Community Counseling Center

The Basics of Clinical Documentation

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Community Counseling Center
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Objectives

Introductions and Opening Discussion WHY: 10 minutes

Objective 1:

Identifying the purpose(s) of clinical documentation: 25 minutes.

Objective 2:

Overview of several different progress note formats (DAP, SOAP, IGBIRP): 25 minutes.

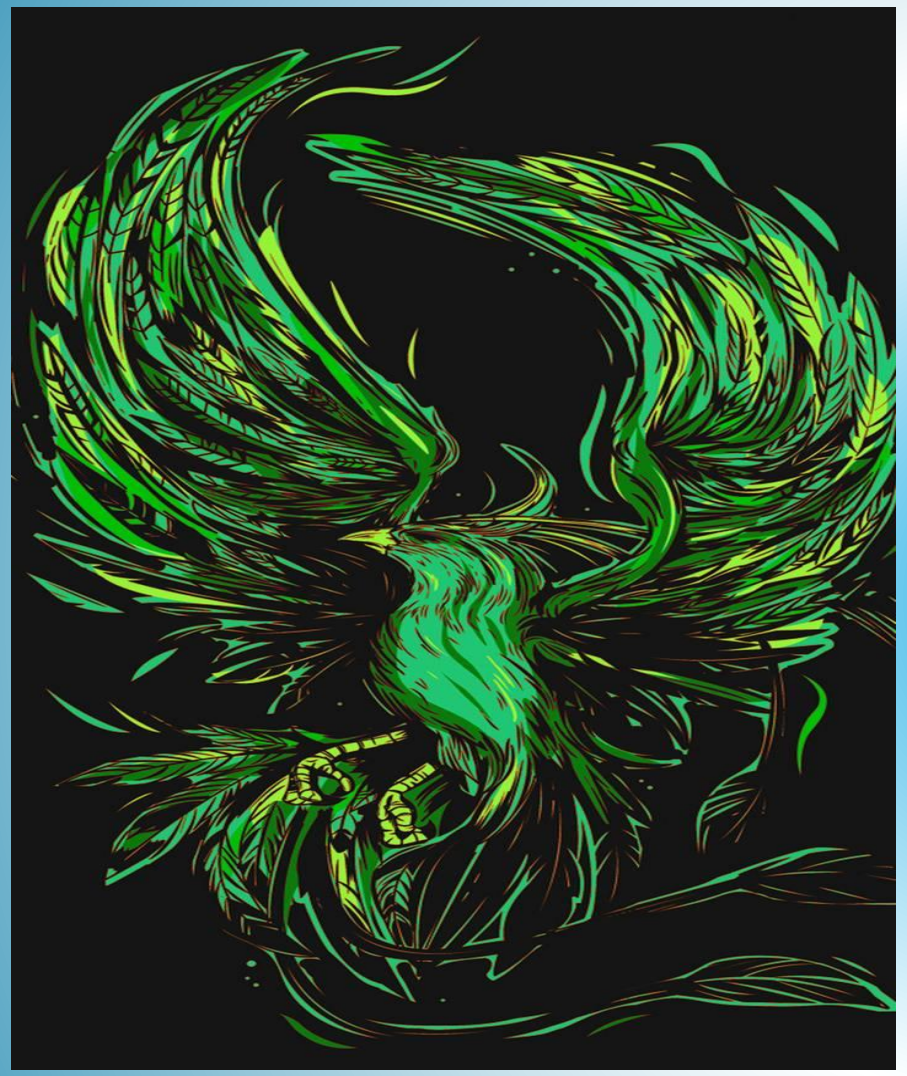
Objective 3:

Person-centered, nonjudgmental documentation: 25 minutes.

Objective 4:

Practical application breakout rehearsal and full-group discussion: 250minutes.

Discussion Q&A: 15 minutes



Objective 1:

Identifying the purpose(s) of clinical documentation.
25 Minutes

Chapter 3701.74 **ORC:** "Medical record means data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment."

What is a Medical Record?

Medical Record/Health Record/Clinical Record = “Chart”

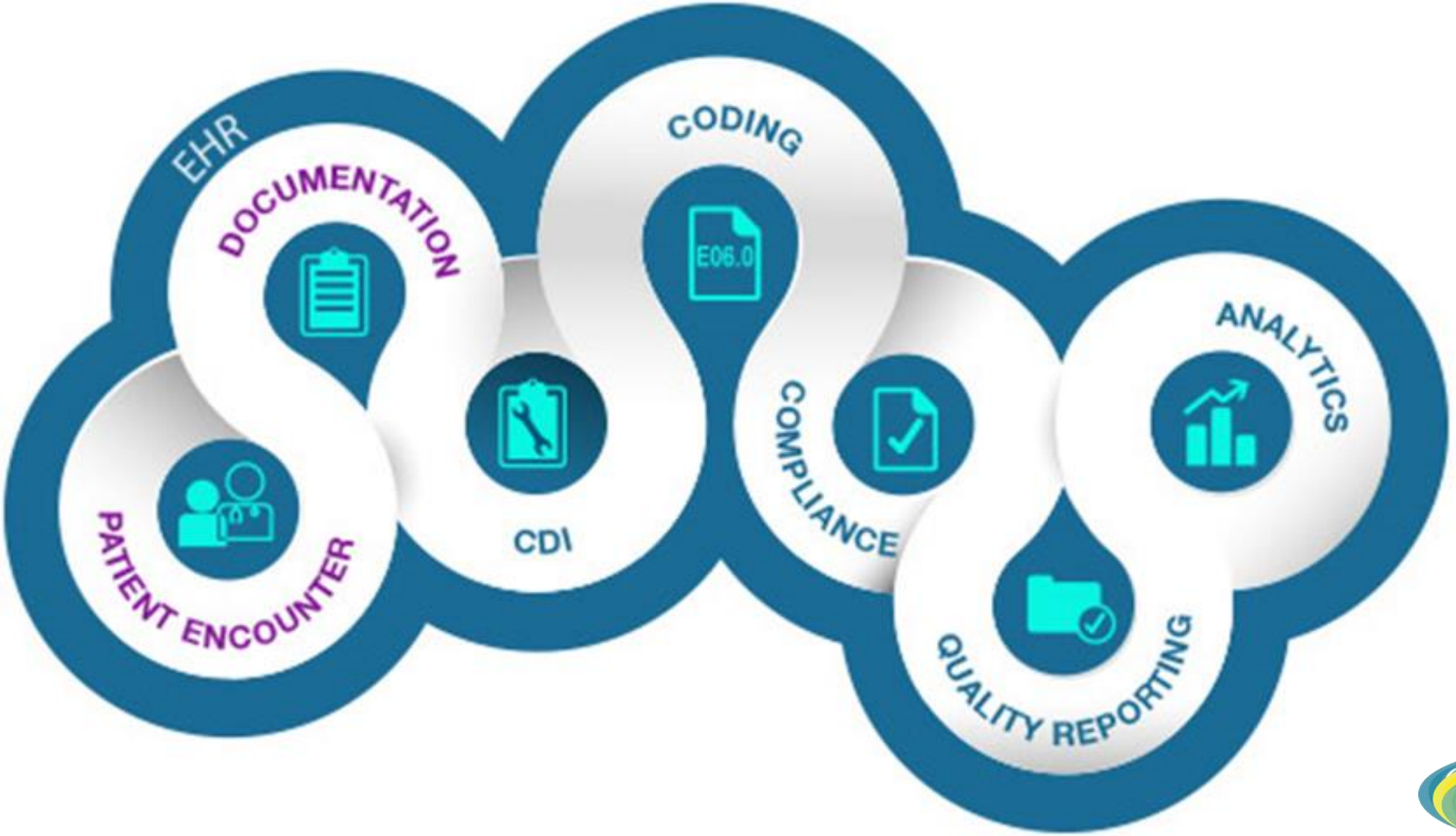
- Identifiable Client Information
- Financial Documentation
- Assessment
- Treatment Diagnosis
- Medical Information
- Emergency contact
- Treatment plan
- Individual progress notes
- Group progress notes

If you don’t document, it didn’t happen!

