

**Record Keeping:
Covering the Bases**

Yikes!

Records are for WHAT??

Supporting Good Treatment Only ONE Function of Records
The Function We Hate to Think Of:

What might I need for my self-defense?
Evidence relating to my client's life
Records to Justify Reimbursable Services

what do I
have to write down
to be legal??

Client name
Fee arrangement & record of payment
Dates of service
Disclosure form (w/ 2 signatures)
Presenting problems, purpose of counseling, or diagnosis
Notations & results or outcomes from formal consultations
Information from collateral parties (& ROIs)
Progress notes (appropriate to theoretical orientation)

Evaluate the Risk of
"Minimal Records"

Meet the "Basic Business" Requirements #1

Written statement of fees & policies
Cost per Unit of Service
Written Refund Policy
3rd Party Payor Policies

Meet the "Basic Business" Requirements #2

Dates of Service
Type of Treatment & Length of Session
Record of All Charges & Payments

Full record - 3 years

Full record or summary - 2 more years

Disposal no sooner than 15 years after completion of planned services or date of last contact
(whichever is later).

American Psych Assoc Record Retention Recommendation

Planning for the Future with Couples Charting

Couples Therapy / Conjoint Sessions

Individual w/ Conjoint Charting

Individual Therapy w/ Occasional Conjoint Sessions

Couple Charting

Couples Therapy / Conjoint Sessions + Occasional Individual Session

Couples Charting

Couples Therapy + Occasional Individual Sessions with Each Member of Couple

The Federal Government
Obfuscates Our Record Keeping Like they Do to Most Processes...

We now have "Designated Record Sets" &
A whole new take on "psychotherapy notes"

Psychotherapy Notes

Created by treating clinician

Not disclosed to anyone other than clinician who created them

Kept physically separate from treatment record

Cannot be disclosed to anyone without client's specific authorization

Authorization cannot be compelled for payment, underwriting, or plan enrollment.

Exceptions: defense against malpractice lawsuit and/or response to licensing authority (DOH regulatory process)

Sample "Psychotherapy Notes"

3/9/04

Ct sullen. Staring off & little eye contact. Punish me for not pursuing her hurt feelings ??

How can I keep her engaged w/o nurturing her acting out?

More Goth look! New piercing – she did it herself. (Looked like she liked it that I asked about it)

Think about bringing in parents sooner than first planned.

Dad looking at her to see what kind of mood after session.

Amorphous, Ambiguous
"Medical Necessity"

Symptom Description Consistent with Diagnosis

Presenting Sx =

Spontaneous, distressing violent thoughts and images that the client finds abhorrent and which cause the client significant distress, several times per week.

Daily uncontrollable need to return to the house after leaving for work to verify that the stove and coffee pot are turned off.

DX = ??

Addressing Medical Necessity

Case Example:

20 yro Ct came to TX to address question of whether she should seek out her bio parents. She had typical anxieties related to this situation: worries that her adoptive parents would feel betrayed, fears she might discover she had never been wanted, & that bio parents would reject her overtures now, fears about kind of people they are, etc.

Why is Ct's Treatment Really Necessary?

"Ct is obsessed by need to find her birth parents, is thinking about her search constantly, which has led to inability to concentrate on her schoolwork, and problems in educational functioning (i.e., missing classes to make calls to state & private adoption agencies, which can negatively affect her grades)."

Activities of Daily Living (ADLs)

Assistance Level

Self Care Skills

House Care / Chores / Domestic Skills

Cooking
Child Care
Financial Skills
Shopping
Transportation
Lifestyle

Regence Evaluation
Documentation Guidelines

Detailed explanation of why the client is seeking TX (subjective).

Pertinent info from other sources (e.g., parents, spouse, court psychological tests, referring physician/provider, medical history, pertinent family history, etc).

Mental Status evaluation, inclusive of objective observations of client's appearance, cognition & behavior.

Regence Evaluation
Documentation Guidelines

Medications and/or substances client is taking currently, including dosages, frequency, responses and prescribing provider.

Multi-axial assessment (as described in DSM-IV).

