **“Jordan will engage in productive and/or leisure activities outside the home at least twice a week.”**
- “David will be able to identify situations that make him frustrated/angry in school and will be able to articulate and demonstrate 2 strategies for appropriately dealing with them.
- **“David will reduce verbally aggressive outbursts in class from 3 or more times daily to once or less weekly.”**
- “Client’s mother will learn and implement 3 key strategies for dealing with Jason’s oppositional behaviors.”
- **“John’s will follow his mother’s directions with only one follow-up prompt 70 percent of the time.**

Service Planning

Objectives

- Attempt to develop a measurable change that:
 - Will be apparent to the client
 - Meaningful to the client
 - Achievable in a reasonable amount of time
 - Can be assessed in a nonjudgmental way
- Discuss the relationship of the desired change to achieving the behavioral health goal and personal life goal(s)

Service Planning

Interventions (Methods)

Definition:

An intervention is a clinical strategy or type of action that will be employed within a Service type (modality) and is expected to help achieve an Objective.

Interventions briefly describe what approach, strategy and/or actions the Treatment Plan is prescribing.

Service Planning

Examples of Interventions:

- “Explore with client the reasons for his/her panic attacks”
- “Help the client identify triggers for his anger and strategies to for avoiding these triggers or responding differently”
- “Teach client meal planning, shopping, and meal preparation skills”
- “Use CBT to help client change destructive irrational believes that lead to feelings of guilt”
- Teach the client about benefits of medication, coping with side effects”
- “Pharmacological treatment for X symptoms”
- “DBT” (When an intervention strategy is very well articulated, has defined steps and outcomes, it may not be necessary to do more then indicate the type of intervention strategy with some key elements that are understandable to the client.)

Service Planning

Services

Definition:

Services are the modalities or formats in which interventions are provided.

Interaction/ Progress Notes

Importance of Service Plan Awareness !

- Be Aware of the Service Plan BEFORE the session and know what Goal(s) Objectives you plan to work on with client.
- Your plan may need to change but you should have a plan.
- Focusing on the Service Plan reinforces the value of the plan.
- If the plan becomes irrelevant – change it.

Interaction/Progress Notes

1. New, salient information provided by client.
2. Changes in mental status
3. Goal(s) and Objective(s) that were focused on
4. Interventions , work done.
5. Client's response to intervention (today)
6. Client's progress re the Goal/ objective being addressed
7. Plan for continuing work

Relevant Clinical Content

Documentation Manuals can also assist in helping to support the proper use of forms and form content.

Questions?