Medical Record/Health Record/Clinical Record = "Chart"

- Releases of information
- Written consent forms
- Attendance
- Care coordination
- Requested records, court orders
- Client correspondence outside of sessions/Asynchronous Electronic Communication (texts, emails, Voicemail messages, attempted outreach).

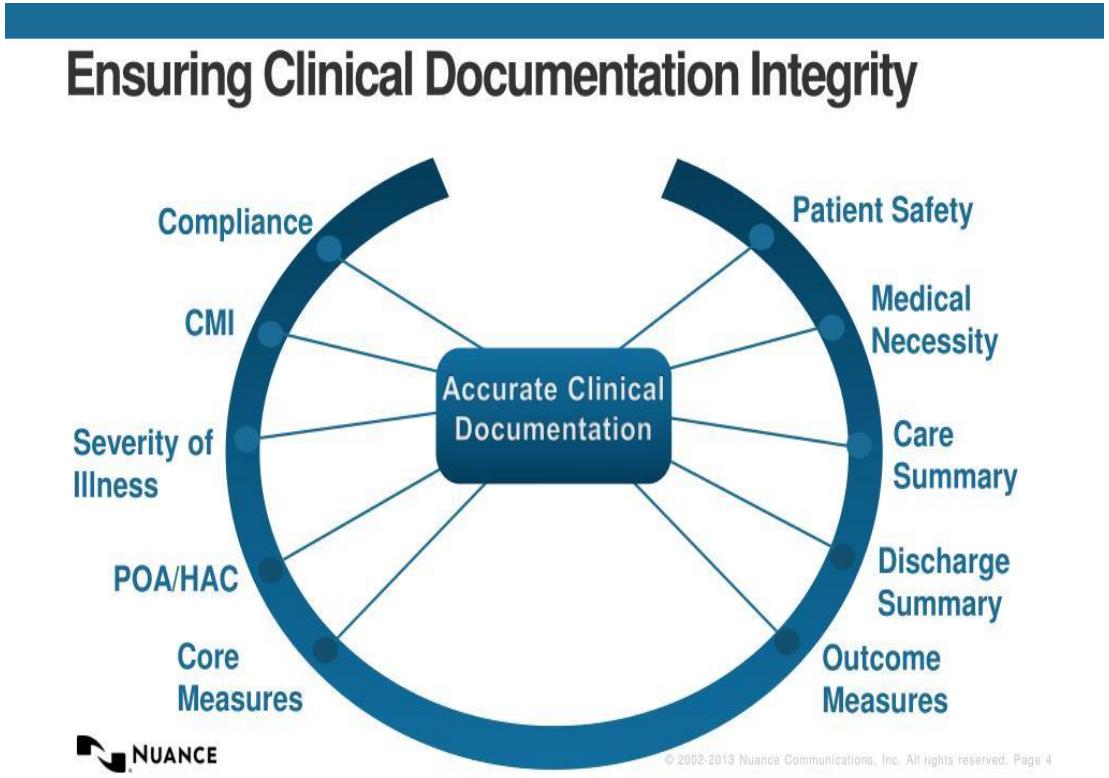
If you don't document, it didn't happen!


EHR
DOCUMENTATION
PATIENT ENCOUNTER
CODING
E06.0
CDI
COMPLIANCE
QUALITY REPORTING
ANALYTICS

DOCUMENTATION

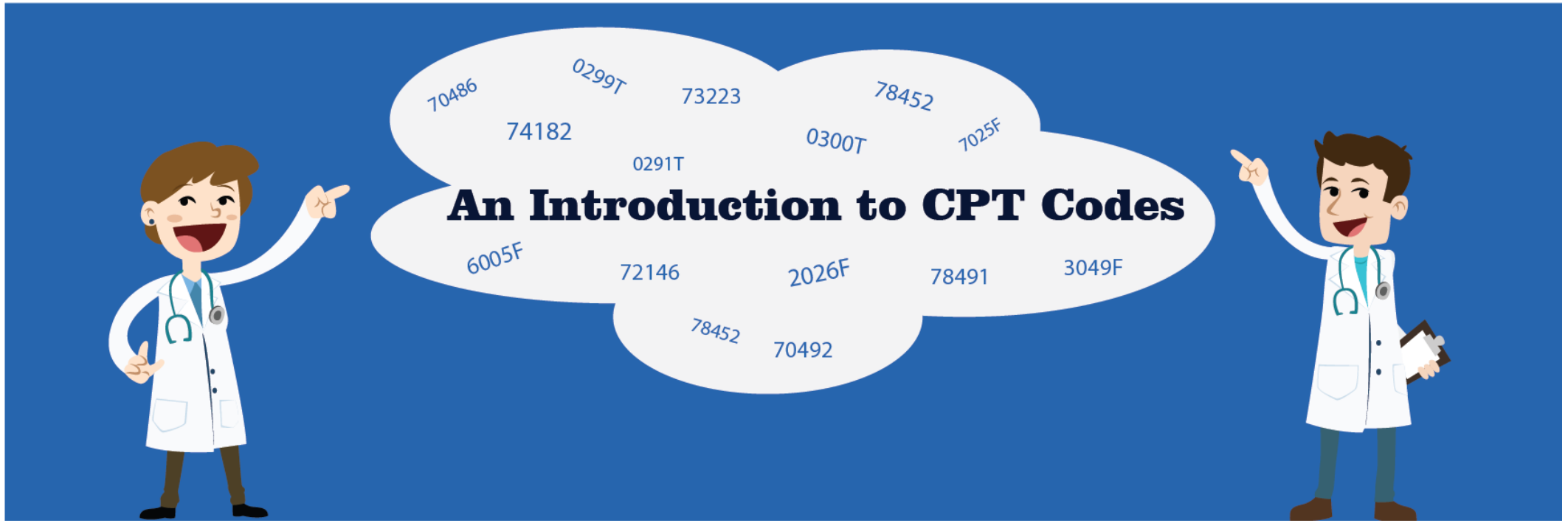
- Timely
- Honest
- Ethical
- Clear
- Concise
- Professional

CDI



Most organizations will utilize an Electronic Health Record (EHR).

You will need to learn and utilize the organizations policies and procedures pertaining to clinical documentation.



CODING: "Current Procedural Terminology (CPT) codes are numbers assigned to each task and service a healthcare provider offers. They include medical, surgical, and diagnostic services. Insurers use the numbers to determine how much money to pay a provider."

Source: https://www.verywellhealth.com/what-are-cpt-codes-2614950

Compliance

- Agency policy
- State and federal requirements
- Insurance requirements
- Grant funding requirements
- Board requirements
- Accreditation standards
- Evidence-based practices (EBP)

		Who must comply?	Protected information	Permitted disclosures[1]
FERPA	The **Family Educational Rights and Privacy Act (FERPA)** is a federal law enacted in 1974 that protects the privacy of **student education records**. The Act serves two primary purposes: 1. Gives parents or eligible students more control of their educational records 2. Prohibits educational institutions from disclosing "personally identifiable information in education records" without written consent 	• **Any public or private school:** – Elementary – Secondary – Post-secondary • **Any state or local education agency** Any of the above must receive funds under an applicable program of the US Department of Education	**Student Education Record:** Records that contain information directly related to a student and which are maintained by an educational agency or institution or by a party acting for the agency or institution	• School officials • Schools to which a student is transferring • Specified officials for audit or evaluation purposes • Appropriate parties in connection with financial aid to a student • Organizations conducting certain studies for or on behalf of the school • Accrediting organizations • Appropriate officials in cases of health and safety emergencies • State and local authorities, within a juvenile justice system, pursuant to specific state law • To comply with a judicial order or lawfully issued subpoena
HIPAA	The **Health Insurance Portability and Accountability Act (HIPAA)** is a national standard that protects sensitive **patient health information** from being disclosed without the patient's consent or knowledge. Via the Privacy Rule, the main goal is to • Ensure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. 	• Every healthcare provider who electronically transmits health information in connection with certain transactions • Health plans • Healthcare clearinghouses • Business associates that act on behalf of a covered entity, including claims processing, data analysis, utilization review, and billing	**Protected Health Information[2]:** Individually identifiable health information that is transmitted or maintained in any form or medium (electronic, oral, or paper) by a covered entity or its business associates, excluding certain educational and employment records	• To the individual • Treatment, payment, and healthcare operations • Uses and disclosures with opportunity to agree or object by asking the individual or giving opportunity to agree or object • Incident to an otherwise permitted use and disclosure • Public interest and benefit activities (e.g., public health activities, victims of abuse or neglect, decedents, research, law enforcement purposes, serious threat to health and safety) • Limited dataset for the purposes of research, public health, or healthcare operations

1. **Permitted disclosures** mean the information can be, but is not required to be, shared without individual authorization.

