Documenting Collaborative Sessions

Presented by: Quality Assurance Department

Updated: July 2023

Introduction

Writing concise progress notes ensures that we are providing a clear clinical picture to the reader, and it informs your consumer and other service providers of the services you are providing ensuring continuity of care. In addition, writing comprehensive progress notes will guarantee we are documenting risk factors, meeting our legal obligations and justifying reimbursement for services.

Quick Reminders

Structure of Progress Notes

- The structure of notes remain the same
  - *Session Narrative* – service activities/ interventions provided by staff, including how the service addressed the client's behavioral health needs (i.e., symptoms, condition, diagnosis, risk factors)
  - *Plan* – planned action steps that will be taken by the staff and/or by the client, including care coordination
- Interventions should still satisfy the procedure code selected

Quality vs. Quantity

- Progress Notes are **not** process notes. They are **progress notes**
- Avoid writing irrelevant information and details that are unimportant to treatment
- Note writing does not need to be lengthy to satisfy time billed. To satisfy billing, progress notes should simply hit the necessary components

Collaborative Progress Notes

- Clients should be involved in the note writing process
- Clients should ***understand the verbiage*** utilized in your documentation
- The provision of psychoeducation may need to take place when documenting your sessions with your client

Additional Reminders

Collaborative Progress Notes

- Should there be a disagreement between the client/guardian and staff about how to document and/or what is documented, the provision of psychoeducation may be included as part of your intervention:
  - **Ex:** *"Clarified the behaviors as they relate to the client's diagnosis and implications for treatment…"*

Progress Notes Created *Collaboratively*

Example

Therapy Services
Progress Notes

Sample Individual Therapy Progress Note – CHILD

Date: 7-19-23 **Service Type: Psychotherapy** **Service Duration: 56 min** **Documentation Time: 6 min** **Travel Time: 0**

Session Narrative:
Therapist engaged Sarah in a collaborative session and **inquired about her mood and recent behaviors**. Sarah expressed feeling upset today and stated that she continues to experience angry outbursts approximately 6 days a week, which interfere with having positive relationships with her parents and peers at school. **Therapist introduced an art project to assist her with identifying body signals** when she is becoming angry. Sarah identified her body signals when starting to "feel angry", such as face feeling hot and heart racing. **Discussed anger management techniques** she can utilize when she recognizes these cues, such as counting ten, taking deep breaths and asking for her art journal. Therapist **talked about the when angry outbursts began and helped with elaborating on her thoughts and feelings** related to the loss of her sister two years ago. Sarah was able to express that her sister's passing was when she started to experience angry outbursts and required assistance with expressing her feelings related to this event.

Plan: **Therapist will continue to assist Sarah with further discussing the connection between her sister's passing and angry outbursts as well as discuss the stages of grief and loss** during next session on 7-26-23. **Sarah will continue to practice anger management techniques at home and school.**

Jane Doe, M.A., LMFT, 11111

Blue Font: **Interventions that reflect therapy services**
Green Font: **Plan that identifies the client's and staff's next steps**

Sample Individual Therapy Progress Note – ADULT

Date: 7-25-23 **Service Type: Psychotherapy** **Service Duration: 52 min** **Documentation Time: 5 min** **Travel Time: 0**

Session Narrative: Therapist engaged James in a collaborative session and **inquired about his mood and behaviors in the past week**. James reported feeling "sad" and continuing to make negative self-statements daily, which impair his ability to develop and maintain relationships. **Redirected** James when he made negative self-statements and **assisted with identifying all or nothing thinking** that contribute to him feeling sad and how it impacts his confidence. **Challenged all or nothing thinking** and discussed the possible origins of these thoughts. He reported that his negative thoughts stemmed from his relationship with foster parents. **Practiced the technique of thought stopping and assessed for suicidality** due to his reported feelings of depression. He denied suicidal ideation. Towards the end of session, he was able to see how his all or nothing thinking contributes to his depressed mood.

Plan: **James will write down one positive self-statement each day and bring these statements to the next session on 8-3-23. Therapist will continue to monitor his depression and informed him that a consult with the psychiatrist will take place due to his level of depressive symptoms.**

Jane Doe, M.A., LMFT, 11111

Blue Font: **Interventions that reflect therapy services**
Green Font: **Plan that identifies the client's and staff's next steps**

Example

Rehabilitation Services Progress Notes

Sample Individual Rehabilitation Progress Note – CHILD

Date: 7-20-23 Service Type: Psychosocial Rehabilitation Service Duration: 55 min Documentation Time: 5 min Travel Time: 24

Session narrative: MHW traveled to Wilson Middle School in Pasadena to conduct a collaborative session. MHW **checked in with Sarah regarding her compliant behaviors** in the past week. She reported engaging in compliant behaviors 1 time in the past week and having difficulty positively interacting with her teacher and peers at school. **Redirected Sarah** when raising her voice at her teacher during a group assignment and **modeled positive communication skills such as making basic "I" statements to state her needs and using an appropriate tone of voice when talking to others. Modeled coping skills when she became frustrated with group project such as asking for a five-minute break and breaking up the task into smaller manageable parts**. Praised Sarah for utilizing these suggestions and completing the assignment in a timely manner. Although Sarah continues to struggle independently, she responded well to MHW's interventions in the classroom and was able to utilize her coping skills with assistance.

