INTAKE ASSESSMENT, DAP NOTE & SERVICE PLAN PRIMER

MIDWESTERN COLORADO MENTAL HEALTH CENTER

INTAKE ASSESSMENT, DAP NOTE & SERVICE PLAN PRIMER

This primer is designed to assist you with your documentation of consumer services. It will address the clinical formulation of intake assessments, client diagnoses, service plans and DAP Notes. This handbook is derived from several sources: A PowerPoint presentation given by Dr. Steve Dixon, Clinical Director of the Colorado Health Networks, materials by MTM consultant David Lloyd, and notes from MWCMHC therapists Teresa Thompson, MSW and Jed Kovach, LCSW.

INTRODUCTION

Along with all Community Behavioral Healthcare Organizations (CBHO), Midwestern Colorado Mental Health Center is facing more stringent federal and state standards, and our compliance with these external accountability requirements is becoming more demanding. Some of these standards relate to efforts to reduce fraud and abuse in healthcare and to prevent submission of false claims. In some cases, large sums of Medicaid funds are being recaptured from CBHO's when audits reveal that existing service documentation does not validate and support the medical necessity for services rendered and charged. As a recipient of annual Medicaid payments, the Center is working to ensure our compliance with federal and state laws and regulations related to the Deficit Reduction Act, False Claims Act, and Criminal Penalties for Acts Involving Federal Health Care Programs Act, and with any government initiatives to reduce healthcare fraud, waste, and abuse. This primer is to assist the Center and its staff in this effort.

MEDICAL NECESSITY

The term "Medical Necessity" means that a covered service is considered a medical necessity, or "medically necessary" in a manner consistent with accepted standards of medical practice. Medical necessity indicates the service provided is found to be an equally effective treatment among other less conservative or more costly treatment options, and meets at least one of the following criteria:

- The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.
- The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability.
- The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.
- The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living (ADL).
- Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

THE GOLDEN CHAIN

Preserving the medical necessity of services rendered has been compared to a "Golden Thread." A better comparison is to a "Golden Chain" with interlocking links that symbolize the preservation of consistent medical necessity throughout the course of the treatment chain. This "chain" begins at the Initial Assessment and Diagnosis, is more clearly delineated in the Service Plan, and is carried through the length of the service provision in Progress Notes related back to the Service Plan (or Service Plan Updates). Each chain link serves as the justification for the provision of specific services. The chain continues throughout the course of treatment until the completion of services at discharge in which the consumer's needs and goals have been met and there is no longer a medical necessity for continuation of services.

THE PATH OF THE GOLDEN CHAIN

- The Intake Assessment is the first link that leads to service or treatment planning. Thus use the Intake Assessment for service or treatment planning.
- The Intake Assessment leads to the Diagnosis
- Assessment and Diagnosis leads to goals and objectives on the Service (Treatment) Plan
- Treatment planning should be linked to DAP notes.
- Reference identified problems from the treatment plan in DAP notes.
- Reference diagnostic criteria from DSM-IV in treatment planning and DAP notes
- There should be a smooth link from the Description to the Assessment to the Plan in a DAP note.

THE BROKEN CHAIN

Problems result when the medical necessity chain has missing or broken links. This can occur if the chain has no substantial beginning, such as (1) incomplete or inaccurate information at initial assessment, (2) misdiagnosis, (3) poor understanding of consumer problem(s) and desired results, (4) simply not identifying the medical necessity of why this client should receive services (i.e., what are the diagnoses, factors, issues and needs that justify a certain service or array of services), and (5) Treatment focusing on "problems in living" or on issues not identified in the assessment or diagnosis and not seen by the state as billable under "medical necessity" (such as marital therapy).

The medical necessity chain can also have missing or broken links at the juncture of Service Planning. Broken or missing links could be caused by (1) poor identification of consumer s needs and problems, (2) abstract terms for goals and objectives that are inaccurate and/or immeasurable, and (3) consumer strengths and resources are excluded.

The most important place to preserve the integrity of the medical necessity chain is the consumer's or Progress (DAP) Notes, including case management notes. Each session of service provision is a vital link in the established chain. Here the chain links can either interlock, or not. Here are the places that the chain can become easily broken, even lost. Ideally, each session link should interlock with the preceding links, and set the stage for anticipation of the links to follow. This smooth linkage is achieved by the session document demonstrating medical necessity in some form or another. That is, (1) content and process of the session must relate to one or more of the stated needs, goals and objectives in the Service Plan, (2) the session may include an assessment update due to new problems and the subsequent need to update the Service Plan and, (3) consumer progress, regression or digression is clearly defined and documented.