2. **Protected health information** or **individually identifiable health information** includes demographic information collected from an individual and 1) is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and
   (i) That identifies the individual, or
   (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

For more information, please visit the Department of Health and Human Services' HIPAA website and the Department of Education's FERPA website.

CDC

Quality

Person-centered: Use person-first language. Direct quotes that capture client response. Reflects client's desired outcomes.

Timely: Collaborative is best!

Factual: When, where, what, and how.

Honest: If it happened, say it. If it didn't, don't.

Ethical: Only provide services you are qualified to provide.

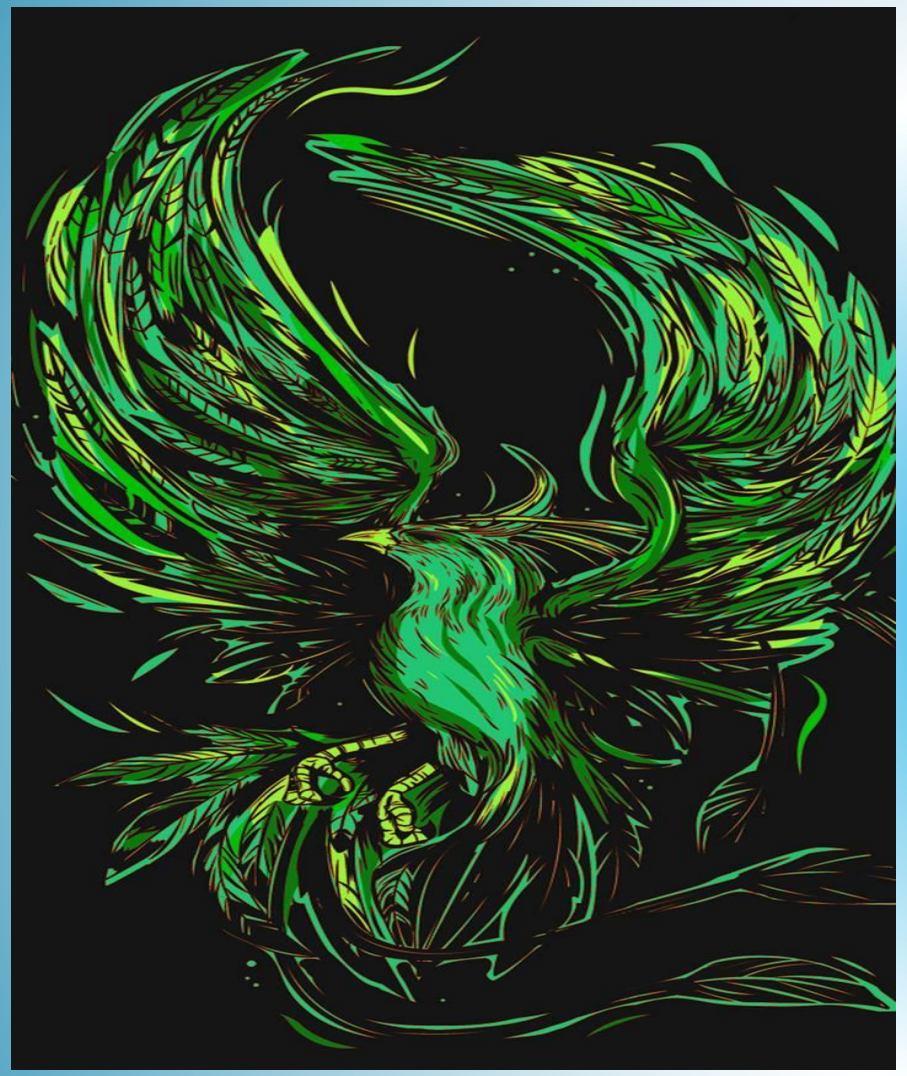
Clear: Legible, correct. If I request my records, will I understand what is written?

Concise: This should be a snapshot that provide a quick representation of content of session, not a word-by-word transcription.

Professional: Approved abbreviations only. Observations should not be written as facts. Use words like "appeared," or "presented," and "as evidenced by." For example: Client appeared to be under the influence of alcohol as evidenced by slurred speech, staggered gait, and verbal report of intoxication. Site source and use quotation marks: Client stated, "I was drunk." Or, Client reported to be under the influence of alcohol. Do not write "Client was drunk."

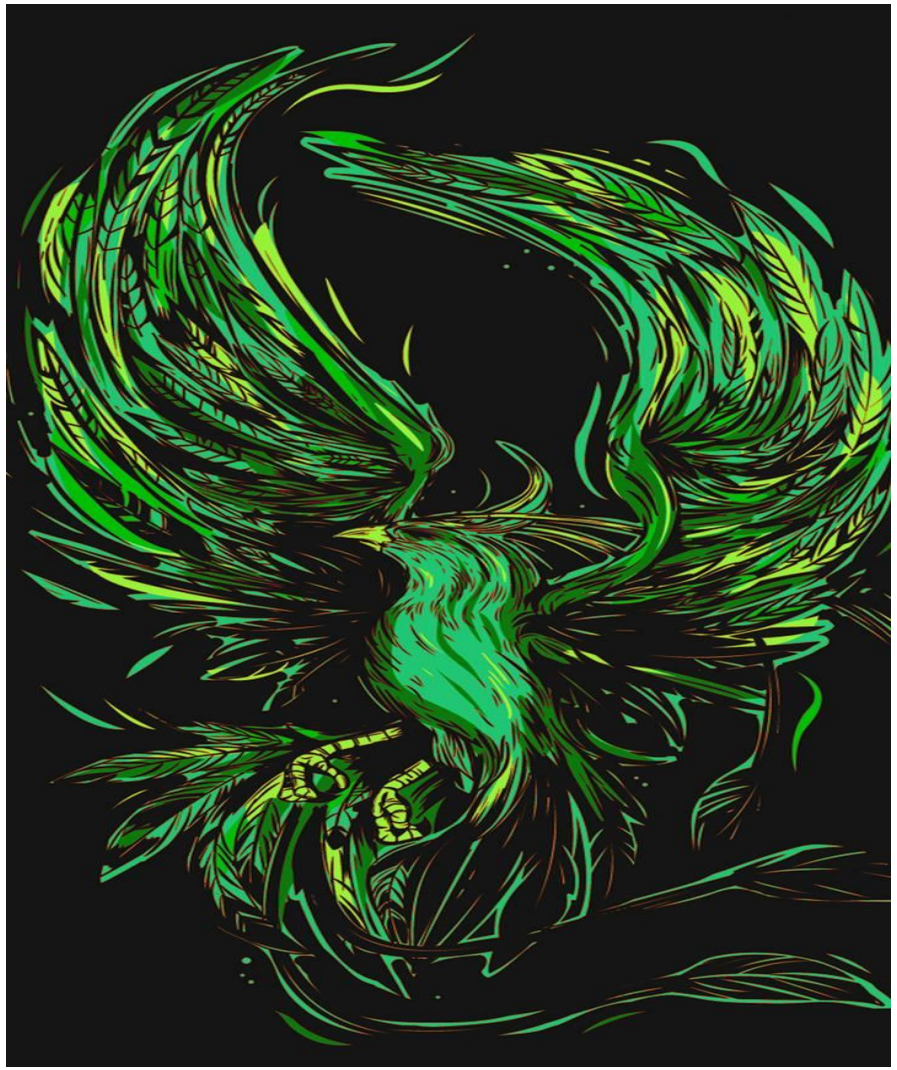
ANALYTICS

- Interpreting Data = "Meaningful use."
- Impact on person served.
- Impact on service delivery.
- Exploration of trends, themes.
- Necessary action?



