SAMPLE BEHAVIORAL HEALTH SOAP NOTE

MDD — POST-CARDIAC DECOMPENSATION, MEDICATION NON-ADHERENCE

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME	Margaret A. Holloway
DOB	03/22/1965
AGE / SEX	61 / Female
CREDENTIALS	MD, Board Certified Psychiatry (ABPN)
SESSION DURATION	45 minutes
DATE OF SERVICE	05/06/2026
PROVIDER	Dr. Karen Walsh, MD — Psychiatry
MRN / PATIENT ID	CCM-2026-0178
VISIT TYPE	Follow-up — Medication Management + Brief Supportive Psychotherapy
CARE SETTING	Outpatient Psychiatry — quarterly; moved up due to PHQ-9 16 reported to PCP (Dr. Kim) via CCM visit

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

> *'I feel like I can't do anything right. Everything feels like a chore. I don't want to see anyone. I thought the medicines were supposed to help.'*

Patient presents for follow-up psychiatric medication management with an interval concern of worsening depression since her HFpEF decompensation hospitalization (03/12–03/16/2026). PHQ-9 score 16 today (moderate-severe), up from 14 at last quarterly contact (04/22/2026 — 44 days ago). She also reports worsening tearfulness and increased difficulty managing her complex medical regimen, which her CCM care manager (Linda Chen, RN) flagged as a primary driver of her diuretic non-adherence.

S SUBJECTIVE

3 PATIENT-REPORTED SYMPTOMS

3a CURRENT SYMPTOMS

- **Mood:** Persistent low mood x6 weeks — 'I've been sad pretty much every day… there are no good days anymore.' Pervasive and worse in the morning (diurnal variation).
- **Anhedonia:** Marked — 'I used to enjoy cooking, now I don't even want to eat.' No hobbies or social activities since the March hospitalization.
- **Energy:** 'I am exhausted all the time. Even getting dressed takes everything I have.' Fatigue partially attributable to HFpEF (NYHA II–III) and partially to MDD — difficult to fully separate.

- **Sleep:** Early morning awakening (3–4 AM, unable to return to sleep); sleep onset ~45 minutes; ~4.5–5 hours/night.
- **Appetite:** Reduced — ~1 full meal and 1–2 snacks/day. Weight 148 lbs (appears stable; scale variation vs PCP).
- **Concentration:** 'I forget things… My daughter had to remind me to take my blood pressure pill three times last week.' Contributes directly to medication non-adherence.
- **Worthlessness:** 'I feel like a burden to everyone… I used to be the one who took care of things.'
- **Hopelessness:** Present but conditional — 'I don't think anything is going to get better unless the heart stuff gets better.' No passive death wish at this time.

3b ONSET, COURSE & FUNCTIONAL IMPACT

- **MDD onset:** Diagnosed ~3 years ago amid increasing medical burden (T2DM, HTN, CKD). Sertraline 100 mg x18 months with partial response (PHQ-9 18 → 10 at best).
- **Current exacerbation:** Clear precipitant — HFpEF decompensation hospitalization (03/2026) and fear of disease progression. PHQ-9 trajectory: 10 (baseline) → 14 (04/01/2026 CCM) → 16 (today).
- **Functional impact:** Significant. Diuretic non-adherence driven partly by depression-related fatigue and apathy (furosemide taken ~50% of the time per pharmacy data). Missed an April PCP appointment (rescheduled). Stopped all social activities including calls with her sister. Retired (no occupational impact). Maintaining basic hygiene but bathing less than baseline; delegating grocery shopping to daughter. QOL severely reduced.

3c STRESSORS & TREATMENT RESPONSE

- **Primary stressors:** (1) Fear of cardiac disease progression — 'I almost died in March. What if the water pills stop working?' Health anxiety centered on HFpEF. (2) Medication burden — 13 medications, overwhelming ('They're all fighting each other.'). (3) Loss of independence and self-efficacy — previously the family caregiver/household manager, now requires reminders and assistance. (4) Financial concerns — coverage adequate, but worries about medication and healthcare costs.
- **Treatment response:** Sertraline 100 mg — partial response historically. Current worsening despite adequate adherence (88% per pharmacy). Dr. Kim (PCP) raised a sertraline dose increase at today's earlier PCP visit — discussed and coordinated between Dr. Kim and Dr. Walsh by phone.

