

# **CLINICAL DOCUMENTATION AND RECORDKEEPING**

By: Hillel Bodek, MSW, LCSW-R, BCD  
Chairperson of the Committee on Ethics and Professional Standards  
and the Committee on Forensic Clinical Social Work  
New York State Society for Clinical Social Work, Inc.

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## **THE PURPOSE AND ROLE OF CLINICAL DOCUMENTATION & RECORDKEEPING**

Clinical documentation and recordkeeping requirements, often viewed as a chore, yet another burden heaped upon behavioral health care practitioners, are a familiar part of agency practice. However, the importance of clinical documentation and recordkeeping is often overlooked by behavioral health practitioners in private practice. A particular problem is that many behavioral health practitioners in private practice improperly eschew maintaining legally required adequate clinical records in order to avoid the possibility of having to disclose these confidential records at some later date if a patient requests them or if the patient becomes involved in legal action and places his or her mental or physical state at issue. However, legally mandated clinical documentation and record-keeping serve several important purposes, all of which are equally applicable to agency as well as private practice settings. The clinical record has an important place in assuring the quality of health and mental health services. Professional practice standards require that treatment must be based on a proper differential diagnostic assessment and must be implemented in a planned manner, which is reviewed periodically, with identified goals, methods, time frames, and criteria to measure its efficacy and appropriateness. The clinical record should document compliance with these basic practice standards.

### **The Legal Mandate for Clinical Documentation in New York State**

The Rules of the New York State Board of Regents defining unprofessional conduct define unprofessional conduct by a health care professional as including, "*failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years,*" 8 NYCRR 29.2(a)(3). In *Suslovich v. New York State Education Department, et. al.*, 571 NYS2d 123 (3rd Dept. 1991), a New York State appellate court affirmed a finding that a psychologist whose patient records consisted of copies of insurance claim forms and the notes he kept in his head, violated this regulation and upheld the suspension of the psychologist's license for professional misconduct. The court noted that, "*[t]he purpose behind the requirements that a proper record be kept for each patient is in part to ensure that meaningful information is recorded in case the patient should transfer to another professional or the treating practitioner should become unavailable. (emphasis supplied)*" 571 NYS2d at 124. Similarly, New York State's highest court, the Court of Appeals, has held that failure to comply with the Department of Social Service clinical documentation standard for Medicaid providers, that requires providers to maintain a record for each patient which, "*fully discloses the extent of care, services or supplies furnished,*" violates the clinical documentation standard as set forth in the Rules of the Board of Regents. *Camperlengo v. Barell*, 378 NYS2d 504 (1991).

## **Purposes of Clinical Documentation**

The seven key purposes of clinical documentation which, at times, overlap with each other, are:

**1) to document professional work:**

- to record what was done, by whom, with, to, for, and/or on behalf of whom, when, where, why, and with what results;
- to document assessment and differential diagnosis, treatment and other services provided, the patient's clinical course and clinical decision making (including assessment-based treatment and service planning and periodic reviews and modifications of the treatment/service plan); and

**2) to serve as the basis for organization and continuity of care of the patient by the practitioner:**

- to record clinically meaningful information that the practitioner can later rely on to refresh his or her memory of crucial events in treatment, the patient's response to treatment and other services, problems experienced in treatment, key historical facts and details of substantive collateral contacts;
- to create a longitudinal record of the history of the patient's complaints, symptoms, comorbidities, assessments, diagnoses, treatment and other services provided, clinical course, and response to treatment and other services so that the treating practitioner and other practitioners who are, or who later become involved in working with the patient can use this information to identify potential trends, guide their assessment and guide their development and implementation of their treatment/service plans;
- to provide a basis for practitioner reflection and self-supervision on the patient's evaluation, diagnoses, treatment and services, assessment-based treatment/service plan, clinical course and progress; and

**3) to serve as the basis for subsequent continuity of care of the patient by recording for use by other practitioners who may serve the patient in the future clinically meaningful data regarding the patient's:**

- assessment, diagnoses, treatment and other services provided, clinical course, progress and response to treatment and other services;
- assessment-based treatment and service plans and the periodic reviews and modifications of those plans; and