Objective 2:

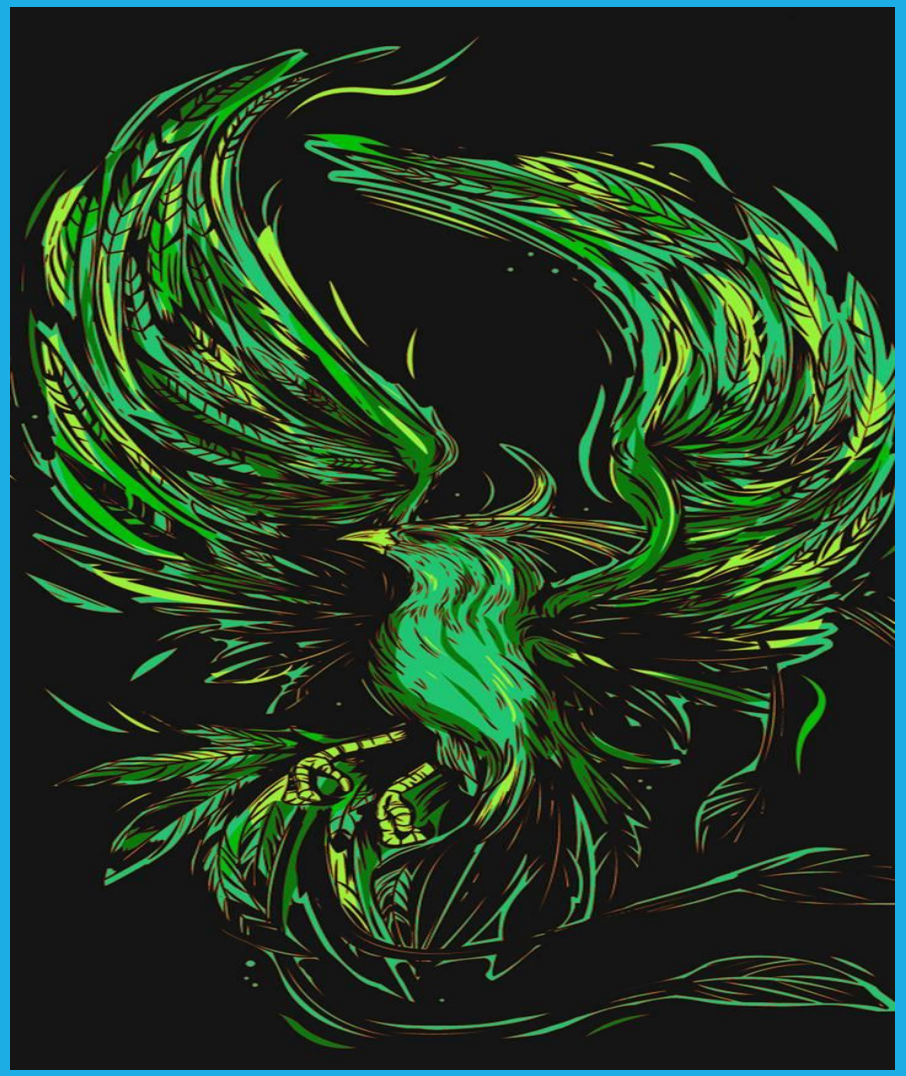
Overview of several different progress note formats (DAP, SOAP, IGBIRP). 25 minutes



Patient Encounter:

"Hi Phoenix. It's good to see you today!"

Goal Plan



Client Desired Outcome: "I want to get off probation and live my life."
Transition Planning: CI will complete treatment upon successful completion of probation. CI will transition to a higher level-of-care if symptoms to interfere with daily functioning.

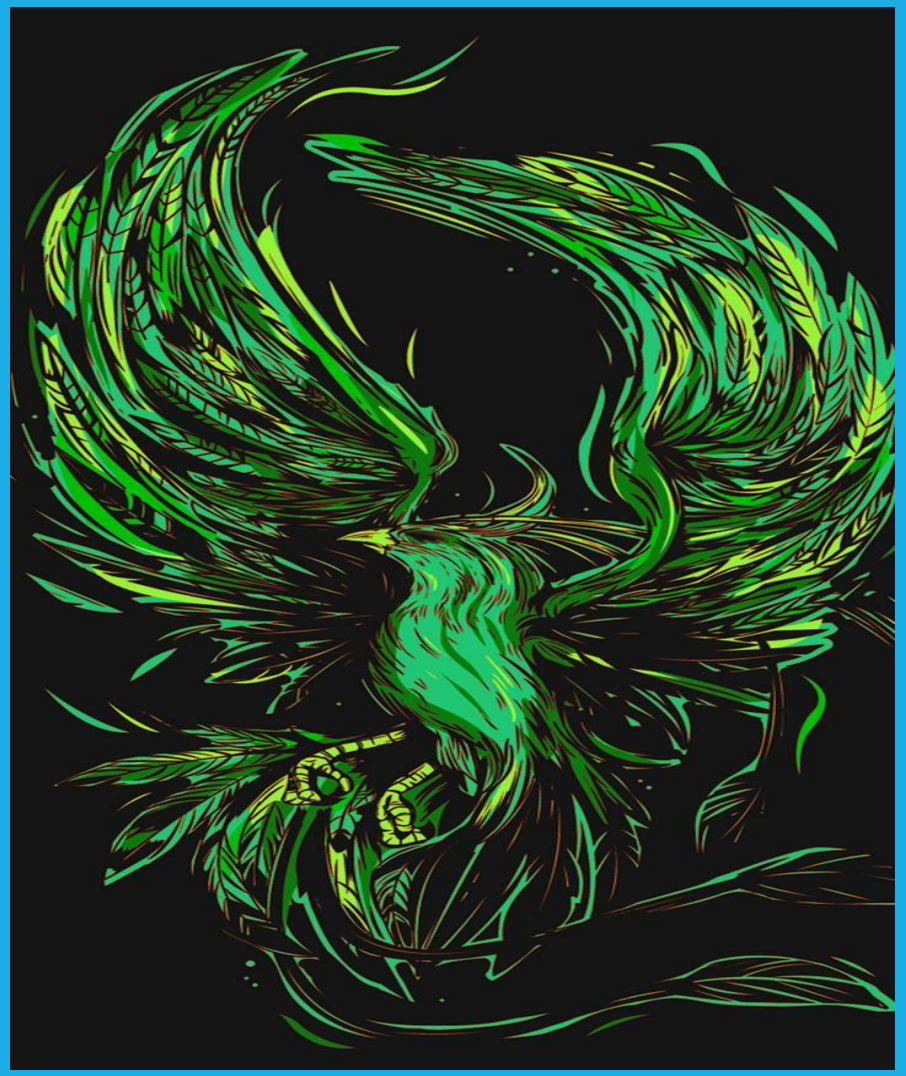
Strengths: Resilient, "ride or die."

Needs: Strategies to live a full life without violating terms of probation.

Abilities: CI is capable of learning and applying new skills as evidenced by completion of GED, and sustained opioid use recovery with medication assistance.

Preferences: CI prefers individual treatment without groups.