THE MEDICAL NECESSITY "TRAIN"

To use another analogy, the chain can also be compared to a train, with an engine, numerous cars and a caboose. The Intake/Assessment is the locomotive engine that pulls (or "drives") the therapy train. The services rendered are the individual passenger, box and freight cars. The caboose is Termination and Discharge. All must be interlocked in order for the train to move forward and reach its destination.

DOCUMENTATION IS CRITICAL

- To clients and family members – they rely on your documentation to advocate for the most appropriate and effective care.

- To health care professionals – they rely on the EHR as an official and practical means of communicating with each other, to provide a unified treatment approach consistent with your work with the client and for continuity of care from one treatment setting to another.

- To employers and managed care companies – they rely on your documentation to justify the needs for admission and for continued treatment, to demonstrate appropriateness and cost-effectiveness of care, and to demonstrate all billable services were provided.

- To licensing and accreditation agencies – they rely on your documentation to verify the quality of care and to approve license to operate.

INTAKE/ASSESSMENT - THE INITIAL CHAIN LINK

- Identifies symptoms that brought the consumer into treatment.
- The direct link to the Service Plan is the symptoms that drive the diagnosis, and the notion that our treatment will reduce or eliminate these symptoms.
- Identifies the consumer's goals and expectations.
- Includes a list of the consumer's strengths that the service provider will utilize to help consumer achieve his or her goals.
- It is important to successfully establish this initial link in order to move onto the next link which is Service Planning.

DIAGNOSIS

- To truly be a "Diagnosis," it must meet DSM-IV criteria. One common error is to use a historical diagnosis without a review of recent and current symptoms.
- Diagnostic formulations need to list the diagnostic criteria, according the DSM, that justify the diagnosis.
- Symptoms should be clearly identified. These should be used in some way to determine the goals and objectives on the Service Plan.
- Also drives the Medical Necessity criteria. If a consumer has a covered diagnosis and is amenable to therapy, outpatient care is appropriate to treat this. Higher levels of care have more restrictive Medical Necessity definitions and criteria.
- Rule outs, and NOS are at times appropriate, but not for common usage. Stay away from this as a diagnostic "fall back." Also R/O diagnosis should be deleted after six months, as there should be enough clinical information by then to make a definitive diagnosis.
- It is suspect when charts have 3+ diagnoses. Usually the criteria are not met for all of these diagnoses.
- Use the differential diagnosis decision trees that in the back of the DSM-IV.

TREATMENT OR SERVICE PLANNING

- Identifies the problem areas for which the consumer has requested help.
- Identifies specific symptoms that are measurable and objective, so we can determine consumer progress, or not.
- Identifies our best recommendation for the modality (or modalities) of treatment to address problems.
- Identifies how we will utilize consumer's strengths and the recovery philosophy to reach a desired end.
- Identifies time frames whereby service provider and consumer can expect results.
- Identifies discharge as the end result, or at a minimum a less restrictive environment and/or professional involvement for the consumer.

SERVICE PLANS PROBLEMS

- Abstract goals that can not be measured (outside of patient satisfaction or patient self-report)
- Identifies support for client without describing what support is specifically.
- Resource or support is not related to the related objective
- Brings in life circumstances as candidates for therapy when they do not have a diagnosis, and do not need therapy process for remediation.
- No specific time frames for course of service may contribute to dependency rather than movement toward and actual recovery.
- Rarely identifies advocate role of therapist to help client access other systems and services.
- Has too many goals, and thus defocuses the therapy process into a series of professional visiting sessions.

BEHAVIOR GOALS

Behavior goals should be:

- Measurable
- Observable
- Of specific duration (time limited)
- Realistic and achievable
- Relevant to the problem and diagnosis
- Appropriate and consistent with client values
- Should be able to describe what the client should be able to do to demonstrate improvement/symptom relief

State behavior goals in terms of:

• Subject/Verb	Anna will
• Action/Object	giver her son positive reinforcement
• Frequency	at least two times
• Duration	every day for a week
• Monitor	as reported by client & son. Can also use AEB (as evidenced by…)

<u>Example</u>: If your goal is to increase self esteem? How will you know it is achieved or accomplished? What is self esteem? Do not rely too heavily on consumer self-report. Have them establish <u>objective</u> and <u>measurable</u> goals.

CONSUMER STRENGTHS

Strengths are the positive assets or "strong points" that each person has in his or her life that help them achieve their objectives. These can be in numerous areas of one's life – physical, mental, emotional, behavioral, environmental, relationships and spiritual. Like the poles that support a tent or teepee, strengths help bolster and support a person's ego, functioning and life in general.