- trends, crises and problems in treatment, so that they may have sufficient data based upon which they can provide meaningfully clinically informed continuity of care to the patient;
- 4) **for risk management purposes to protect against malpractice lawsuits and professional discipline complaints, and to aid in defending effectively against any such lawsuits or complaints; *(in this regard, be aware that if you didn't document something of importance contemporaneously in the patient's clinical record and that becomes the subject of contention in a legal or disciplinary proceeding against you, it can be treated by a court or administrative body as if it did not happen or you missed it or you ignored it or you did not address it, etc., all of which may well enure to your detriment in such proceedings):***
- to document informed consent (i.e., for treatment, disclosure of information) and the nature and extent of the professional relationship and of duty owed with regard to the patient;
  - to explain, detail and justify professional decision-making, problems encountered in working with the patient, and the professional response to crises and other special or problem situations;
  - to record the details of supervision/consultation obtained in relation to the assessment and treatment of the patient, particularly with regard to crises or other special or problematic situations that arise;
  - for supervisors (who, under the legal doctrine of *respondeat superior*, are legally professionally responsible and accountable for the professional services provided by their supervisees) to document each of their supervisory sessions, each of their contacts with the patients whose care they are supervising, and their oversight of the assessments, treatment and other services rendered by their supervisees under their supervision in order to enable them to defend the quality and appropriateness of their supervision and the quality of their supervisee's professional work against any malpractice lawsuit or professional discipline complaint alleging negligent supervision or malpractice by them or their supervisee;
  - to record information that will support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan and the application of professional skills and knowledge in the provision of professional services; and
  - to substantiate the treatment/services provided and the results of such treatment/services;

**5) to comply with legal, regulatory and institutional requirements**

- to assure compliance with clinical documentation and recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations and rules;
- to assure compliance with clinical documentation and recordkeeping standards set by specific accreditation programs (i.e., JCAHO) and by health care institutions, facilities and agencies; and
- to fulfill clinical documentation and recordkeeping requirements of various third-party payers (i.e. Medicare, Workmen's Compensation, Medicaid, insurance, managed care plans);

**6) to facilitate quality assurance and utilization review**

- to record professional activities, the process and substance of assessment, differential diagnosis, treatment and service planning, clinical decision-making and the results of treatments and other services provided;
- to document the appropriateness, clinical necessity and effectiveness of treatments and other services provided;
- to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services;
- to facilitate supervision, consultation and staff/professional development;
- to help improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be undertaken to improve and assure the quality of care;
- to provide data for use in planning educational and professional development activities, policy development, program planning and research in agency settings;
- to provide data to guide choices of continuing professional education programs to attend, ongoing review and revision of the organization and operation of the practitioner's professional practice and research in private practice settings; and

**7) to facilitate coordination of professional efforts by fostering communication and collaboration between members of the treatment team**

- to assure coordinated rather than fragmented treatment/service delivery; and

- to assure appropriate utilization of team members from multiple disciplines in order to bring to bear collaboratively in an interdisciplinary/transdisciplinary manner the particular competencies of team members from various disciplines and/or who have specific specialties to maximize the quality of services to patients.

## **The Role of Clinical Documentation in Quality Assurance**

Writing up appropriate initial assessments and proper progress/session notes requires thought and reflection. Having to prepare proper clinical documentation serves an important role of helping assure quality patient care by making practitioners think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work and weigh alternative approaches to the care of their patients. The capacity for professional self-reflection and self-appraisal of one's professional work is essential to a practitioner's professional development, to the maintenance of his or her professional skills and to the provision of high quality clinical services. Rather than viewing clinical documentation as a meaningless chore that consumes precious time, practitioners should view it in this light, as a form of self-supervision that is an essential element of their professional practice and of their provision of quality clinical services.

## **ELEMENTS OF GOOD CLINICAL DOCUMENTATION**

Good clinical documentation should reflect the gathering, recording and analysis of clinical information in a manner that facilitates its use to carry out the purposes of clinical documentation as detailed above.

### **Elements of Good Clinical Documentation - Recording & Organization**

Clinical documentation should be recorded and organized as follows:

- 1) Each page of a patient record should have the patient's name clearly printed or typewritten on the top.
- 2) **ALL entries in the patient record should be signed** (either in handwritten form or electronic form) **by the practitioner making the entry.**
- 3) Entries in the patient record should be written contemporaneously with the events they are documenting.
- 4) Each entry in a patient record should be dated the day it is written.