Goal Plan



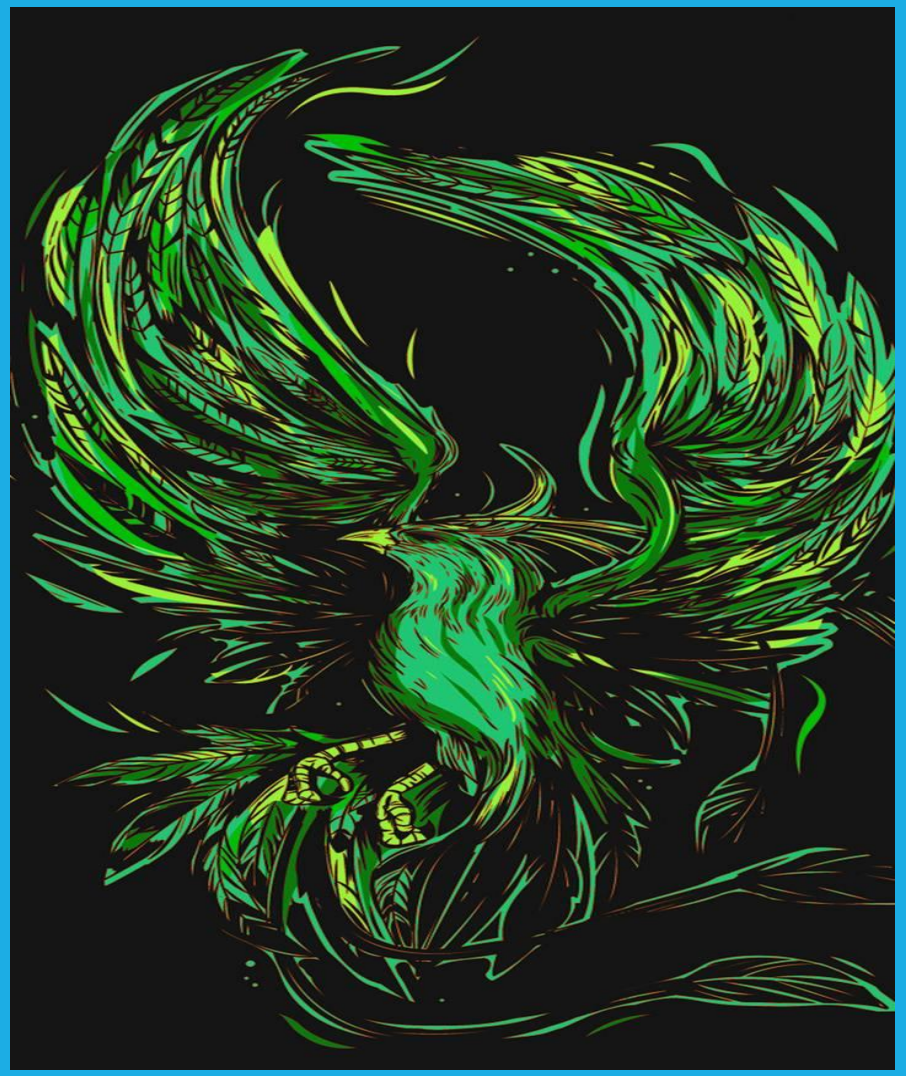
Goal(s) - Specific: Client will learn how to satisfy terms of probation, while still having fun.

Objective(s) – Measurable, Attainable, Relevant, Timely:

1. **Client will learn and process the identified terms of probation through integrated care, discussion, and reflection weekly in session.**
2. **Client will participate in random urine drug screens to aid in recovery process.**
3. **Client will work through history of trauma and develop improved sense of self.**
4. **Client will develop clear boundaries and communication with others as evidenced by sense of safety in relationship.**
5. **Client will identify and engage in at least 3 meaningful activities that do not interfere with probation.**

Sessions will occur weekly.

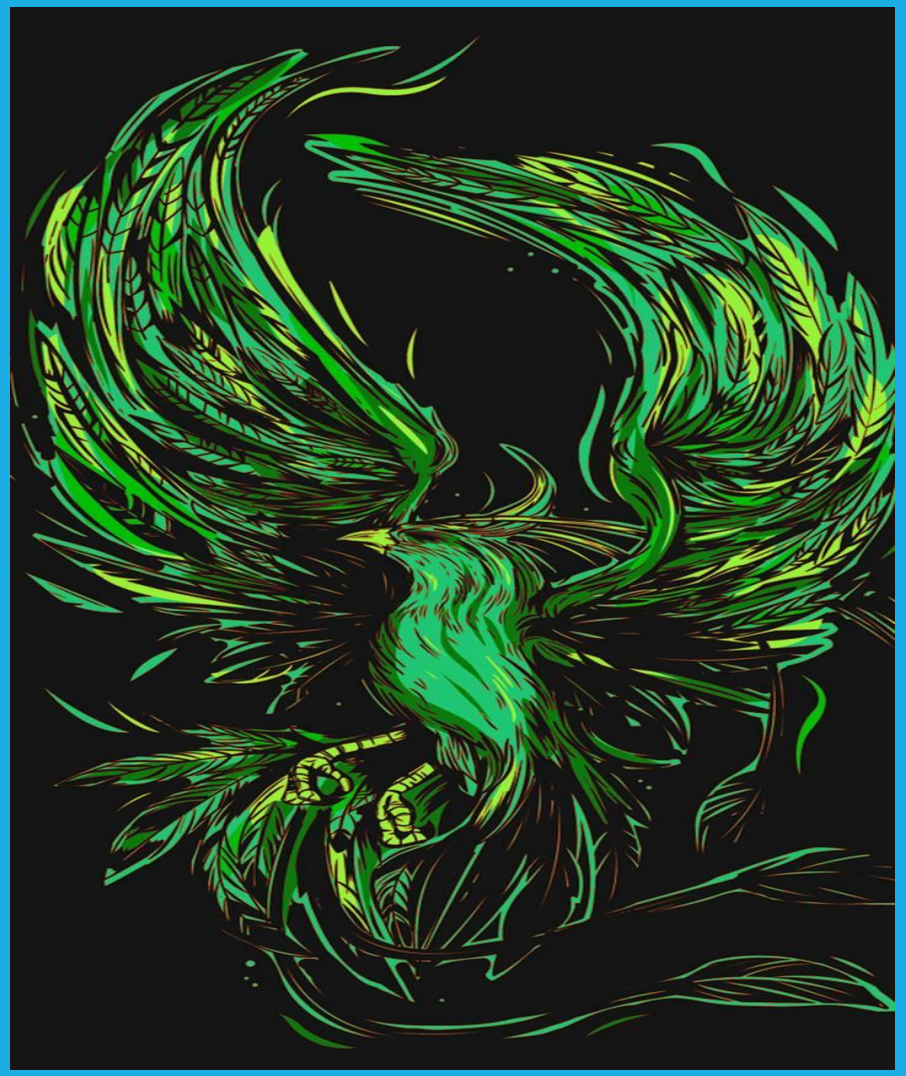
Goal Plan



Intervention(s) – Interventions for each team member. CDCA, Mental Health Therapist, Peer Support.

1. **CDCA will use motivational interviewing to elicit change talk through open-ended questions, exploration of discrepancies, reflective listening, and support.**
2. **Qualified providers will observe random urine drug screens, following agency protocol.**
3. **Therapist will facilitate processing of trauma history through use of time lines, reflective listening, narrative processing and provide support.**
4. **Therapist will assist client in improved sense of self through use of CBT, reflection of cognitive disortions, and introduction and rehearsal of open communication skills.**
5. **Peer Support will introduce Client to at least one pro-social activity per week, based upon client's interests and desired outcomes.**

Goal Plan

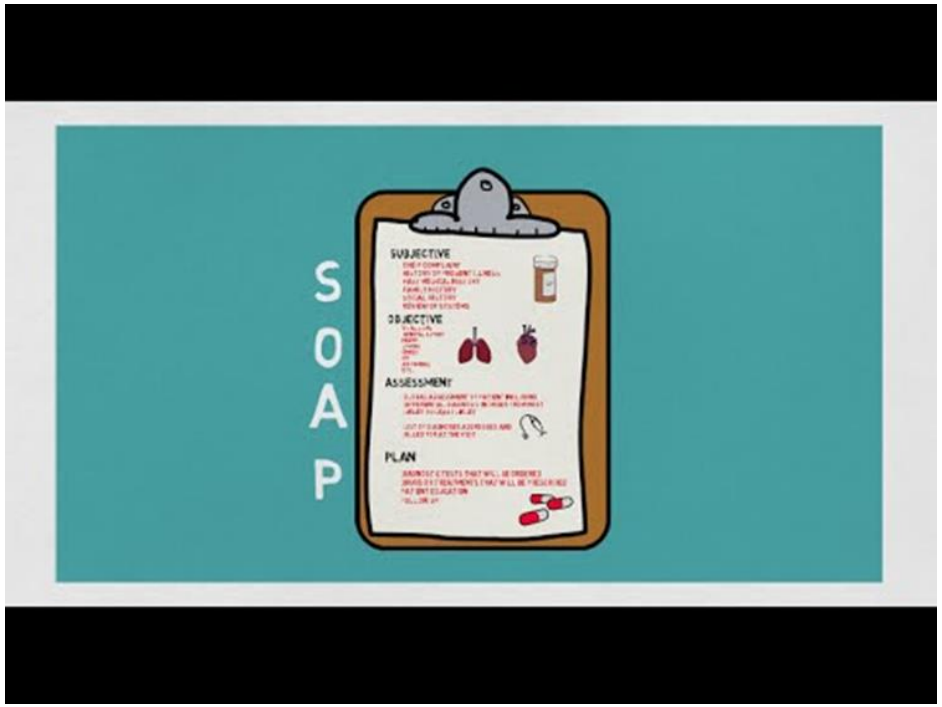


Coordinated care: Probation Officer

Client copy? Y / N If no, why?