3d MEDICATION ADHERENCE, SUBSTANCE USE & SAFETY

- **Psychiatric medications:** Sertraline 100 mg daily — adherence GOOD (88% per CVS refill data). No side effects attributable to sertraline (no sexual side effects, GI disturbance, activation, or serotonin syndrome).
- **Substance use:** Non-smoker. Alcohol social — 1 glass wine ~1×/week. No cannabis or illicit substances.
- **Safety:** No active suicidal ideation — denies thoughts of self-harm. C-SSRS administered today: no ideation endorsed. No prior attempts. No access to lethal means beyond standard household items (no firearms, confirmed).
- **Passive death wish:** 'I don't want to die, but sometimes I think it would be easier if I didn't have to deal with all of this.' Directly explored — clarified as exhaustion and demoralization, not a wish for death. Protective factors: daughter, faith community (Presbyterian church, attendance declined), desire to see grandchildren.
- **Overall safety:** LOW RISK. No safety plan indicated; will re-evaluate if PHQ-9 does not improve within 4 weeks.

ROS BEHAVIORAL HEALTH REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Depression / low mood / anhedonia:** POSITIVE — persistent low mood daily x6 weeks; anhedonia marked; loss of interest in all prior hobbies
- **Anxiety / excessive worry:** POSITIVE — health anxiety centered on HFpEF and medication complexity; not meeting full GAD criteria; secondary to medical illness
- **Sleep disturbance:** POSITIVE — early morning awakening (3–4 AM), difficulty initiating; ~4.5–5 hours/night
- **Appetite / weight change:** POSITIVE — reduced appetite; eating 1–2 meals/day; weight fluctuating but stable overall on scale variance
- **Irritability / anger:** MILD POSITIVE — 'snappy' with daughter at times; not aggressive
- **Trauma symptoms / flashbacks:** NEGATIVE — no PTSD symptoms from hospitalization; processes it as scary but not traumatic in a PTSD sense
- **Obsessions / compulsions:** NEGATIVE — no OCD symptoms; health preoccupations are reality-based, not obsessional
- **Hallucinations / paranoia / delusions:** NEGATIVE — no perceptual disturbances; reality testing intact
- **Mania / hypomania:** NEGATIVE — no history; no current symptoms; MDQ 2023 negative
- **Substance use / cravings:** NEGATIVE — 1 glass wine/week; no concern
- **Suicidal ideation / self-harm:** NEGATIVE — C-SSRS negative today; exhaustion/demoralization statement explored and resolved as passive; no plan, intent, or means access
- **Concentration / executive function:** POSITIVE — forgetfulness, difficulty completing tasks, medication reminders needed; consistent with MDD cognitive symptoms and medical burden

O OBJECTIVE / MENTAL STATUS EXAMINATION

5 MSE

APPEARANCE
Well-groomed, appropriately dressed for weather. Appears stated age of 61. No nutritional concerns on inspection. Seated comfortably, posture slightly slumped — improved slightly as the session progressed.

BEHAVIOR
Cooperative throughout. Eye contact initially avoidant, improving as rapport established. Psychomotor mildly slowed — pauses before responding, limited spontaneous movement. No agitation or abnormal movements.

SPEECH
Rate mildly slowed. Volume soft, not whispered. Fluency intact. Articulation clear. Coherence intact. Spontaneity reduced — responsive but brief; does not elaborate without encouragement.

MOOD
'Sad. Tired. Overwhelmed.' (patient's own words). Consistently low across the session.

AFFECT
Range mildly constricted. Congruent with depressed mood. Intensity muted. Reactivity mildly reactive — slight brightening discussing granddaughter; tearfulness discussing hospitalization. Appropriate to content.

THOUGHT PROCESS
Linear and goal-directed. No loosening of associations, tangentiality, or circumstantiality. Mild rumination on themes of burden and medical illness.

THOUGHT CONTENT
No SI (C-SSRS negative). No HI, delusions, or paranoia.

PERCEPTION
No hallucinations, illusions, dissociation, or

Primary preoccupations: fear of cardiac progression, medication burden, and self-perceived inadequacy as caregiver of her own health. Hopelessness present but conditional (tied to medical prognosis).

depersonalization.

COGNITION

Alert and oriented ×4. Attention intact to conversation. Reports subjective concentration impairment but demonstrates adequate concentration in the 45-minute session. Memory: no gross deficits — recalls prior medication names and last visit content accurately. Fund of knowledge appropriate.

