Behavioral Health Documentation Using TherapyNotes® Electronic Health Record

MARCH 2, 2024

Welcome & Introduction

Welcome to Behavioral Health Documentation Using TherapyNotes ® Electronic Health Record! I'm Dr. Victoria Miller, PhD, LPC-S, LMHC.

I'm glad you're here to participate in this 1-day training that covers a few of my favorite topics:

- documentation.

- electronic health records.

- storytelling.

This course includes a combination of lecture, discussion, and experiential practice. Let's get started!

Agenda

- 8:45-9:00AM – Provider Remote Check-in
- 9:00-9:30 AM – Group discussion of strengths and challenges with behavioral health documentation
- 9:30-10:30 AM – Progress note chart practice application
- 10:30-10:45 AM – 15-minute break
- 10:45 AM-12:00 PM– Review common behavioral health documents and practice concise documentation
- 12:00-12:30 PM – BREAK
- 12:30-2:30 PM – Cont. review of common behavioral health documents and practice concise documentation
- 2:30-2:45 PM – 15-minute break
- 2:45-3:15 PM – Chart errors using chart audit template
- 3:15-4:00 PM – Questions and Closing

Learning Outcomes

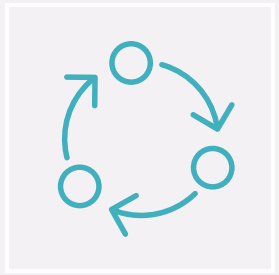
After the session, participants will be able to:

- Analyze behavioral health documents.
- Discuss experiential challenges with behavioral health documentation.
- Practice concise behavioral health documentation.
- Chart a behavioral health progress note using the TherapyNotes® electronic health record template.
- Discuss common chart errors.
- Analyze a chart audit template.

Course Statements

- The accuracy of the materials presented in this course are based on TherapyNotes® most current software version.
- The limitations of the content being taught in this course include the instructor's:
  - understanding and interpretation of behavioral health documentation.
  - use of TherapyNotes® software.
  - scope of practice and experience completing behavioral health documentation.
- Severe and most common risks associated with the course materials include:
  - internal or external audit findings of learners' charts.