- 5) If an entry in a patient record documents an interview, therapy session, missed session, any follow-up of the missed session, assessment or other substantive patient related collateral contact (i.e.; with another treating practitioner, with a family member, with the parents of a child who is in treatment) that took place earlier than the day the entry is written, the entry should include clear documentation of the day the activity being documented occurred.
- 6) Any materials or information received regarding a patient which are entered in the clinical record should be dated and initialed on the day the information or material is initially reviewed and placed in the patient record. Additionally, a progress note should be written to document the review of the material or information and any action taken as a result of that review.
- 7) All substantive collateral contacts with others relating to the patient and all referrals made relating to the patient should be documented contemporaneously in the patient's clinical record. Timely follow-up on any referral made should be documented in the patient's clinical record.
- 8) The record should be kept neatly, in date order for each section, in at least the following sections:
  - a) basic contact and demographic information about the patient,
  - b) intake information including demographic and contact information about the patient,
  - c) progress notes, initial and interval updates of treatment/service plans and closing/termination summary,
  - d) referrals made, tests requested, and the reports of consultations, referrals or test results which are received,
  - e) communications with other practitioners received or sent relating to the patient,
  - f) non-professional correspondence to or from the patient or from non-professional collateral contacts,
  - g) billing records including copies of bills provided to patients, claims submitted to third-party payors, correspondence with patients and third-party payors relating to billing and payments,
  - h) a chronological financial ledger by date:
    - (1) of services rendered - with the following information for each service [including separate services rendered on the same day]: date of service(s),

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description of service(s) with CPT [Current Procedural Terminology] codes, if the charge for a service is based on time spent the amount of time spent, and the charge(s) for the service(s);

(2) of financial transactions with the following information, the date and amount of the financial transaction, the nature of the transaction [payment, payment of coinsurance, denial of payment in whole or in part by third-party payor, etc.], the source of the transaction [patient, parent or guardian of patient, insurance or managed care third-party payor, etc.], write-off of charges and reason, and

(3) running outstanding balance; and

- i) documents relating to HIPAA compliance, informed consent for treatment documents, consents and authorizations for use and/or disclosure of clinical information and records, etc.

### **Elements of Good Clinical Documentation - Writing**

Clinical documentation should be written in a manner that is well organized and that allows rapid location, recovery and utilization of clinical and other information about the patient. Writing good, useful clinical documentation requires thinking about and reflecting on the event(s) being documented in the context of the patient's history and condition, the treatment and services being provided, and the patient's treatment/service plan. In this regard, good clinical documentation:

- 1) provides relevant information in appropriate detail;
- 2) is organized with appropriate headings and logical progression;
- 3) is thoughtful, reflecting the application of professional knowledge, skills and judgement in the treatment/services provided;
- 4) is appropriately concise;
- 5) serves the purposes of clinical documentation (as outlined above) that are applicable to a given situation;
- 6) uses relevant direct quotes from the patient and from other sources identified as such by utilizing quotation marks;
- 7) distinguishes clearly between facts, observations, hard data and opinions;
- 8) states the source(s) of the facts, observations, hard data, opinions and other information being relied upon, and provides an assessment of the reliability of that material;



- 9) is internally consistent; and
- 10) is written in the present tense, as appropriate.

### **Elements of an Appropriate Initial Assessment & Treatment Plan**

An initial differential diagnostic assessment, **which may be abbreviated or elongated depending on the circumstances of a particular case**, provides the basis for the development and implementation of the treatment plan. In clinical practice the lack of a proper clinical assessment is likely to result in less than optimal and, perhaps inadequate or inappropriate treatment. Thus, the failure to conduct an appropriate differential diagnostic assessment or to develop an appropriate treatment plan is a serious deviation from the standard of care owed by a clinician to a patient. The conduct and documentation of a proper initial assessment, and the development of an initial treatment plan includes:

- 1) identification of the referral source(s), gathering information about the background and reasons for the referral and assessing the patient's response to and expectations with regard to the referral;
- 2) defining the presenting problem(s) and what the patient wants to accomplish in treatment, both in the patient's own words using appropriate quotes (identified by using quotation marks), as well as in terms of the practitioner's perception of the presenting problem(s) and needs of the patient;
- 3) detailing the history and clinical course of presenting problem(s) and the details of treatment or services the patient has sought or received to deal with those problems in the past (either in the long term or in the immediate past);
- 4) gathering and documenting **relevant history** from the patient and from collateral sources, in appropriate detail, by topic, identifying the sources of such historical information and assessing the reliability of the information, regarding:
  - a) family history including a list of family members in families of origin and procreation and basic demographic information about them (i.e., age, birthplace, education, occupation, age, and cause of death if applicable), a brief description about their relationship with the patient, marital history, and any family history of mental, neurological, substance abuse/alcoholism or serious medical problems;
  - b) medical history including details of serious or chronic ailments, hospitalizations, serious physical trauma and/or surgery, allergies or adverse drug reactions; any physical disabilities and how the patient has and/or is coping with them; any chronic medications and all current medications including OTC drugs, supplements, herbs and other alternative treatments, and information about their relationships and feelings about past and current treating practitioners;

- c) psychiatric history including details of mental health symptoms, diagnoses and treatments, hospitalizations (including whether voluntary or not), what precipitated or triggered the symptoms, treatment or hospitalization, and the patient's response to prior mental health treatment (including response to and side effects of particular psychotropic medications that have been prescribed), prior psychotherapy and/or psychopharmacotherapy and the patient's response to and feelings about psychotherapy and/or psychopharmacotherapy; history of treatment compliance and non-compliance (if patient left treatment, why he or she did so and with what results), details of the degree of the patient's mental disability and how the patient is coping with this; and information about their relationships and feelings about past and current treating mental health practitioners;
- d) history of alcohol and other substance abuse and alcoholism and substance abuse treatment including, for each substance of abuse, including alcohol, the substance, the first and most recent use of the substance, the route(s) of use, the amount used/time period (i.e., \$10 of crack/day, five 40oz cans of beer/weekend), the frequency of use (i.e., steady on a daily basis, bingeing once every three of four weeks for one to three days) the duration of use, any significant periods of abstinence (including how these were achieved and why they ended), the social context of the substance abuse (i.e., alone, sharing with others, only at parties), identified triggers for the substance abuse, treatment programs attended (which ones, when and for how long, what the patient liked and disliked about the program, what the patient felt that he or she accomplished and did not accomplish in the program, and whether the patient completed the program successfully, if not, why), and the biopsychosocial impact of the substance abuse on the patient and his or her significant others;
- e) child and adolescent developmental history including family and peer group relationships, home life, socio-economic status, schooling, parenting and discipline, type of neighborhood and housing, learning disabilities and other developmental delays (in children and young adolescents a more detailed developmental history is usually indicated);
- f) educational history including level of academic achievement, academic strengths and weaknesses, relationships with teachers, history of being denied regular promotion, placement in special education or other special educational programs, school behavior including any suspensions, expulsions or school transfers;
- g) history of occupational training/skills and work history including significant employment, work related difficulties, how the patient views his or her work, the patient's career goals, general salary information and adult economic status;
- h) history of interpersonal relationships including the nature and extent of peer group relationships, marriages and other close relationships over the life span, what has

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kept or keeps these relationships functioning, why and how these relationships end, the patient's reactions and feelings about the end of close interpersonal relationships, the nature and type of any significant interpersonal problems the patient has had or is having;