Regence Evaluation
Documentation Guidelines

Description of signs & symptoms upon which the primary diagnosis is based; should be evident in the documentation.

A treatment plan with measurable goals.

Regence Progress Charting Guidelines

Type of session
Session length
Identity & relationship of all present
Brief description of current mental/physical status
Focus of therapy for that session
Rationale for any changes to the treatment plan

Medicare Documentation Requirements
(90801 – Diagnostic Interview)

Presenting Complaint

Background info and history of presenting illness

Social and family history

Present evaluation

Clinical observations and detailed mental status exam

Assessment and recommendations including plan for future follow-up

Medicare Documentation Requirements
(90806 – Individual Psychotherapy)

Type of therapeutic techniques and approaches used

List of general topics addressed

Risk Factors

Briefly, how present session relates to therapeutic treatment goals

Think Symptoms

One Diagnosis at a Time

50 yro married male who enters TX describing depressed mood, weekly or bi-weekly anxiety attacks, lack of pleasure in response to a career he says he usually enjoys, disturbing lack of sexual desire, feelings of hopelessness about his future. Anxiety attacks have resulted in disrupted sleep cycles, time with his wife, and social interactions.

Depression or Anxiety as Initial Focus??

Attention to Risk

Any history of suicide attempt

Any family history of completed or attempted suicide

Current suicidal ideation w/o plan

Past history of aggressive or violent behavior

Poor impulse control

Child abuse

Elder abuse

Domestic Violence

Risks due to chemical dependency

Medical complications

Eating disorder

Defining the "Problem"

Identification of the symptom(s) being currently addressed in the therapy

For Example:

Difficulty accomplishing basic tasks of living

Decreased ability to focus on work

Unexplained feelings of anger and rage

Excessive nervousness and worry

Treatment Goal

A global long-term goal that indicates a desired positive outcome to treatment and is directly associated with the identified Problem.

Objectives

Incremental steps by which treatment goals are achieved.

Intervention

What the therapist does to help the client achieve the objective(s) and goals.

Outcome

The expected result of the intervention, (i.e., how the therapist will be able to identify that change has taken place).

Ten "Easy" Steps for writing a treatment plan

Key to Defining the "Problem"

Use the Sx list compiled in Step #1 (which matches the DSM criteria for the DX you have chosen) Describe the Sx as they show up in the person's life using language that contains observable / cognitive / excessive or deficit descriptors and descriptor terms for intensity and duration. (help in Appendix J)

Observable Excesses or Deficits as Tangible Measuring Devices

Observable / Cognitive Excessive
Descriptors

Observable Excesses or Deficits as Tangible Measuring Devices

Social withdrawal
Diminished interest
Poor Concentration
Loss of interest
Sleeplessness

Observable Excesses or Deficits as Tangible Measuring Devices

Prolonged Excitement
Persistent Delay
Consistent dread
Chronic Feelings of low self esteem
Pattern of daily drinking

Observable Excesses or Deficits as Tangible Measuring Devices

Strong feelings of
Easily distracted
Diminished interest
Predominating fear

Defining the "Problem"

The symptoms described must validate and support the Axis I Diagnosis

Include only symptoms of current treatment focus

Not appropriate to provide prolonged TX of other symptoms without revising the Dx or TX Plan

TX Plans are intended to be revised

Step #9 - Objectives

Behaviorally specific language
Description of incremental steps
Describe adaptive behaviors that result in symptom reduction
Expected to move client toward attainment of goal

Sample Objectives

Client will tell entire story of the abuse, identifying and expressing the feelings connected to the abuse.

Client will take medications daily as prescribed by MD; will use daily medication reminder case as needed.

Wording Objectives

Behaviorally specific objectives include indicators by which it will be known the client has achieved the objective, and ultimately the goal.

Example: When ready for discharge, client will report school tardiness once per month or less, and school will have taken him off probation in this regard.

