QA KNOWLEDGE ASSESSMENT SURVEY # 5 Answer Rationales

Question 1. Which of the following is true about writing a Progress Note?

- **A.** The progress note should document everything that occurred in the session
- **B.** Only information that is relevant to Treatment Plan Objectives and Interventions should be documented
- **C.** As long as documentation in the Progress Notes describes that a Specialty Mental Health Service was provided and the service was medically necessary it is reimbursable
- **D.** As long as the Progress Note provides a succinct but clear description of what occurred in the session, it is acceptable
- **E.** Documenting details, such as the client redecorating her apartment clearly helps illustrate client's level of functioning

Question 1. Answer: C

Rationales for Question 1 Answer Options:

Option A:
The progress note should document what is clinically relevant in client care from the session. Document all necessary information to support treatment, including information critical to explaining treatment decisions/interventions, alternative approaches for future interventions, or significant information linked to the client's mental health condition.

Option B:
In general, it is required to document the interventions applied by the practitioner while in session and relevant aspects of client care, including documentation that supports medical necessity for the service. There may be times when the situation requires more immediate and expedited care for emergencies or crises, in which there may be no treatment plan objective. Also, during a session other issues may come up, and should be documented on the progress note, that will result in additional objectives/interventions on the treatment plan.

Option C:
SMHS are reimbursable when the service provided is medically necessary for client care and documentation in a progress note clearly supports the clinical decisions for the intervention(s).

Option D:
A progress note is not a journal entry that describes what happened during a session. There is a purpose to the progress note, which includes substantiating that medically necessary services were provided to the client to address their mental health concerns and to document the client's progress and responses to the interventions. Documentation describes information of clinical relevance to client care.

Option E: Documenting details that are not relevant to the clinical treatment of the client is unnecessary, for example documenting how the client liked or disliked a movie he/she saw over the weekend. Other details, however, may provide information about the client's mood and level of functioning. In the example above, rearranging her apartment may indicate that the client has motivation and the ability to attend to redecorating her apartment, which is useful clinical information. However, if such a

detail is going to be included in the progress note the clinical relevance should be clearly identified in the documentation.

Question 2. If you were to document the session described above, what would be most important to consider in writing your note, from a QA perspective?

- **A.** Ensuring that everything that took place in the session is documented in specific detail so that the reader can understand in the best possible way what actually happened in session
- **B.** Describing the interventions provided and responses of the client in a way that demonstrates the clinician's fidelity to the evidenced based model being utilized, and the strong therapeutic relationship between the client and clinician
- **C.** Providing information that summarized concisely the interventions provided, conveying relevant aspects of client care, including documentation that supports medical necessity for the service, the response the client had to the interventions, and also any information that would result in additional treatment plan objectives
- **D.** Utilizing a format that structures the note

Question 2. Answer: C

Rationales for Question 2 Answer Options:

Option A:
From a QA perspective, a progress note should have relevant and pertinent clinical information about the client, medically necessary client care, clinical decisions, alternatives for future treatment (if any), interventions, client response to interventions, and plans for future treatment. It is recommended to document all necessary information to support treatment and avoid unnecessary details.

Option B:
While it may be important to maintain fidelity to an evidence-based treatment model or fidelity to a model that a program has adopted and have it reflected in documentation, from a QA perspective, a progress note serves the purpose to substantiate an intervention is medically necessary in client care, the progress and response of the client to treatment, any information that leads to additional treatment objectives and plans for future treatment.

Option C:
From a QA perspective, C is the best option for this question as the option provides many of the important elements needed in a progress note. For more comprehensive information on the required elements for progress notes, please refer to the *Organizational Provider's Manual*.

Option D:
While utilizing a structured format in a progress note may be helpful to organize the clinical information, track the progress of the client, and collaborate with others involved with the client, LACDMH does not require that practitioners use any particular structured format for progress notes (e.g. SOAP).

Question 3. Which of the following is TRUE regarding the sample Progress Note above:

- **A.** Technical terms such as “imminent stressors/mental health barriers” and “CDA oriented processes” are professional and specific terms that would be clearly understood by any mental health professional or practitioner viewing the clinical record
- **B.** Technical terms such as “Imminent stressors/mental health barriers” and “CDA oriented processes” need to be explained or substituted with plain language in order to clearly describe what’s going on with the client and the interventions being provided in a way that can be easily be understood by all that may be viewing the clinical record
- **C.** Technical jargon, such as abbreviations (e.g. SI, HI), usually is a good practice because it conveys clear and concise information that is well understood by other professionals

Question 3. Answer: B

Rationales for Question 3 Answer Options:

Option A:
Although technical jargon/terms such as “imminent stressors/mental health barriers” do convey general information, they do not provide information specific to the circumstances affecting the individual client. Therefore, the use of such terms does not make clear to all viewing the documentation/record the clinical circumstances that need to be addressed in treatment.

Option B:
Describing the specific circumstances affecting the client in plain language, in lieu of or in addition to using technical jargon, helps to clearly illustrate (to all viewing the note/record) how and the intent in which particular interventions were provided as it relates to the client’s specific clinical issues and goals for treatment.

Option C:
Although technical jargon may be generally understood by other mental health professionals viewing the record, it does not convey the specific information and circumstances necessary to fully understand the clinical issues the client is facing. In this way, technical jargon makes the specific clinical information affecting the client unclear.

Question 4. Which of the following is TRUE about the sample Progress Note above:

- **A.** Based on what was said in the vignette, the Progress Note could have better documented the relevance of the client’s dog-sitting to her mental health condition
- **B.** The Progress Note did not specify a reimbursable intervention that was provided therefore is not reimbursable
- **C.** Some portions of the note could have contained more concrete descriptions rather than vague phrases (for example, “Client was receptive to receiving resources”) so that the clinical relevance could be better understood
- **D.** The Progress Note was too short and did not contain enough clinically relevant information

E. A and C

Question 4. Answer: E

Rationales for Question 4 Answer Options:

Option A:
In the vignette, the practitioner reminded the client of how walking has been helpful to her in the past in combatting negative thoughts and making her feel better, and the client then suggested that she could increase the length of her walks with the dogs so that she can benefit from the walking as well. In the vignette, the client also mentioned how being around the dogs has been enjoyable and made her feel less lonely, and the practitioner stressed the mental health related benefits of being around animals. The Progress Note mentions that client has been dog-sitting but does not document or capture the coping strategies connected to the client's dog-sitting that were specifically discussed in the vignette.

Option B:
The progress note documented clinical interventions within the Individual Therapy Service Component of Mental Health Services. One of those interventions was administering a guided meditation to improve client's mood and reduce distress.

Option C:
"Client was receptive to receiving resources" provides general information about the client's response. Specifying how the client responded (for example, stated that she will make contact with a referred service next week), as well as the concrete resources that were provided (for example, referral to Yoga classes) will provide a clearer understanding of what occurred and how it is relevant to the client's clinical treatment.

Option D:
The Progress Note was not too short in that it was able to convey the clinical interventions that were administered, the client response, as well as details that conveyed client's level of functioning and general mood. All things being equal with respect to conveying the required clinical information, shorter progress notes are preferable to longer ones.

Option E:
Both answer A and C are correct.