- i) history of past and current social support systems including the nature and impact of these or the lack of these on the patient's development and functioning;
  - j) juvenile and criminal justice history including the nature of any arrests, convictions and any sentences imposed, and history of patterns of antisocial behavior;
  - k) history of sexual relationships or psychosexual problems and issues including sexual orientation issues and any sexual dysfunction;
  - l) history of religious affiliation and practices and issues relating to religion;
  - m) spirituality (aside from religion) including the values, thoughts, emotions, motivations, needs, dreams, experiences, assumptions and relationships that make the person a unique individual, and provide him or her with the vitality, drive and determination to develop and function as a fully actualized person;
  - n) social issues his or her functioning in relation to other persons and his or her environment including, but not limited to interpersonal and social relatedness, skills and capacity; behavioral responses to environmental, mental and emotional events and stimuli; responsiveness to the environment and to other persons; adaptive functioning and behavior; stress and frustration tolerance and impulse control; linguistic and communicative functioning; social judgement; and the influences of age, culture, customs, disability, discrimination, economic factors, gender, geographic and other environmental factors, health status, illness, injury, loss, national origin, pain and suffering, politics, race and religion his or her development and functioning; and
  - o) history of physical, emotional or sexual abuse or other victimization including where and when these occurred, the patient's view of the impact of these on his or her life, whom the patient told about these events and the response of people who learned about these occurrences.
- 5) describing the practitioner's observations of the patient and the results of a **mental status examination** which generally includes an assessment (**which may be abbreviated depending on the patient's presentation**) of the following:
- sensorium (attention, concentration, orientation, memory, intelligence, cognition and learning);

- appearance, eye contact with practitioner, and psychomotor functioning;
  - the form, nature and quality of speech and other communication;
  - mood, feelings, affect and emotions, suicidality and violence potential;
  - the form, nature, process and content of thought, and perception;
  - attitudes, motivations and behavior;
  - stress and frustration tolerance and impulse control;
  - ego functioning and ego defenses;
  - adaptive functioning and behavior;
  - sense of self, autonomy and competence;
  - interpersonal and social relatedness, skills and capacity (object relations);
  - other specific symptoms (hallucinations, obsessions, compulsions, phobias, hypochondriacal ideation, somatization, dissociation, etc.);
  - patient's self-assessment of his or her strengths and weaknesses; and
  - reality testing; insight, and judgement.
- 6) gathering information about the patient's current/recent general physical health (including any current or recent symptoms or health problems and any current or recent health care treatment);
  - 7) detailing prior clinical services, the background and reasons for which those services were sought and provided, the results of such services and the reason(s) for termination of those services;
  - 8) making a differential bio-psycho-social diagnosis using all five DSM-IV-TR axes, and an assessment of the patient in functional as well as diagnostic terms, which distinguishes between observations, hard data and opinions, sets forth the support for generalizations and conclusions in the assessment, and makes a determination about the practitioner's degree of confidence in the assessment;
  - 9) an assessment of whether the patient poses a risk of decompensation, suicidality, assaultiveness, homicidality, relapse back to alcoholism or substance abuse, inability to care for himself or herself, of being victimized, of victimizing others, or is at any other

serious risk; include the basis for the risk assessment, details of the steps taken at intake to address any of these risks, and the results of those steps;

- 10) developing an initial differential treatment/service plan with identified short-term goals and longer-term objectives, methods to be used, time frames and standards to measure treatment progress in functional terms, with a rationale for prioritizing of treatment goals and for the choice from among various treatment alternatives and strategies; the plan may include services from other providers, in which case these should be identified by function and/or name, and the services to be provided by them specified;
- 11) an assessment of prognosis with supporting rationale; and
- 12) describing the patient's response to the assessment and to the proposed treatment plan and, if the patient agrees to proceed with that plan, documenting informed consent for implementation of that plan.

### **Elements of Documentation of a Treatment Session**

The ongoing provision of clinical social work services should be documented, keeping in mind the seven key purposes of clinical documentation and the ten elements of good clinical documentation set forth above. Depending on the evolving circumstances of each case, certain purposes of documentation will be more crucial than others at various points in treatment. For instance, if a patient's mental status deteriorates and he or she becomes threatening, the purpose of carefully documenting the practitioner's professional response and clinical decision-making and the purpose of risk management/malpractice protection will predominate. In a case where a patient who has significant medical, family and mental health problems is being served by several different practitioners, documentation dealing with coordination of the professional efforts of the various practitioners will predominate. A proper progress note, which need not be particularly extensive, in most cases merely several sentences, should include:

- 1) the date and length of the contact;
- 2) the specific services provided, including CPT [Current Procedural Terminology] descriptions and codes; in the case of other non-clinical services (i.e., case management, advocacy, referral, etc.) indicate the service(s) in words;
- 3) description of the type of contact (i.e.; in person, telephone, mail);
- 4) indication of who initiated the contact (i.e.; regularly scheduled session, patient showed up without appointment, phone call by patient, phone call by patient's family who put patient on the phone, inquiry from another practitioner/service provider who is with the patient in the emergency room and puts the patient on the phone);