INSIGHT

FAIR-GOOD — acknowledges she is depressed and worsening. Accepts psychiatric help. Ambivalent about medication change but open to discussion.

JUDGMENT

INTACT — making reasonable decisions about her care. Agreed to medication adjustment and safety assessment. Appropriately engaged in care planning.

IMPULSE CONTROL

INTACT — no impulsive behaviors noted or reported.

SAFETY

No acute safety concerns. C-SSRS: no ideation. Low risk.

AS STANDARDIZED SCREENING / ASSESSMENT TOOLS

6 VALIDATED MEASURES

PHQ-9

Score 16 / MODERATE-SEVERE / prior 14 (04/22/2026 CCM, 44 days ago) / change +2 — worsening. Highest items: anhedonia (3/3), fatigue (3/3), concentration (2/3), sleep (2/3). Item 9 (SI): 0/3.

GAD-7

Score 9 / MODERATE anxiety / prior not formally administered. Reflects health anxiety and situational anxiety; does not meet full GAD criteria as symptoms are primarily tied to medical illness context.

C-SSRS

Administered today — all ideation items NEGATIVE. Intensity items not applicable (no ideation). Behavior items NEGATIVE. Overall risk category: LOW. No safety plan required at this time.

PHQ-9 ITEM 9 — SUICIDAL IDEATION

0/3 — ‘not at all.’ Directly reviewed; the ‘easier’ statement was explored and resolved as demoralization, not suicidal ideation. No further safety escalation needed.

RA RISK ASSESSMENT

7 CURRENT RISK LEVEL

- **Suicidal ideation:** ABSENT — C-SSRS negative. The statement ‘it would be easier if I didn’t have to deal with all of this’ was explored in depth; she clarified: ‘I don’t want to die. I just want to feel normal again.’ No passive death wish persists after clarification.
- **Self-harm / homicidal ideation / psychosis:** Absent. No history.
- **Substance-related risk:** Minimal — 1 glass wine/week. **Abuse/neglect/DV:** Denied; no clinical indicators.
- **Overall risk level:** LOW. Rationale: no ideation, plan, intent, or means access (no firearms); strong protective factors (daughter, faith, grandchildren); engaged in treatment and accepting care.

- **Protective factors:** Strong relationship with daughter (daily support); faith community; grandchildren as a meaningful reason to improve; engaged with CCM care manager and PCP.
- **Risk trajectory:** Monitoring closely — if PHQ-9 does not improve to <12 within 4 weeks of medication adjustment, will re-evaluate risk and consider IOP referral. Escalation criteria discussed with patient and daughter.

IN INTERVENTIONS PROVIDED

8 CLINICAL INTERVENTIONS THIS SESSION

1. **Motivational interviewing:** Explored ambivalence about medication adjustment and self-care. Reflected the sense of being overwhelmed without reinforcing hopelessness. Elicited change talk — she spontaneously identified 'I want to be there for my grandchildren' as a primary reason to engage. Rolled with resistance when she questioned whether another medication change would help.
2. **Psychoeducation:** Explained depression as a medical illness, not a personal failure — linking her worsening depression to the biological impact of cardiac illness, HFpEF, chronic pain, and the physiological stress of hospitalization. Normalized post-hospitalization depression; addressed misattribution to personal inadequacy.
3. **Behavioral activation:** Collaboratively identified 2 small, achievable activities for the next 2 weeks: (a) daily 10-minute walk at her own pace (acceptable to cardiology); (b) one weekly phone call with her sister — framed as experiments, not obligations.
4. **Cognitive restructuring:** Gently challenged 'I can't do anything right' by reviewing what she IS doing correctly (85%+ adherence on most medications, participating in CCM, attending this appointment) — without minimizing real challenges.
5. **Care coordination:** Reviewed Dr. Kim's recommendation for sertraline uptitration (discussed by phone today, 11:00 AM). Medication adjustment discussed in detail — see plan.
6. **Sleep hygiene counseling:** Reviewed strategies appropriate for depression and cardiac status — consistent wake time, stimulus control, limiting daytime napping, limiting evening fluid intake (relevant for HFpEF/furosemide).
7. **Safety assessment:** Full C-SSRS administered and documented. Demoralization statement explored and resolved.