SOAP:

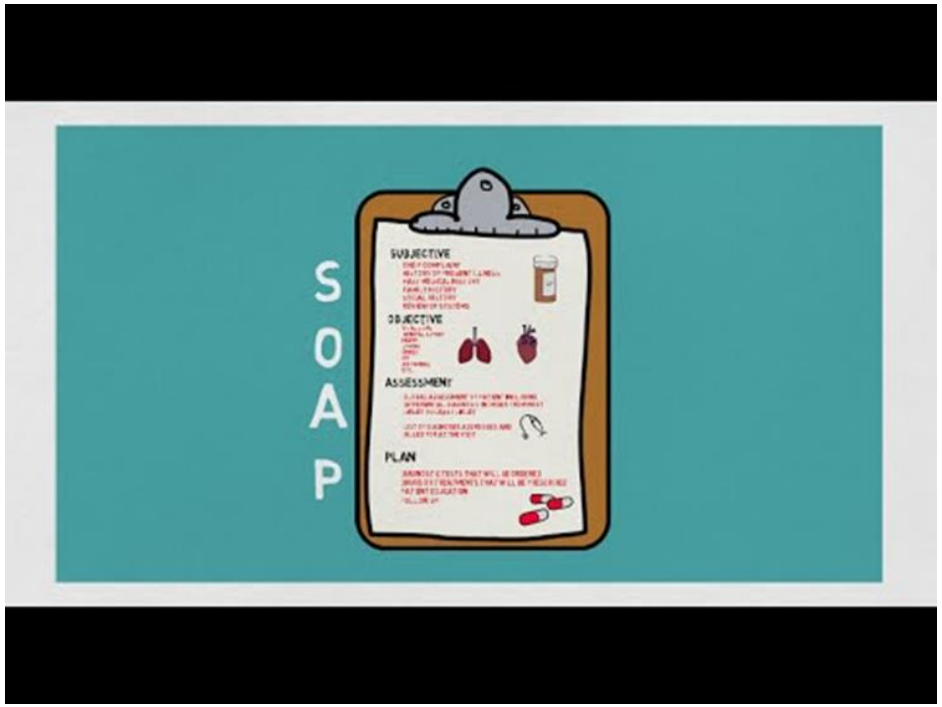
Subjective
Objective
Assessment
Plan



Subjective: Client statement, history of symptoms, family history, presenting concern.
Objective: Measurable – Screening tools, measurable progress toward goals. Client symptoms, mood and affect.
Assessment: Clinical interpretation of presenting symptoms, stressors, needs. Documentation of interventions provided, and client response. Diagnosis.
Plan: Next steps, dose and frequency.

SOAP:

Subjective
Objective
Assessment
Plan



Subjective: "The damn PO won't get off my back. Something about 'sober living not happening in a bar.'" Cl was referred to CDCA after an arrest related to a fight in a bar. Client reported fight was in response to gender identity persecution. Cl continues to participate in pool league at same bar. Cl reports PO has stated this will be considered a probation violation if Cl does not stop going.
Objective: Administered CAGE-AID. Score = 4. Random UDS administered preliminary results positive for Suboxone (prescribed), and THC.
Assessment: CDCA met face-to-face with Cl via Telehealth. Cl was at their home address in Ashtabula, OH. Cl denied others present in space. Privacy recommendations reviewed. CDCA facilitated processing, listened reflectively and provided support. Cl actively processed stressors. Presentation is precontemplative with some transition to contemplation. Explored discrepancies. Cl noted awareness that anxiety is elevated while at pool league, expressed fear of being attacked. Cl recognized conflict with not wanting where they go to be dictated by the actions of others.
Plan: F/U scheduled in one week. CDCA submitted weekly update to PO. Cl assigned complete pros/cons grid of continued pool league participation.

Data * Assessment * Plan

DATA: What happened in the session? Observations? (i.e. Client presentation) Goals Addressed? Interventions utilized.

ASSESSMENT: Evaluation of client's progress toward goals, perceived barriers, strengths, and needs. Note any screening results, if any. Client response.

PLAN: Follow-up recommendations, next appointment, stakeholder involvement, homework, if any.

Client met with CDCA face-to-face via Zoom. Client reported to be at home address in Ashtabula OH for appt. Cl prefers they/them pronouns. Cl stated they weighed pros/cons of continued participation in bar pool league. Cl stated, “My PO will violate me if I keep going, so that is a huge motivator to stop.”

CDCA met individually with Cl. Utilized MI skills to listen reflectively and elicit change talk. Reviewed homework with Cl. Cl presented as alert, and oriented. CDCA Assessed substance use since last session. Cl reported continued daily use of THC. Reported taking Suboxone as prescribed. Cl denied use of alcohol. Cl presented with increased motivation to find alternative recreational activities that will not interfere with probation.

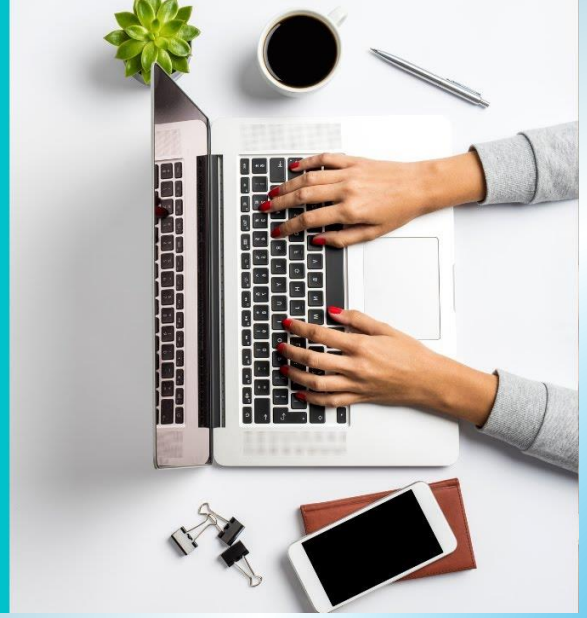
Client will schedule to meet with Peer Support to identify some pro-social activities that do not involve substance use. Client will try at least two activities prior to next session.

Next session scheduled for 2/22/2022 at 2:00pm.

CDCA submitted weekly progress report to Probation.