Strengths can be:

- Personal Qualities - what makes the consumer uniquely him or herself
- Knowledge - what the consumer has already learned and knows
- Experiences - what the consumer has been through in life
- Abilities & Capabilities - what the consumer can do
- Unexplored Potential - what the consumer might be able to do
- Interests, sports and hobbies
- Support persons and groups

Note: See pages 7a and 7b for Strengths List

EFFECTIVE PROGRESS OR "DAP" NOTES

- Provide a complete, consistent and comprehensive record of client care.
- Accurately represents the client's situation.
- Utilizes the goal above in the electronic chart as a descriptor for what was done and how it was done.
- Are focused on one or two specific goals that tie back specifically to the Service Plan.
- Identify the client strengths and how the strengths are being used to make progress toward the goal.
- Identifies the therapeutic intervention; what the treatment provider did to help the client move toward their goals and objectives.
- Uses factual information and examples to support conclusions.
- Addresses when a goal is reached, or amount of work needed to complete a goal.
- Removes a goal after it is met, and when all goals have been removed, this is criteria for discharge.
- Enable an action or actions to be taken based on their review.
- Can be used in court, in school, by social agencies, and by insurance companies.

SUBSTANDARD NOTES

- Simply cut and pasted from previous sessions without adequate editing that reflects the current session.
- No specific focus on a given problem.
- Offer inconsistent data.
- Contain no or minimal information on what was done.
- Abstract language not defined in measurable terms
  Example: "Client has made minimal or (or moderate) progress." "Client is feeling better."
- Are not tied back to Service Plan.
- May suggest regression or de-compensation without being specific.
- Reader has no idea what the therapist did in the session because it offers no explanation of any intervention, other than talking.
  Example: If active listening is the intervention it should be stated, and it should be followed with how helpful the active listening was toward reduction of symptoms.

"DAP" NOTES…SIMPLY

- **DESCRIPTION** of the content and the process of the session
- **ASSESSMENT** of what is going on; progress/lack of toward goals and objectives.
- **PLAN** for what will be done before the next session and/or in the next session

DESCRIPTION

- Include ***subjective*** information - report what the client says or feels
- Should identify the focus of the session, and which problem and goal was addressed.
- Documents what the service provider ***did*** in therapy to address the problem and goal. In other words, what interventions did the service provider utilize in the session to focus on the problem and goal?
- Use ***ACTION*** verbs.
  Example: "…***helped*** client ***identify*** three coping mechanisms for anxiety to include; 1) distraction (client will go exercise) 2) deep breathing-relaxation, and 3) call a peer for peer support."

See next 2 pages for list of action words:

ACTION WORD LIST

Examples of action words that describe functional skills:

Abstracted
Achieved
Acquired
Acted
Adapted
Addressed
Administered
Advertised
Advised
Advocated
Aided
Allocated
Analyzed
Answered
Anticipated
Applied
Appraised
Approved
Arranged
Ascertained
Assembled
Assessed
Assisted
Attained
Audited
Augmented
Authored
Bolstered
Briefed
Brought
Budgeted
Built
Calculated
Cared
Charged
Chartered
Checked
Clarified
Classified
Coached
Coded

Communicated
Compared
Completed
Complied
Composed
Computed
Conceived
Conducted
Conserved
Consulted
Contracted
Contributed
Converted
Cooperated
Coordinated
Copied
Correlated
Counseled
Created
Critiqued
Cultivated
Dealt
Debated
Decided
Defined
Delegated
Delivered
Designed
Detected
Determined
Developed
Devised
Diagnosed
Directed
Discovered
Discriminated
Dispatched
Displayed
Dissected
Documented
Drafted

Edited
Eliminated
Empathized
Enabled
Enforced
Enlightened
Enlisted
Ensured
Established
Estimated
Evaluated
Examined
Exceeded
Excelled
Expanded
Expedited
Experimented
Explained
Explored
Expressed
Extracted
Facilitate
Fashioned
Financed
Fixed
Followed
Formulated
Fostered
Founded
Gained
Gathered
Gave
Gave Feedback
Generated
Governed
Guided
Handled
Headed
Helped
Identified
Illustrated

Imagined
Implemented

Monitored
Narrated

Restored
Revamped

Improved
Improvised
Inaugurated
Increased
Indexed
Indicated
Influenced
Initiated
Inspected
Instituted
Integrated
Interpreted
Interviewed
Introduced
Invented
Inventoried
Investigated
Judged
Kept
Launched
Learned
Lectured
Led
Lifted
Listened
Located
Logged
Made
Maintained
Managed
Manipulated
Mapped
Mastered
Maximized
Mediated
Memorized
Mentored
Met
Minimized
Modeled
Modified