Documentation

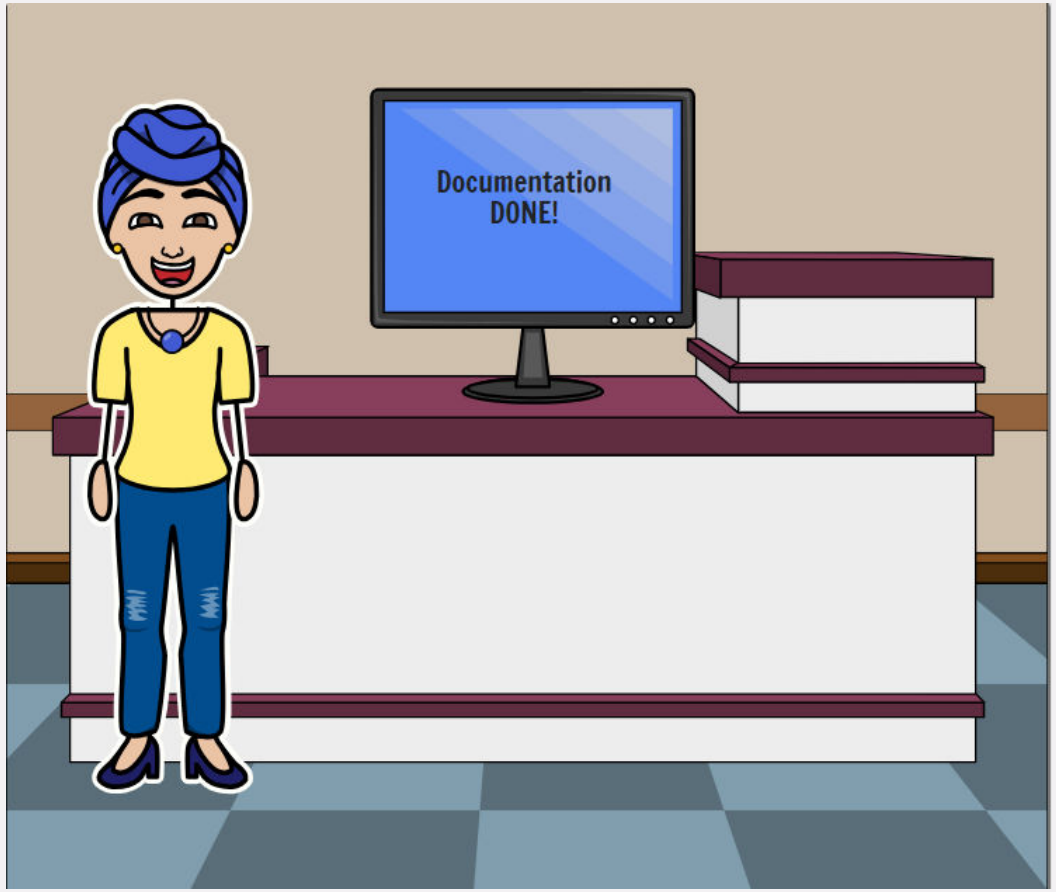


- is a requirement.

- tells a story

-is a form of self-care.