IGBIRP NOTES

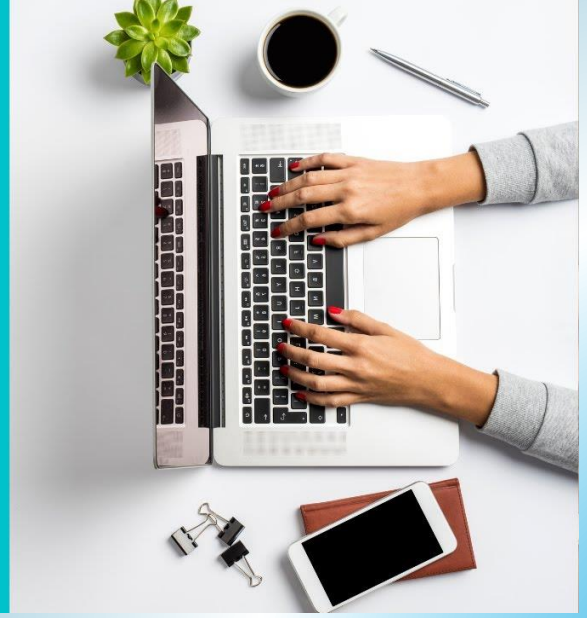
Introduction for Therapists



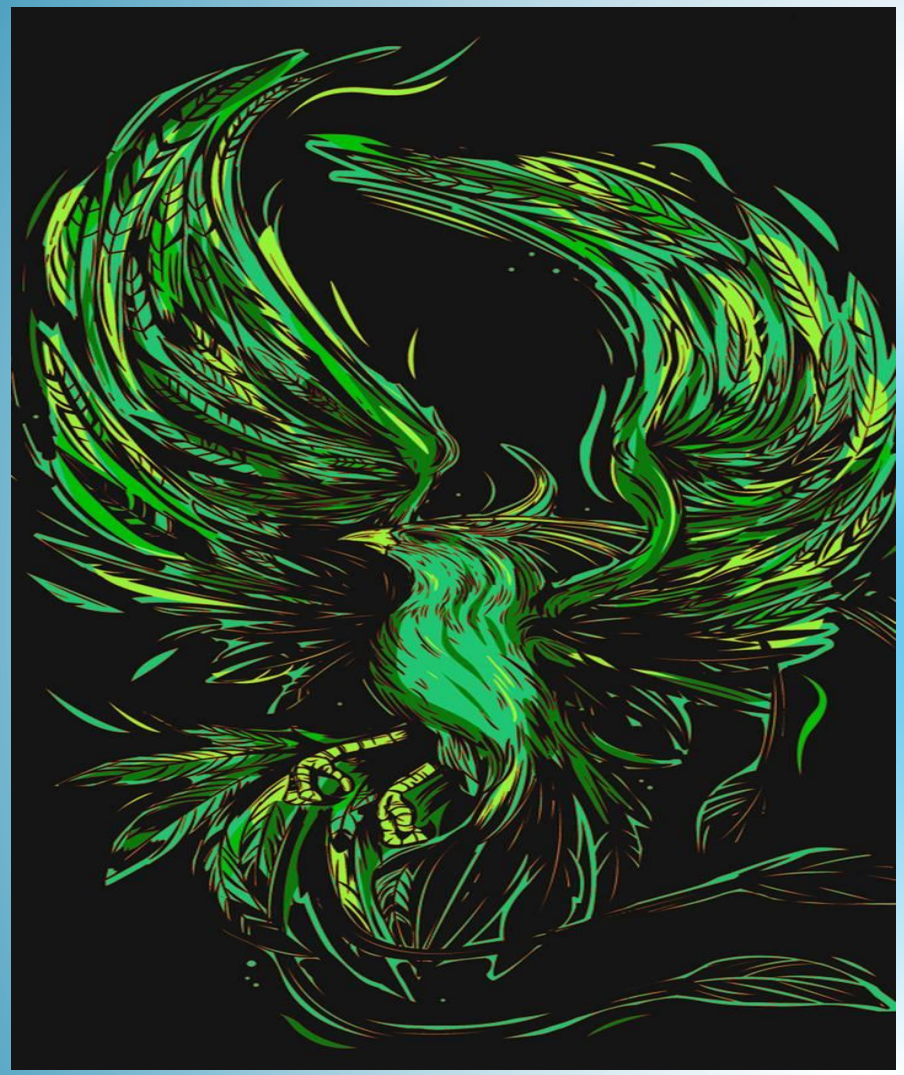
INFORMATION/INTRODUCTION: Presenting Symptoms, stressors, treatment needs, strengths. Client and support system input. Location, type, and time of service. Think "who, what, and where…"
GOAL(S): Objective, desired outcome, and progress noted. Think "why.."
BEHAVIORS: Cl mood, affect, presentation, and participation level.
INTERVENTIONS: Services provided. Think "how…"
RESPONSE: Client response, progress noted. Think "direct client quote…"
PLAN: Next session, stakeholder appointments, planned care coordination, and Client homework.

IGBIRP NOTES

Introduction for Therapists



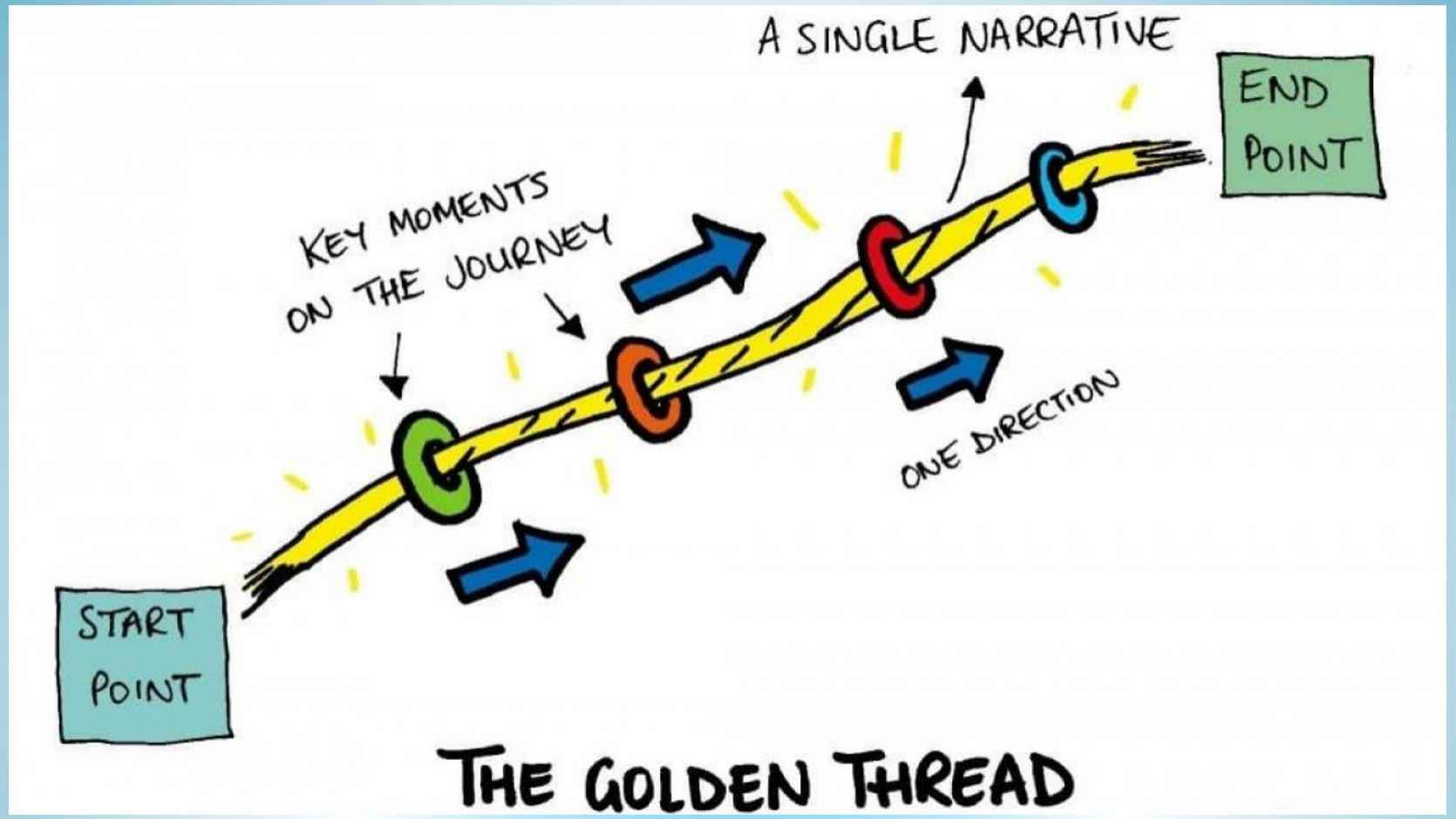
INFORMATION/INTRODUCTION: Met face-to-face with Client in office.
GOAL(S): "Living a life that will meet expectations and still be fun." Gain an understanding of expectations and demonstrate fun living within those expectations.
BEHAVIORS: Client presented with stable mood, bright affect, motivated to share experiences since last session.
INTERVENTIONS: CDCA used Motivational Interviewing open-ended questions to engage in exploration. Listened reflectively. Affirmed Cl insight. Explored discrepancies.
RESPONSE: Client expressed excitement. Shared that they met with Peer Support and learned about three sober leagues: Pool, bocce, and bowling. Cl stated they attended pool and "had a blast." **PLAN:** Next appt: 2/28/2022 at 2:00pm. Cl will follow random UDS protocol. CDCA will submit weekly update to client's PO by 2/24/2022.



Objective 3:

Person-centered, nonjudgmental documentation: 25 minutes.