Wording Objectives

Don't forget the phrase:

"...as evidenced by..." [AEB] and follow with description of means by which therapist will know progress has occurred.

i.e., "...as evidenced by crying episodes no more than one time per week"

Step #10 –

Describe what you intend to do to/with/for client to help them achieve the incremental steps listed in

Step 9:

For Goal #1

Explore symptoms, severity, & history of panic attacks

Explore nature of any stimulus, thoughts, or situations that precipitate panic

Encourage sharing of feelings from past through active listening, positive regard, and questioning

Reinforce insights into past emotional pain and present anxiety

Clarify and differentiate between current irrational fear and past emotional pain

Treatment Plan: Tony Soprano

Step #1 - Current Symptoms & Problems in Functioning:

Unexpected, sudden, debilitating panic symptoms (i.e., shallow breathing, sweating, heart pounding, dizziness, trembling, chest tightness, fear of losing control, fainting) that have occurred repeatedly resulting in significant anxiousness about having additional attacks, and interference of normal routines.

Step #2 - Areas of Life Being Affected

Occurrence of unpredictable episodes of panic and unconsciousness have disrupted CT's work plans with missed meetings, erosion of business relationships, etc., resulting in an increase in CT's perceived sense of risk.

Step #3 - Stressors Making Circumstances More Difficult

Bitter and selfish Mother

Violent Lifestyle

Threat of Power Struggle with Potential Lethal Consequences

Being on FBI Watch List

Tension in Marital Relationship

Step #4 - Axis I Diagnosis

300.01 – Panic Disorder without Agoraphobia

Step #5 - Risk Factors

Past & Present Aggressive & Hostile Behaviors

Poor Impulse Control

Child Abuse

Step #6 – Prioritize Problems

Step #7 - Definition of Problem

Make Use of SX List Compiled in Step #1 (that match DSM Criteria)

Describe SX as they show up in CT's life Using Language that Contains Excessive / Deficit / Duration / Intensity Indicators

(with a little help from appendix J)

#7 - Definition of Tony's Problem

Unexpected, sudden, debilitating panic symptoms (i.e., shallow breathing, sweating, heart pounding, dizziness, trembling, chest tightness, fear of losing control, fainting) that have occurred repeatedly resulting in significant anxiousness about having additional attacks, and interference

with normal activities.

Step #8 – Write Long-Term Goals that Indicate Desired Outcome

1. Reduce fear of the specific stimulus/situation that previously provoked immediate anxiety
2. Eliminate interference in normal routines and remove distress from feared stimulus/situation

Step #9 – Objectives for Goal #1:

Reduce fear of specific stimulus / situation that previously provoked immediate anxiety.

- 1.a. Describe the history and nature of the situations that evoked anxiety reaction
- 1.b. Identify symbolic significance that the stimulus/situation may have as a basis for fear
- 1.c. Share the feelings associated with past emotionally painful situation that is connected to the stimulus/situation
- 1.d. Verbalize the separate realities of the irrationally feared stimulus/situation and the emotionally painful experience from the past that has been evoked by the stimulus

Step #9 – Objectives for Goal #2:

Eliminate interference in normal routines and remove distress from feared stimulus/situation

- 2.a. Utilize deep muscle relaxation and deep breathing skills to terminate panic symptoms & return to a feeling of calm
- 2.b. Cooperate with medication evaluation and take medication as prescribed

Step #10 –

Describe what you intend to do to/with/for client to help them achieve the incremental steps listed in

Step 9:

For Goal #1

Explore symptoms, severity, & history of panic attacks
Explore nature of any stimulus, thoughts, or situations that precipitate panic
Encourage sharing of feelings from past through active listening, positive regard, and questioning
Reinforce insights into past emotional pain and present anxiety
Clarify and differentiate between current irrational fear and past emotional pain

Typical Interventions

Teach communication skills
Probe to identify triggers of anxiety
Confront avoidance of responsibility
Monitor medication compliance
Make a referral
Explore fears
Explore cognitive messages
Ask client to complete
Reinforce insights
Assign and process a list of changes
Assist client in developing...

Client Example

34 yro male who adamantly maintains there is "nothing whatsoever wrong with me, but I can't keep a job longer than 3 months."

Ct is professionally trained with a graduate degree. He would like to be licensed but the process requires sustained employment experience.

continued...

My Impression

Axis II "Stuff"
Paranoid Traits
Schizotypal Personality Traits

How to Proceed...