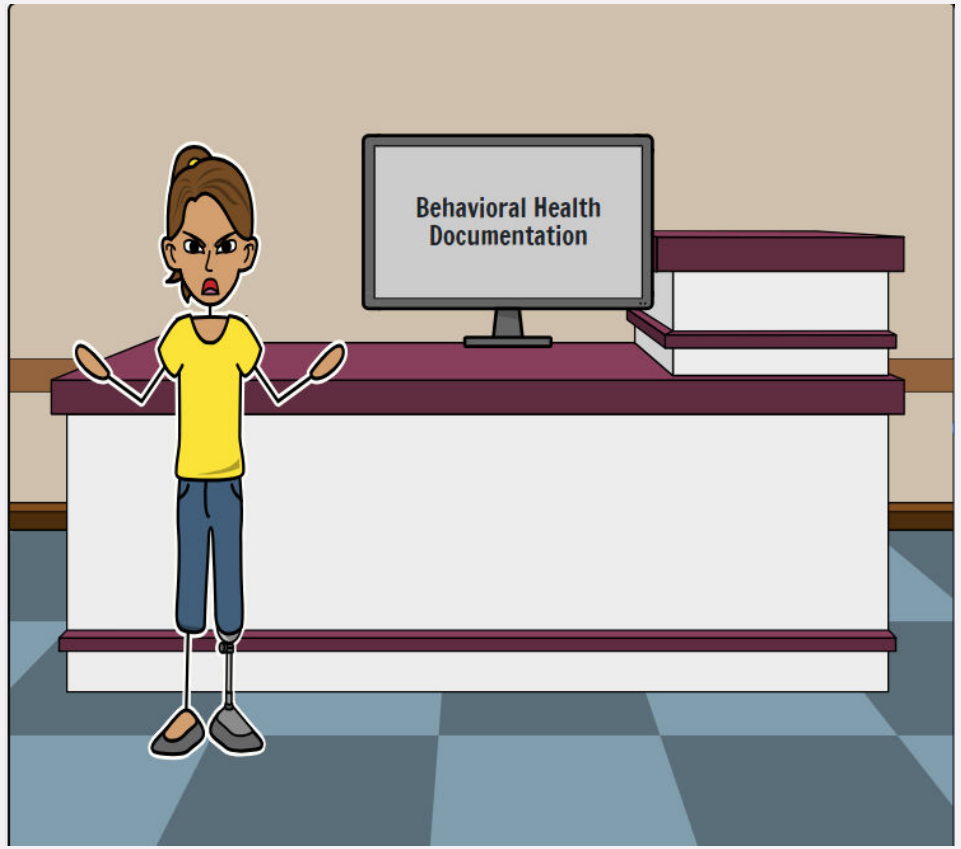
Let’s Discuss Strengths

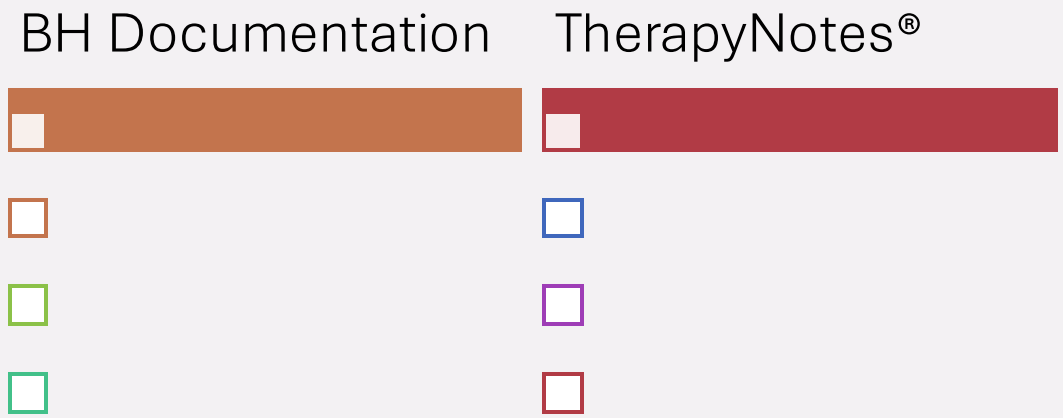


BH Documentation

TherapyNotes®

Let’s Discuss Challenges





Progress Note – Chart Application Demonstration

Victoria Miller

Progress Note – Chart Application Practice

Using the case study and treatment plan provided, write a progress note (using the template provided) documenting:

- a 50-minute individual therapy session in which you (clinician) attempted to teach Johnny T. Appleseed an emotional regulation skill.

Note – Johnny T. Appleseed presented as inattentive and highly anxious during the session.

J. Appleseed-Tx Plan.pdf

TN Progress Note Template_LCS.docx

Johnny T. Appleseed – A Case Study

Johnny T. Appleseed is a 36-year-old Hispanic male who has been diagnosed with Generalized Anxiety Disorder. He does not take medication and has declined recommendations to see a psychiatrist, as this does not align with his religious beliefs. Johnny has been in therapy for almost one month. He presents for sessions on time and reports that he is "eager to learn" ways that he can manage his anxiety since the symptoms negatively impact every aspect of his life. Johnny works at a local warehouse where he has recently been promoted to manager. However, he has had to leave work early 2-3 times each week due to worried thoughts that leave him unable to make decisions, put him behind on paperwork, and more recently resulted in a verbal confrontation with the assistant manager. Johnny is still on probation for this new position. If he continues to have trouble with managing his emotions in the workplace, he could be at risk for being demoted.

This morning, Johnny arrived for his therapy session on time. He reported feeling like he should just "give up" but denied thoughts of harm to self or others. You walk Johnny through three rounds of deep breathing to get him settled into the session. It is somewhat successful – he participates in all three rounds, but his breathing is shallow, and he can't seem to regulate his breathing or decrease the anxious feelings. When you ask him to gauge his level of anxiety at the start of the session, he reported it is "way past a 10". The second time you ask him to gauge his level of anxiety, he says, "a 10, I guess." You introduce guided imagery as an emotional regulation technique and attempt to engage Johnny in learning and practicing it. He tries the exercise while also glancing at his phone every time he gets a text notification. When you recommend he silence the phone, Johnny says, "It's better if I know the texts are coming in instead of wondering about them." Five minutes before the session ends, he asks, "Can we just sit in silence the rest of the time? I'm having trouble focusing."

Please be concise.

When is too much information too much?

How do I know if my progress note is too long?