Offered
Operated
Ordered
Organized
Originated
Overcame
Oversaw
Participated
Perceived
Perfected
Performed
Persuaded
Planned
Practiced
Predicted
Prepared
Presented
Prioritized
Produced
Programmed
Projected
Promoted
Proposed
Protected
Proved
Provided
Publicized
Published
Purchased
Queried
Questioned
Raised
Ran
Ranked
Rationalized
Read
Reasoned
Recorded
Received
Reduced
Responded

Reviewed
Rewarded
Scanned
Scheduled
Schemed
Screened
Set goals
Shaped
Skilled
Solicited
Solved
Specialized
Spoke
Stimulated
Strategized
Streamlined
Strengthened
Stressed
Studied
Substantiated
Succeeded
Summarized
Synthesized
Supervised
Supported
Surveyed
Sustained
Symbolized
Tabulated
Talked
Taught
Theorized
Trained
Translated
Upgraded
Utilized
Validated
Verified
Visualized
Won
Wrote

SOME EXAMPLES OF THERAPEUTIC INTERVENTIONS:

- Reviewed current and past functioning
- Evaluated client's current level of function
- Evaluated progress toward service goals
- Assisted with development of treatment goals
- Provided linkage
- Provided information
- Provided support
- Provided psycho-education regarding _____ (topic)
- Encouraged family to utilize strategies
- Assessed risk/harm/current needs
- Developed/contracted safety plan
- Encouraged client to utilize resources
- Praised client by _____
- Validated client by _____
- Challenged client to _____
- Role modeled _____
- Redirected inappropriate behavior
- Encouraged client to use coping skills (describe which ones)
- Encouraged client to use problem solving techniques
- Identified family dynamics
- Facilitate family communications
- Discussed issues of termination of therapy
- Developed and reviewed discharge plan

ASSESSMENT

ASSESSMENT of what is going on based on the content of the DESCRIPTION section. It might include your "working hypotheses". It also includes:

1. Objective information - report observable behavior seen by the therapist. Service provider's statements about the client's progress/lack of progress toward their goals and objectives

- "Depression is improved this week As Evidenced By (AEB)…"
- "Client appears more resistant AEB…
- "Client appears less involved AEB…"
- "Client engaged in one social activity this week."
- "Client reports that he had no school referrals in the last week."

2. Consumer's comments regarding progress toward their goals and objectives.

Service provider might conduct a mini-mental status exam (MSE) which could include the following: (1) Orientation to person, place, time and situation, (2) Affect, (3) Mood, (4) Emotional Response, (5) Speech, (6) Eye contact, (7) Attention and concentration, (8) Insight and judgment, (9) Memory, (10) Thought Process, (11) Impairment of ADLS, (12) Suicidal risk, (13) Homicidal risk, and (14) Gravely Disabled.

Below are samples of actual MSE's done at the MWCMHC:

Mental Status Exam: Client was alert and cooperative. Speech was normal in rate, rhythm, and volume. Motor activity was normal on gross exam. Affect was appropriate, mood relaxed. There was no evidence of a thought disorder. He denied hallucinations, delusions, or illusions. He denied homicidal, suicidal, or paranoid ideation.

MSE - alert, cooperative to semi-cooperative, slightly defiant in passive/aggressive way. Mood- 'everything is fine...' Affect - bright at times but constricted for most part. No s/h ideation, no anhedonia. Sleep good. No obvious anhedonia. No psychosis. Dx:PDD, BPAD, conduct ds, ADD(by hx).

Identify changes in mood, thought, or behaviors that warrant therapy attention. If Risk factors have been identified for suicide, homicide and/or gravely disabled, AND your scores are 3, 4, or 5, please ensure that you document accurate information in this ASSESSMENT section of the chart tied to this risk. For level 3 comments alone may be sufficient (Is this a new score? Is this baseline?). Scores of 4 and 5 necessitate a specific intervention from the service provider in this note under the "Plan" section.

PLAN

NOTE: The PLAN should address what is directly cited in the DESCRIPTION and ASSSESSMENT sections.

- Future appointments go here too, but PLAN section should have more than "See next week."
- Next session date and time
- Plan for what will be done in the next session and in the meantime.
- Topics to be covered in the next session
- Relevant homework assignments given
- Include plan for staff too. (What are you doing follow up, etc…?)
- Plan will also include a specific outline of a "safety plan" if the client has a risk score of 4 or 5. Safety plan should include:
    - Client was provided number for ES and instructions to call ES, 911 or go to the ER if needed.
    - Specific distress tolerance skills they are going to utilize to cope with symptoms (activities, coping skills, contact w/ support system, etc.)
    - Why client does not need inpatient services at this time (no intent, statements such as "I would never act on suicidal thoughts because of my children", etc.)
    - If client has a specific plan and means what we have done to block means (guns out of the house, meds kept by relative, etc.).
    - It is advisable to put this safety plan in writing and have the client indicate agreement to it by his or her signature.