If I am to conduct "symptom-focused treatment" I need to focus this episode of treatment on specific manifested symptoms.

5-Axis Diagnosis

Axis I Diagnosis: Adjustment Disorder with Disturbance of Emotions & Conduct – Chronic

Axis II – Paranoid Traits

Axis III – None

Axis IV – Occupational Problems – inability to maintain employment

Axis V – 45 Current GAF

Symptoms & Problem Statement

Symptoms: Inability to hold a job; excessive feelings of resentment toward employers; theft of work products from previous employers.

Problem: Client reports inability to maintain employment beyond 3 months accompanied by fantasies that employers are intending to take advantage of him. Client reports he feels compelled to retaliate against employers by taking work products with him when he leaves employment.

Writing a TX Plan for "Roger"

50 YRO married male who enters TX describing depressed mood, weekly or bi-weekly anxiety attacks, lack of pleasure in response to a career he says he usually enjoys, disturbing lack of sexual desire, feelings of hopelessness about his future. Anxiety attacks have resulted in disrupted sleep cycles, time with his wife, and social interactions.

Using the 10 "Easy" Steps

#1 – What are current SX and/or problems in functioning?

Depressed mood
Diminished interest or pleasure in sex, work, relationships
Fatigue
Insomnia
Anxiety attacks
Feelings of hopelessness & guilt

#2 – Areas of Life Affected

Work
Interpersonal
ADLs
(exercise, yard work, etc.)

#3 - Stressors

#4 – Axis I Diagnoses

296.21 Major Depressive Disorder, Single Episode w/ melancholic Features, Mild

300.01 Panic Disorder w/o Agoraphobia

#5 – Risk Factors

Past Aggressive Behaviors

#6 – Priority of Problems

Depression
Panic Attacks

#7 – Definition of Primary Problem

Depressed mood every day, diminished interest in sex, job & relationships. Chronic fatigue and insomnia

Discrete periods of intense fear and discomfort with accelerated heart rate, sweating, trembling, chest discomfort, nausea, feeling light-headed, fears of losing control, sleep disruption & general irritability.

#8 – Long Term Goals

Goal #1 – Alleviate depressed mood and return to previous level of effective functioning

Goal #2 – Reduce overall level, frequency and intensity of anxiety so daily functioning is not impaired

#9 – Objectives

Verbally express understanding of the relationship between depressed mood and repression of feelings (i.e., hurt, anger, sadness, etc.)

Express feelings of hurt, disappointment, shame, and anger that are associated with early life experiences

Begin to experience sadness in session while discussing the disappointment related to the loss or pain from past

continued....

Objectives (continued)

Tell the story of the anxiety including ways he has attempted to resolve it

Identify major life conflicts from past & present

Complete physical evaluation for medications

Reduce overall level, frequency and intensity of anxiety so daily functioning is not impaired

Develop appropriate relaxation and diversion activities to decrease level of anxiety

#10 Interventions

Explore how depression is experienced in client's day-to-day living

Encourage sharing of feelings of depression in order to clarify them and gain insight as to causes

Explain connection between previously unexpressed (repressed) feelings or anger and helplessness and current state of depression

Interventions cont.

Encourage CT to share feelings of anger regarding pain inflicted on him in childhood that contributes to current depressed state

Encourage sharing of feelings of depression in order to clarify them & gain insight as to causes

Explore experiences from the CT's childhood that contribute to current depressed state

"Reporting Progress" Examples

Client began treatment reporting crying episodes daily, is now reporting tearfulness only three or four times per week

Client reports that panic attacks are still occurring daily, but that he is able to calm himself down somewhat more quickly, after only ten minutes as opposed to half hour or so.

Discharge Plan

Target Date for Each Objective

Never more than 3-4 months beyond date of TX Plan (with long-term client, repeatedly specify 3-

4 month time frames on each update of TX plan)

Narrative Discharge Plan

Write one sentence answering question:

“What kind of progress will client be exhibiting when [s]he is ready to terminate?”

Refer to achievement of goals “as listed above”

Plan is to gradually reduce frequency of sessions