15-Minute Break

Behavioral Health Documentation - The Story

Characters

Time Period

Action

Setting

Theme

Resolution

Behavioral Health Documentation – The Audience

Insurance

The Client

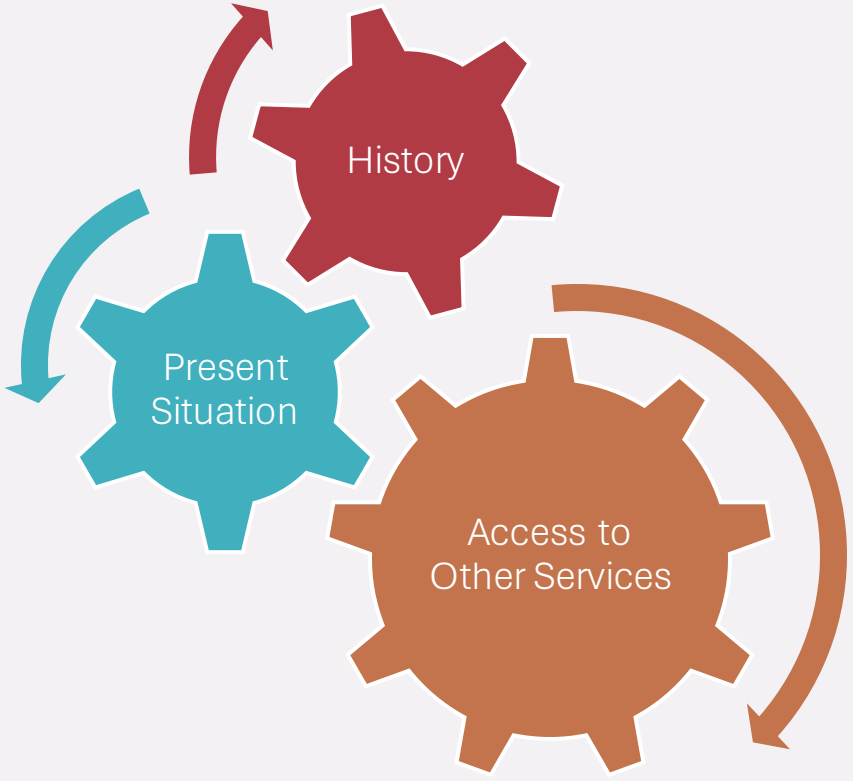
Legal System

Intra-Agency Providers

Inter-Agency Providers

Anyone the client chooses

The Story's Purpose



"History cannot give us a program for the future, but it can give us a fuller understanding of ourselves, and of our common humanity, so that we can better face the future."

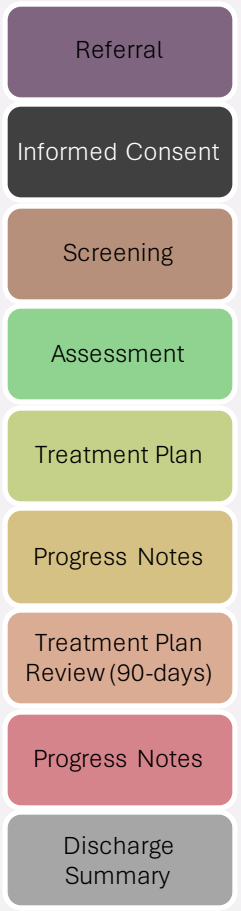
~ Robert Penn Warren

Author/Poet

Let’s Review

PART 1

Documentation Forms & Flow



Other forms may include:

- Good Faith Estimate (GFE)**
- Safety Plan**
- Release of Information (ROI)*
- Transfer Form**
- Emergency & Other Contacts Form*
- Payment Authorization Form*
- Additional Screening(s)*
- Consent Form(s)**
- Others ??