REMEMBER WHY YOU STARTED
YOUR WORLD WITHIN



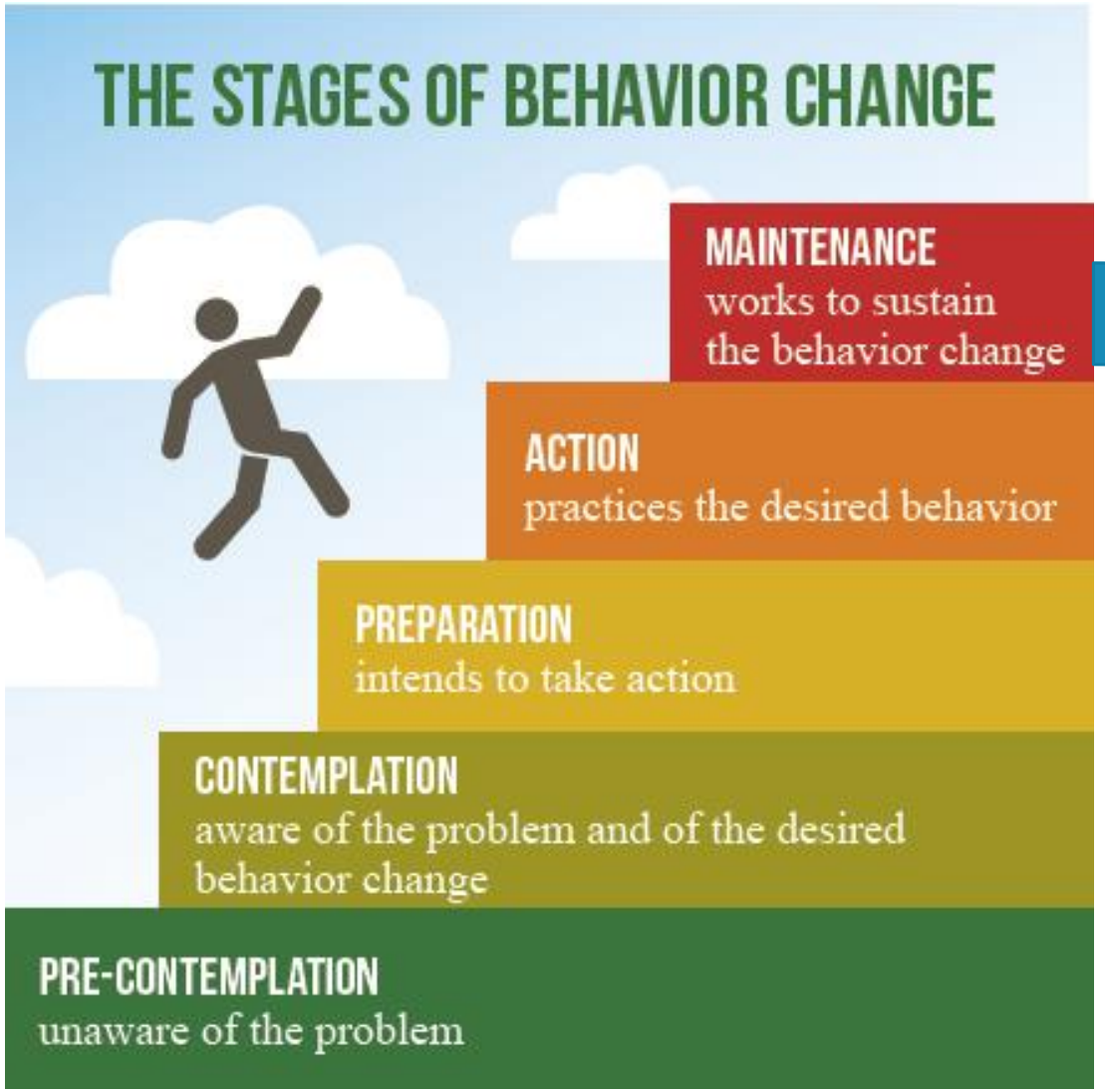
Assessment + Treatment Plan + Progress Notes = Golden Thread

Transition/Discharge Planning

- Starts at the beginning.
- Provides clear expectations.
- Identifies resources to assist in process.

Stages of Change

Transtheoretical Model (Prochaska and DiClemente)



Discharge

Relapse

American Society of Addiction Medicine (ASAM) Criteria

Level-of-care (LOC)

.5 Early Intervention

I. Outpatient Services

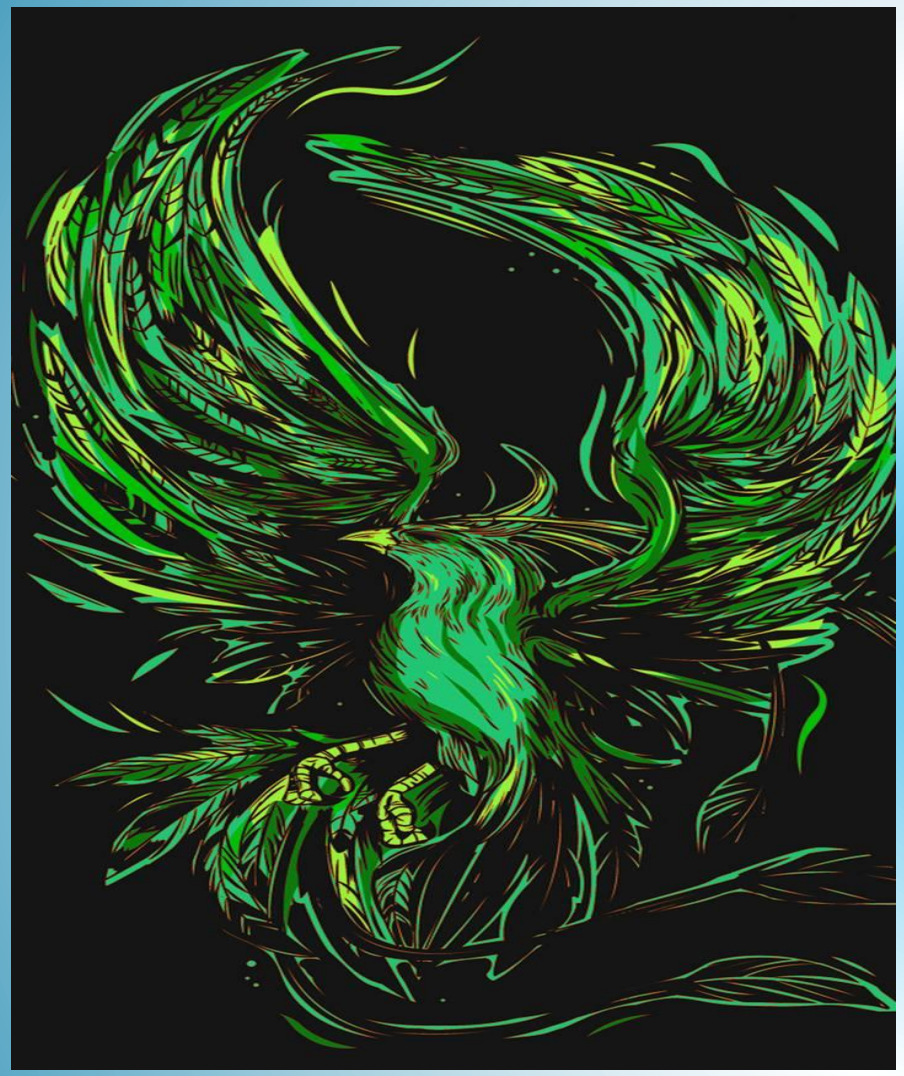
II. Intensive Outpatient Services/Partial-Hospitalization

III. Residential Treatment

IV. Medically Managed Inpatient

Person-First Language

- Person before diagnosis: Client has a history of alcohol use disorder, not Client is an Alcoholic.
- Person before disability/different ability: “Client has a diagnosed history of Autism,” not, “he is Autistic.”
- Non-stigmatizing: “Client reports alcohol use resulting in being charged with DUI,” not, “Client is a drunk driver and got arrested.”
- Informational, not judgmental: “Client reported he consumed six beers and three shots of whiskey prior to driving,” not, “Client chose to get drunk and drive.”



Objective 4:

Practical application breakout rehearsal and full-group discussion: 20 Minutes

Discussion: 15 minutes

References

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