Plan: MHW will collaborate with teacher to assist with behaviors in the classroom. Sarah will practice communication skills such as making eye contact and using an appropriate tone of voice when speaking to authority figures. The next individual rehabilitation session is scheduled for 7-27-23.

Kelly Espinoza, B.A., Mental Health Worker

Blue Font: **Interventions that reflect rehabilitation services**
Green Font: **Plan that identifies the client's and staff's next steps**

Sample Individual Rehabilitation Progress Note – ADULT

Date: 1-26-23 Service Type: Psychosocial Rehabilitation Service Duration: 56 min Other Time: 6 min Travel Time: 0

Session Narrative: MHW engaged James in a collaborative session and **inquired whether he engaged in social activities** in the past week. James reported leaving his apartment one time in the past two weeks to participate in a very small group activity at his local church. **Discussed additional social activities** that he can participate in during his free time such as activities at the nearby park that he enjoys walking to. James reported having more motivation to establish positive relationships by attending a larger church group that occurs weekly. However, he inquired if MHW could attend the first group with him due to feeling nervous about speaking in a larger group. **Modeled social skills** that the he can utilize when he first meets someone new, **such as introducing himself and asking basic questions to get to know the other person**. **Practiced "I" statements** to assist him with stating his needs to others in an appropriate manner. James experienced challenges with some social skills during the session, such as initiating and maintaining conversation, but was able to make basic "I" statements to state his needs with assistance. **Praised** him for making some attempts at participating in social activities at his local church and leaving his apartment.

Plan: **MHW will attend a church group with James on 2-2-23. James will plan to leave his apartment in order to attend positive social activities and report his experience back to MHW.**

Kelly Espinoza, B.A., Mental Health Worker

Blue Font: **Interventions that reflect rehabilitation services**
Green Font: **Plan that identifies the client's and staff's next steps**

“Documentation Time”

When completing your progress note ***collaboratively with your client,*** most of your note writing time will go under “service duration” vs. “documentation time”.

Should you spend time completing portions of the note ***after*** your session with your client, then that time would fall under “documentation time”.

Canned Phrases Feature in EHRS

New optional feature will now allow staff to add canned phrases (e.g., active interventions) on their session notes.