Key:

- * = Included in TherapyNotes® Library
- ** = Not included in TherapyNotes® Library

TherapyNotes® - Documents 1-5

Intake Note

Treatment Plan

Progress Note

Psychotherapy Note

Termination Note

Intake Note

- Purpose
  - Biopsychosocial Assessment
  - Describes presenting problem
  - Provides clinical impression / Dx
  - Indicates medical necessity
  - Creates the foundation of a treatment plan

Treatment Plan

- Purpose
  - Maps course of treatment
  - Justifies time spent w/client
  - Indicates progress (90-day)

Progress Note

- Purpose
  - Documented progress toward treatment plan goals/objectives
  - Interventions & Client's Response
  - Outlines next steps to move treatment forward

Psychotherapy Note

"Psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Termination Note

- Purpose
  - Signifies the close of an episode of care
  - Removes clinician's/agency's liability
  - Provides an overview of the efficacy of treatment (for the episode of care)

15-Minute Break

Let’s Review

PART 2

TherapyNotes® - Documents 6-10

Consultation Note

Contact Note

Missed Appointment Note

Miscellaneous Note

TherapyNotes® - Documents 6-10

Consultation Note

Purpose:

- Reduces liability/risk level
- Documents best practice

*Requires an appointment in TherapyNotes®

TherapyNotes® - Documents 6-10

Contact Note

Purpose:

- If you didn't document, it didn't happen policy
- Continuity of care (with agency; among providers)

TherapyNotes® - Documents 6-10

Missed Appointment Note

Purpose:

- Consistency in managing agency and/or provider calendar
  - Missed appt. charges
- Reduces liability (too many missed appointments = termination note)
- If you didn't document, it didn't happen policy

TherapyNotes® - Documents 6-10

Miscellaneous Note

Purpose:

- Use at agency/provider discretion

*Having guidelines or policy for use of Miscellaneous note will benefit agency onboarding and ensure system/processes in place that meet agency needs.

Consultation Note - Practice

Note Section	Example	Concise Example
HISTORY OF PRESENTING CONCERNS	The client reports experiencing various emotional and interpersonal difficulties that have prompted her to seek professional support. During the initial session, she articulated feelings of stress, anxiety, and a general sense of unease. The client highlighted challenges in managing her emotions, coping with life stressors, and maintaining satisfying relationships.	
BACKGROUND INFORMATION	The client provided a brief overview of her personal history, describing relevant life events, relationships, and significant experiences that may contribute to her current emotional state. It was evident that the client is motivated to gain a deeper understanding of herself and develop effective coping strategies to navigate the complexities of her life.	
GOALS FOR THERAPY	The client expressed a desire to work collaboratively with a therapist to identify and address the underlying factors contributing to her emotional struggles. She articulated goals related to improving emotional regulation, enhancing interpersonal relationships, and developing coping mechanisms to navigate life stressors more effectively.	

Contact Note - Practice

WORDY

Communication Details -

Had a phone chat with John Doe. We talked about how they're doing, what's been going on in their life, and how they're feeling. They shared a mix of emotions, from good moments to tough times. The therapist listened and understood, and the client felt comfortable opening up. We covered different parts of their life, like relationships, work, and self-care. They mentioned feeling stressed about work and talked about ways to handle it. We also revisited past therapy goals and set new ones for future sessions. Overall, it was a good talk, and we're planning more sessions to keep things going.

Because we covered a lot, it makes sense to dive deeper in future sessions. We'll explore specific areas, try different ways to make things better, and keep working towards the goals we set. This call showed the strong connection between the therapist and the client, and we're looking forward to more progress in the upcoming sessions.

CONCISE

Communication Details -

Missed Appointment Note - Practice

SCENARIO – A LONG-TIME CLIENT WAS A “NO-CALL, NO-SHOW” FOR TODAY’S SCHEDULED THERAPY APPOINTMENT.

Miscellaneous Note - Practice

- What needs to be said here?

- Who makes the rules for a miscellaneous note?

15-Minute Break

Documentation – A Requirement

- Justifies
  - the client's need for services.
- Evidence that service was
  - rendered.
  - evidence-based.
  - within the provider's scope of practice.

Who makes the rules?