DAP NOTE CHECKLIST

DESCRIPTION:

√ Persons present; notable environmental factors

Consumer self-report:

√ Significant events that have occurred in consumer's life
√ Stressors and extraordinary events
√ Changes in consumers condition and actions taken

Other pertinent information

√ Problem and goals related to Service Plan that is/are focus of session
√ Relevant discussion and therapeutic processing
√ Intervention(s) provided by service provider to address the problem(s) and goal(s) (I.e., what the service provider **did** in therapy to address the problem and goal. In other words, what interventions did the service provider utilize in the session to focus on the problem and goal? (Use *ACTION* verbs – see list).

ASSESSMENT:

√ Any significant change(s) from last session. If none, indicate this.
√ Service provider observations
√ Service provider assessment of mood/affect, thought processes and orientation, and behavior/functioning…**OR**…Mini-Mental Status Exam (MSE)
√ Are a diagnostic assessment update and service plan revision needed?
√ Progress or lack of progress with the Service Plan
√ Client response to intervention(s)
√ Comment from consumer regarding progress toward goal.
√ Risk for suicide, homicide and/or gravely disabled. That is, is client a danger to self, others and/or property?

NOTE: Risk Assessment Checklist alone is sufficient if level is 1 or 2. If scores are 3, 4, or 5, provide accurate information tied to this risk. Scores of 4 and 5 necessitate a specific intervention from the service provider and should be documented in the "Plan" section.

PLAN:

√ Next session date and time & topics to be covered in the next session
√ Consumer actions related to Service Plan objective(s) to be taken by next appointment (including homework
√ Safety plan if risk score of 4 or above
√ Clinician actions to be taken by next appointment,
√ Any referrals, advocacy or case management to be done before next appointment

TIPS FOR PROGRESS NOTES

Essentials of Record Keeping

- Be thorough yet concise
- Write clear, objective descriptions
- Use concurrent documentation as prescribed
- Proofread, but don't erase information
- Consider how the client is portrayed
- Use respectful terminology
- Use only approved abbreviations

Be Careful with Wording

- Respectful language
- Nonjudgmental writing
- Clear description
- Key terminology

Key Terminology

- Evidenced by
- Appears versus seems
- Client – active language
- Qualifying comments
- Examples - Poor: "From her frown, Carol seems angry."
  Good: "Carol appears angry, evidenced by her frown."

Use the K.I.S.S. Principle - Keep It Short & Simple

Avoid using the words "good" and bad".

- These tend to sound judgmental, like you are making *value statements*:
- For example instead of saying "client has bad judgment" describe behavior, "client reports that he drove after drinking 6 beers last night".
- Use words like "appropriate" and "inappropriate", "positive" and "negative", "helpful" and "harmful" or "hurtful."

Avoid using *"always"* and *"never"*.

- Examples: Tom *never l*istens to his wife. Judy *always* is always depressed.
- Employ words like sometimes, often, periodically, at times, seldom, today

Use a dictionary when you are unsure of how to spell a certain word.

Use ISPELL (spell check for our Internet).

Watch plurals and possessives –

Plural is when **there is more than one** - boys, cars, tomatoes. ***NO apostrophe – '***
Examples: "John missed 2 days of school." Or "Rhonda picked 4 flowers."

Possessive shows ownership – ***uses an apostrophe – 's or s'***

- Singular possessive – One person or thing having ownership - the ***boy's*** hat, the ***bird's*** nest
- Plural possessive – More than one person or thing having ownership - the ***boys'*** hats, the birds' nests

Avoid using slang words or vernacular terms in DAP Notes,

Instead of using _____, use _____.

"Got mad…***became irritated*** or ***became angry***
"Flipping them off" - ***giving the middle finger***
"He goes through spells" – ***He has periods of…she has episodes of…***
"Pushing the envelope" - ***testing the limits or boundaries***
"Cussing"….***cursing*** or ***profanity***
Student was having a fit…***he was acting out*** OR ***was having difficulty managing his anger***
"smart aleck" - ***Presented with a negative and disrespectful attitude***
"pissy" – ***irritable, irritated, angry, impatient,***

"PRESERVE THE GOLDEN CHAIN!"