- 5) statement of where the contact took place (i.e.; office, if a home visit - the address visited, if by phone - the phone number called);
- 6) indication of who, besides the patient, was involved in the contact (i.e.; patient, family, other practitioner, friend);
- 7) a description of the themes of the session, in generic terms, addressing particular symptoms, feelings, thinking, beliefs or behaviors (i.e., pain, anxiety, dysphoria, suspiciousness, avoidance, etc.) or relating to specific relationships or situations (i.e.; work problems, interpersonal relationships, parent-child problems, marital relationship, school problems, the effects of chronic physical illness);
- 8) an assessment of the patient's mental status during the session, relating this to the patient's baseline mental status and the patient's mental status in the recent past;
- 9) notation of any symptoms or complaints that may indicate a physical health problem (i.e., side effects of psychotropic medication, sleep problems, confusion);
- 10) description of any new significant history obtained;
- 11) description of relevant problems newly identified;
- 12) description of relevant significant new events (i.e., changes in medication, results of tests, exacerbation of a concurrent physical ailment, break-up of a relationship, beginning new relationship);
- 13) description of therapeutic interventions with clinical justification and reasoning to support these in relation to the treatment plan and clinical circumstances, particularly when in response to crisis situations or special/markedly changed circumstances;
- 14) statement of what was accomplished in the session;
- 15) statement of what wasn't accomplished in the session that needs to be followed up on;
- 16) details of obstacles to progress in treatment, if any, and a plan to address these; and
- 17) a description of a plan for further care or follow-up (including date and time of next appointment), changes in diagnosis and/or treatment plan/goals, if any, and reasoning to support these changes (particularly when in response to crisis situations or special/markedly changed circumstances) and any referrals made or testing ordered (including the nature of the referral, to whom the referral is made, the reason for the referral, tests ordered and the reason they were ordered, and the patient's response to the referral and/or ordering of tests).

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## **Elements of an Appropriate Interval or Closing/Termination Summary**

An interval or closing/termination summary, **which may be abbreviated or elongated depending on the circumstances of a particular case**, documents the practitioner's thoughtful reflection on the clinical course of the patient's treatment (to date in relation to an interval summary, or with regard to the entire period of treatment in relation to a closing/termination summary). Such summaries can be useful if the patient later seeks treatment from another practitioner and requests that a summary be sent to that practitioner. The documentation of a proper interval or closing/termination summary, includes:

- 1) the dates the patient was referred, first contacted the practitioner and was first seen, the referral source, and the time period covered by the summary (if this is a closing/termination summary, the date the patient was last seen and the last contact with the patient);
- 2) a synopsis of the initial reason for and background circumstance of the referral, the presenting problem(s) from the patient's perspective at intake, the patient's initial clinical presentation, and the initial assessment, including the initial diagnoses and initial identified problems as identified by the practitioner;
- 3) a review of the problem areas and symptoms addressed in treatment, the treatment modalities used, of the patient's clinical course in treatment during the treatment period in question (noting changes, if any, in the patient's symptoms, thinking, emotions, beliefs, behaviors and other areas of biopsychosocial functioning), and of the extent that the identified symptoms/problems were resolved and the treatment goals established were achieved during the treatment period in question; a brief assessment of the patient's condition at the end of the time period in question; and, if this is an interval summary, a notation explaining any changes in diagnosis, prognosis, or the treatment/service plan;
- 4) a summary of any concurrent treatments, including the provider(s) of such treatments, the names and dosages of medications prescribed, other treatments rendered or any other relevant assessments performed; the steps taken to coordinate care with other practitioners (including the extent and success of achieving collaboration, or any problems that interfered with collaborative efforts), the results of any referrals made or testing ordered, and the impact/results of the other concurrent treatments;
- 5) if this is a closing/termination summary, a statement regarding the circumstances of the termination of treatment (precipitants, was it planned or unplanned?, was it mutually agreed upon by patient and the practitioner?, did the patient stop coming and, if so, what steps were taken to address this and with what results);
- 6) if this is a closing/termination summary include final diagnoses and a statement as to the patient's functioning, as well a statement as to which, if any, of the concurrent treatments (including medication) the patient is receiving the patient intends to continue (if so, from

whom and to what extent) and does not intend to continue (if so, what are the patient's reasons for discontinuation of those services);