A ASSESSMENT

9 BEHAVIORAL HEALTH CLINICAL INTERPRETATION

- **Primary diagnosis:** Major depressive disorder, recurrent, moderate-severe episode (F33.1; PHQ-9 16 today).
- **Current status:** WORSENING. PHQ-9 trajectory 10 → 14 → 16 over 5 months; exacerbation clearly precipitated by HFpEF decompensation and hospitalization (03/2026).
- **Clinical interpretation:** A complex biopsychosocial presentation in which her medical illnesses (HFpEF, T2DM, CKD, HTN) and depression bidirectionally drive each other — depression worsens adherence → worsens fluid management → worsens HFpEF prognosis → worsens hopelessness. This cycle must be

interrupted at the psychiatric and medical levels. Sertraline 100 mg gave partial response but is insufficient for current episode severity.

- **Psychosocial stressors:** Post-hospitalization health anxiety; medication complexity burden (13 medications); loss of self-efficacy; reduced social functioning.
- **Response to today's interventions:** Excellent engagement — tearful at start, genuine affect brightening when discussing grandchildren and when depression was reframed as a medical illness. Left with specific behavioral goals and cautious optimism: 'Maybe if I take the new dose and it works, things will get easier.'
- **Medical necessity:** Ongoing psychiatric management is medically necessary given moderate-severe MDD, medication complexity, and the direct impact of psychiatric status on medical adherence and HFpEF outcomes. Risk low; close monitoring planned.

P PLAN

10 BEHAVIORAL HEALTH TREATMENT PLAN

1. **Medication:** Increase sertraline from 100 mg to 150 mg daily — consistent with the standard 50–200 mg range; 150 mg is a common effective dose for moderate-severe MDD. Rationale: PHQ-9 16 despite 18+ months at 100 mg; worsening trajectory despite adequate adherence; no side effects; coordinated with Dr. Kim. Counseled: full effect may take 4–6 additional weeks; partial improvement (sleep, energy) may appear in 2–3 weeks. Prescription sent to CVS electronically. No cardiac medications interact significantly with sertraline at this dose range for this patient.
2. **Behavioral activation:** Daily 10-minute flat-surface walk (consistent with cardiology guidance for NYHA II–III) and one weekly phone call with sister — patient committed to these goals in session.
3. **Therapy:** Referral to weekly supportive psychotherapy with a licensed therapist (Dr. Elena Park, LCSW — health psychology / chronic illness adjustment; in-network). Goal: 8–12 weekly sessions focused on illness adjustment, self-efficacy, cognitive distortions, and behavioral activation.
4. **Coordination:** Communicated today's plan to Dr. Kim (post-session phone call) and CCM care manager Linda Chen (secure message). CCM monitoring to include PHQ-9 at next contact (05/20/2026).
5. **Safety:** No safety plan required. Patient given crisis line information (988 Suicide and Crisis Lifeline) and instructed to call the office or go to the nearest ED if SI develops before the next appointment.
6. **Next visit:** 4 weeks (06/03/2026) — medication response assessment, PHQ-9 repeat, sleep and behavioral activation progress review.

F FOLLOW-UP

11 REASSESSMENT PLAN

Follow-up in 4 weeks (06/03/2026) with Dr. Walsh. Assess: sertraline 150 mg response, PHQ-9 repeat (goal <12), sleep and energy improvement, behavioral activation progress, new therapy initiation with Dr. Park (confirm appointment made), safety reassessment, and medication tolerability. If PHQ-9 does not improve meaningfully by 06/03, consider an augmentation strategy (bupropion or buspirone added to sertraline, coordinated with Dr. Kim). Escalation: if SI develops, patient instructed to call the office or 988 immediately.

TIME DOCUMENTATION & BILLING

TOTAL TIME
45 minutes

COUNSELING / COORDINATION TIME
15 minutes

CPT / E/M CODE(S)
90833 — Psychotherapy 30 min add-on to E/M; 99214 — E/M moderate complexity (medication management + MSE)

BASIS FOR BILLING
Time-based: 45 minutes total (30 min psychotherapy + 15 min medication management E/M)

PRIMARY ICD-10 CODE
F33.1 — Major depressive disorder, recurrent, moderate

SECONDARY ICD-10 CODE(S)
I50.32 — Chronic diastolic HFpEF; E11.9 — T2DM; I10 — Hypertension; N18.3 — CKD stage 3a

PROVIDER SIGN-OFF

PSYCHIATRIST	CREDENTIALS	SPECIALTY	DATE	TIME
Karen Walsh, MD	MD, Board Certified Psychiatry (ABPN)	Outpatient Psychiatry	05/06/2026	4:00 PM

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