Magellan HEALTHCARE

Clinical documentation for sharing with PCPs

Guidelines for behavioral health providers

Effective member-centered healthcare results from an integrated team approach with clear communication and collaboration between physical and behavioral health providers and with members and families. Clinical documentation of services is an important mechanism of communication between behavioral health (BH) providers and primary care providers (PCPs). The following guidelines are intended to assist BH providers in determining what information is important to communicate in clinical notes to PCPs, as well as what information should not be included due to consideration of member confidentiality and privacy.

Clinical progress notes: using the SOAP format

The SOAP format – Subjective, Objective, Assessment, Plan – is a commonly used approach to documenting clinical progress. The elements of a SOAP note are:

- **Subjective (S):** Includes information provided by the member regarding his/her experience and perceptions about symptoms, needs and progress toward goals.
- **Objective (O):** Includes observable, objective data ("facts") regarding the member, such as elements of a mental status exam or other screening tools, historical information, medications prescribed, lab tests or vital signs, as well as the clinician's observation of the member's behaviors, affect and speech.
- **Assessment (A):** Includes the clinician's assessment of the available subjective and objective information. The assessment summarizes the member's current status and progress toward achievement of treatment plan goals.
- **Plan (P):** Documents the steps to be taken as a result of the clinician's assessment of the member's current status, such as follow-up activities, referrals, changes in the treatment plan, continuation of the current interventions or movement toward transition/discharge

SOAP notes to be shared with PCPs: what to include

Subjective (S)

Include	Don't Include
• Member report of physical symptoms, including side effects of medications • Member report of medication non-compliance • Suicidal or homicidal ideation and/or self-injurious behavior, including whether member has contracted for safety • Member report of homelessness and/or loss of significant social supports	• Any information member requests be kept confidential (with relevant legal exceptions, such as duty to protect) • Quotations or paraphrasing of member disclosures in therapy sessions • Member report of illegal drug use or engagement in other illegal activities • Member report of alcohol and other drug use, unless member consents to disclosure

• Member report of change in eating habits, sleep or activity level	• Information about member's family relationships, intimate relationships, sexual behavior/orientation or abuse history • Member disclosure of HIV status

Objective (O)

Include	Don't Include
• Mental status exam • Vital signs, if measured • Changes in medication, including reason for change and member's response and adherence to the medication • Results of lab tests (excluding substance use information, unless have member consent) • Observation of signs of a possible mental or physical health condition • Emergency room visits or hospitalizations since last report	• Urine drug screen results (unless have member consent) • Observations of behavior of family members or other member collaterals in therapy sessions • Reports made as a mandatory reporter for suspicion of child or elder abuse

Assessment (A)

Include	Don't Include
• Clinician evaluation of member safety • Assessment of member's progress toward goal achievement • Member needs identified in the session, and recommendations for follow-up • New or revised diagnoses and rationale • Changes in degree of risk for a higher level of care, such as hospitalization • Need for social services or informal supports	• Assessment of member compliance with court-ordered treatment • Assessment of member's marital or other intimate relationships or member's parenting skills • Assessment of member's prognosis for achieving or maintaining sobriety from alcohol or other drugs

Plan (P)

Include	Don't Include
• Revisions to the BH treatment plan • Referrals to formal services, including psychiatric consultation for medication • New or revised medication prescriptions or orders for lab work • Referrals to social services or other community resources • Referrals to a higher level of care, such as inpatient treatment, including available information on which provider and timing of admission	• Plans for legally mandated reporting (e.g., child abuse, elder abuse) • Information about referrals of family members or other member collaterals for individual or family treatment services