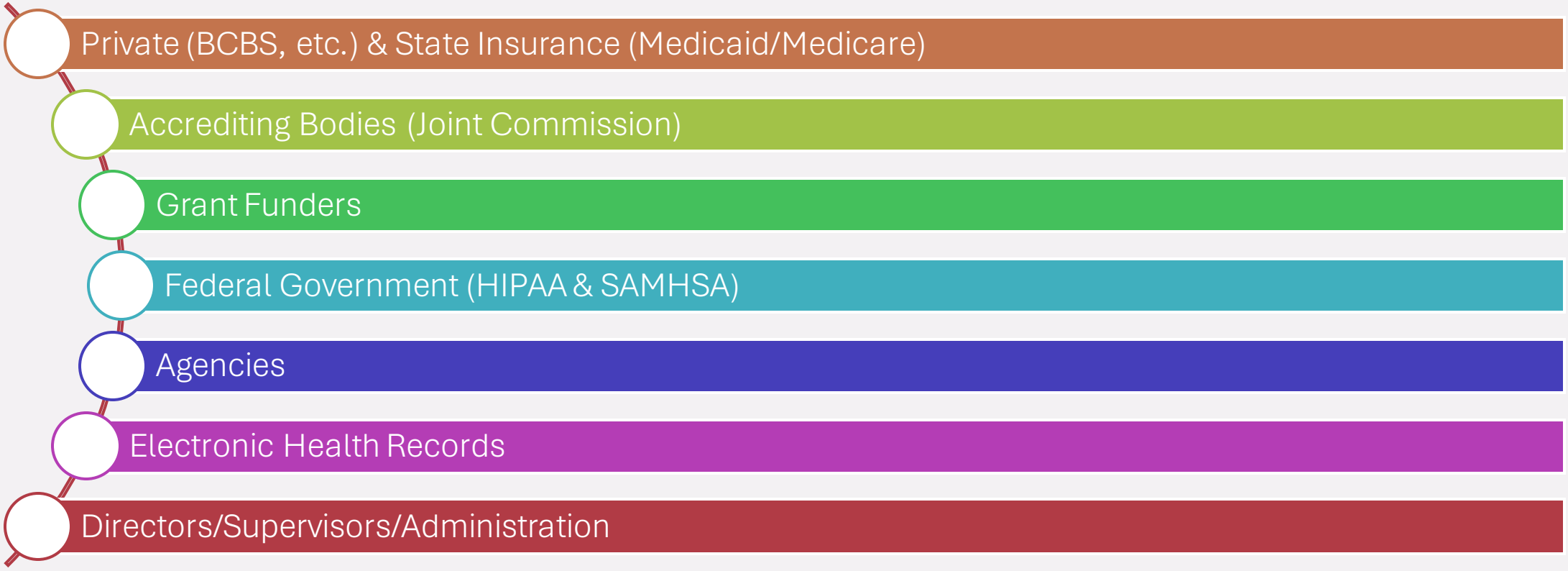


Chart Review

Chart review outcomes may vary based on documentation regulations, client types, agency rules, insurance types, and practicing state board determinations. Despite the variations, there are two primary components to a chart review:

1. Documentation forms and flow
2. Content - specifically,
    1. The golden thread
    2. Medical necessity
    3. Diagnosis justification

Documentation Content – The Golden Thread

IS YOUR DOCUMENTATION CONSISTENT FROM BEGINNING TO END?

Documentation Content – Medical Necessity

WHAT IS THE CLIENT AT RISK FOR HAVING HAPPEN IF THEY DON'T RECEIVE RECOMMENDED SERVICES?

Documentation Content – Justification

WHAT EVIDENCE SUPPORTS THE DIAGNOSIS GIVEN?

SCOPE OF PRACTICE? EVIDENCE-BASED CARE?

Other Common Chart Errors

- Documenting in the wrong chart → Identify the client by at least 2 identifiers
- Failing to complete treatment plans/reviews → The map that justifies treatment
- Failing to document → If you didn't document it, it didn't happen

Audit much?

Ignorance of the regulations you are required to follow does not absolve you of the consequences of an audit.

Read the regs. Know the regs.

Audit Tool.pdf

Documentation is a Form of Self-Care

"I never wrote things down to remember; I always wrote things down so I could forget."

~ Matthew McConaughey, *Greenlights*

Questions?

References

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