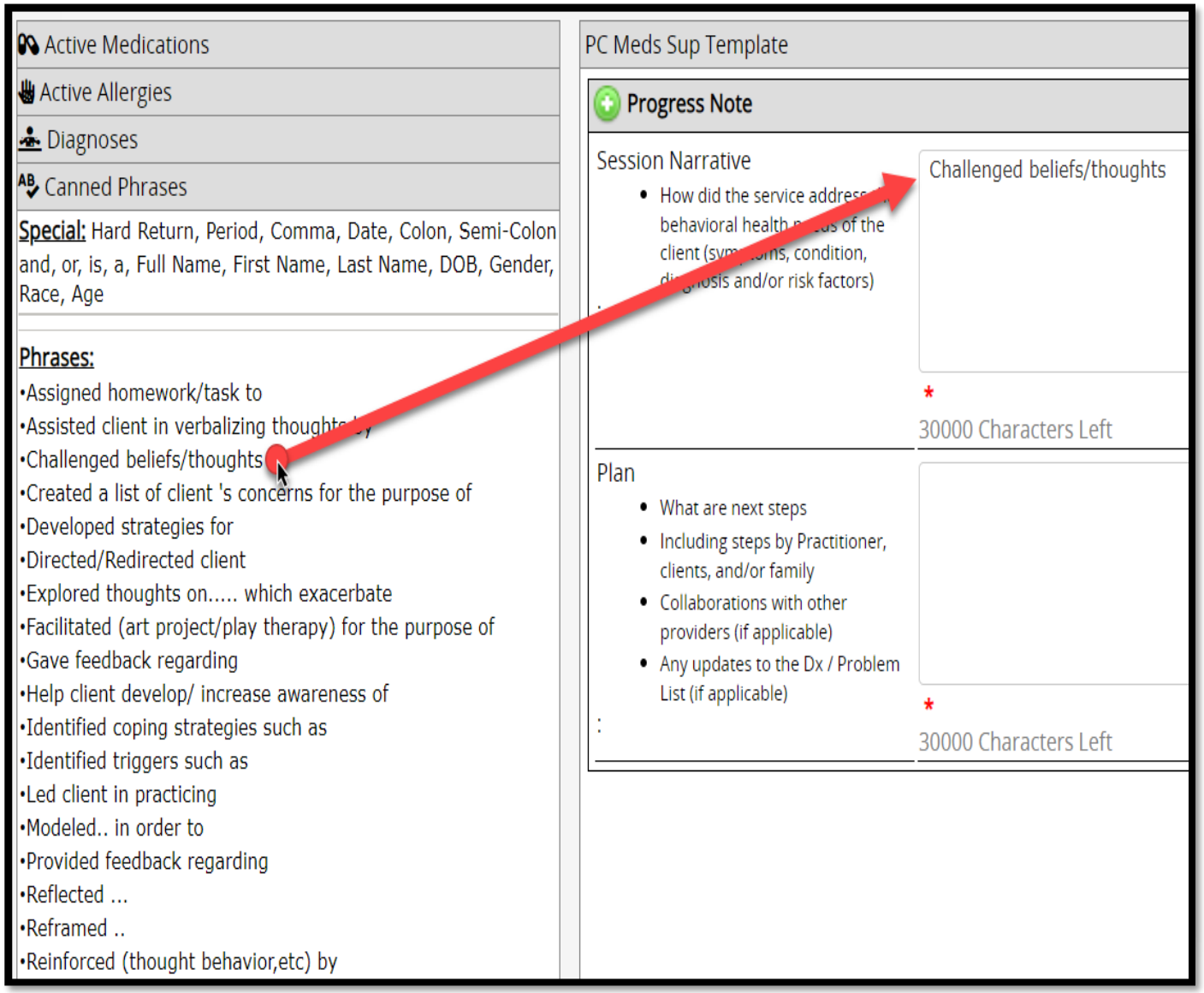
Canned Phrases Example

On the “Enter Notes” tab of a session note:

1) There will be a new section on the left menu bar called *Canned Phrases*

2) Clicking on any of the phrases will auto-fill that particular phrase onto the note section you indicated with your cursor

* Note: Each Service Type will have its own set of default canned phrases



Important Disclaimer!

All clinical documentation must reflect the ***individualized services*** the client received based on each client's unique symptoms, behaviors, condition, diagnosis, risk factors and/or cultural considerations. The specific interventions provided to the client and the plan section of progress notes must demonstrate the ***individualized services*** the client received.

Canned Phrases FAQs

Are the use of canned phrases only, enough to satisfy completion of a note?

- *No. Canned phrases are to assist you with starting the process of note writing. Each note should be individualized and include a description of what was done with the client in session.*

Will each service type have a list of canned phrases available for me to use?

- *Yes. Each service type will have a list of canned phrases suitable for that service. The interventions provided should reflect the service code selected.*

Canned Phrases Noteworthy (FAQs?) – cont.

Do I have to use the canned phrases available in Welligent?

- *No. Remember, these canned phrases are available to assist you when creating your note. You may use them as needed, or not use them at all.*

Does each session note need to be individualized even if I am using the canned phrases available?

- *Yes.* All clinical documentation should reflect the *individualized services* the client received based on each client's unique symptoms, behaviors, condition, diagnosis, and/or risk factors.

Quick Documentation Reminders - Assessments

Supporting the Diagnosis

- DSM 5 should be used as a ***guide*** to ensure the assessment supports the diagnosis selected
- Upon verifying criteria, ensure that diagnosis selected is a valid ICD-10 diagnosis
- Supporting the diagnosis should facilitate the development of objectives and in return ensure we are addressing the needs of the client

Collaborative Assessments

- Client should ***understand the verbiage*** utilized in your documentation
- The provision of psychoeducation may need to take place when discussing the diagnosis and symptoms/behaviors with your client during/upon completion of the assessment
- Utilizing verbiage the client understands may help with individualizing the symptoms/behaviors the client reports
- The diagnosis should still be supported!

Example: Major Depressive Disorder, Recurrent, Mild

Textbook Definition

- Reports the following symptoms 5x a week for the past 2 years on and off: depressed mood most days, diminished interest in activities, fatigue most of the day, increased weight gain (+20 lbs.) in the last month, inability to think/concentrate which has impaired the client's ability to sustain employment.

Depression in the *words of your client*:

- Reports feelings sad and "down" most days than not. She has noticed that she doesn't enjoy the activities she used to enjoy such as reading, going out with friends and exercising, which has resulted in an increase of weight (about 20 lbs.) in the last month. She also expressed feeling "tired" and with very little energy almost every day which results in her isolating and keeping to herself at home about 5 days out of the week. She has been struggling with focusing and concentrating which has resulted in her losing her employment since she is unable to complete her job duties consistently.

Additional Reminders

- When doing collaborative documentation, verbiage used should be something your client will understand
- Collaborative documentation should be easier in that you are working ***with*** your client to document their specific needs
- Although documentation should include verbiage that your client would understand, and may or may not include specific clinical terminology, documentation requirements should still be met as they relate to progress notes and assessments.

Resources

- For additional information related to the *process* of Collaborative Documentation, please refer to the “Collaborative Documentation: A Guide for Practitioners” training.
- Should you have questions related to the *components* required on progress notes, you may access our training modules on:
  - ✓ PCWeb → QA link → Tutorials → **“Progress Notes”** (PDF version)
  - ✓ For a recorded version, you may access our Progress Note module in the **Ultipro Learning System**
  - ✓ LA County Training on PCWeb → QA → Manuals → “LA County Training Manual” (Progress Note section)
- Should you have questions about ***how to conduct*** collaborative documentation please consult with your direct supervisor.
- Any questions related to information included in this training, you may contact your QA liaison for further support.