- 7) if this is a closing/termination summary include a statement detailing any referrals or recommendations provided to the patient regarding further care, and the patient's response to such referrals and recommendations; and
- 8) if this is a closing/termination summary include a statement of whether the patient poses a risk of decompensation, suicidality, assaultiveness, homicidality, relapse back to alcoholism or substance abuse, inability to care for himself or herself, of being victimized, of victimizing others, or is at any other serious risk at the time of termination/closing, the basis of the risk assessment, details of the steps taken to address any of these risks, and the results of such steps.

## ORGANIZING CLINICAL DOCUMENTATION

### The General Medical/Clinical Record Contrasted with Psychotherapy Notes

HIPAA does not alter the requirements for clinical documentation and recordkeeping established by New York State law, regulation and court decisions, as well as by federal statutes and regulations which govern the operation of certain federal health care benefit programs. The elements of clinical documentation noted above remain the standard for information that, **consistent with the type of case**, should be collected and recorded by behavioral health practitioners. However, HIPAA has made provisions for the way that some mental health related material may be recorded and organized in order to provide greater protection for the privacy and confidentiality of some of the material obtained during counseling and psychotherapy sessions.

The passage of HIPAA and the promulgation of the HIPAA Privacy Regulations have impacted on how some mental health information may be recorded and how mental health records may be organized. In this regard, HIPAA provided that psychotherapy notes, "are held to a higher standard of protection because they are not part of the medical record and are never intended to be shared with anyone else." **Psychotherapy notes** are defined in the HIPAA Privacy Regulations as, "notes recorded [in any medium] by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and **that are separated from the rest of the individual's medical record.** **Psychotherapy notes exclude** medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date."



HIPAA does not require mental health practitioners to keep “psychotherapy notes,” as defined above. It merely provides that if a mental health practitioner maintains notes of the information covered in the definition of “psychotherapy notes,” and maintains those notes physically separate from the patient’s general medical/clinical record [which general medical/clinical record is required to be maintained under New York State laws and regulations and the regulations governing various federal health care benefit programs], those notes are subject to special confidentiality protections.

Under HIPAA regulations, **a behavioral health provider who is a covered entity under HIPAA must obtain an authorization for any use or disclosure of psychotherapy notes, to carry out treatment, payment or health care operations, except for** (a) use by the originator of the psychotherapy notes [the treating therapist who created the notes] for treatment, (b) use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (c) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the patient. **Also, a health plan may not condition the enrollment of the patient in the plan or a patient’s eligibility for plan benefits on receiving an authorization from the patient for disclosure to the plan of the patient’s psychotherapy notes.**

The HIPAA dichotomy between the general medical/clinical record and psychotherapy notes is not inconsistent with the New York State’s recordkeeping and clinical documentation requirements for health care providers. **The information that is kept in the general medical/clinical record, is material that is necessary to assure continuity of care if the provider is not or will no longer be available, and to fully document the extent of care, services and supplies furnished.** This includes: diagnoses (including the details of the patient’s history, clinical course, symptoms and functioning needed to support the diagnoses); details regarding the patient’s history, symptoms and functioning needed to document the patient’s clinical course during treatment; the therapeutic interventions used and the patient’s response to them; the identified problems that are the focus of the treatment plan; the evolving short-term goals and long-term objectives of treatment in terms of improving mental, emotional, behavioral, and physical functioning, addressing and resolving biopsychosocial issues, symptoms and dysfunction, and addressing the impact of and resolving various types of events in the patient’s life history; and, prognosis (including the details of the patient’s history, clinical course symptoms and functioning that support the prognosis). Additionally, the general medical/clinical record includes results of tests and consultations, clinical information obtained from other providers, and material gained through collateral contacts.

**Psychotherapy notes document the actual detailed, highly personal and private material elicited in the therapy or counseling session, which information the patient never intended to be shared with anyone else, and the therapist’s analysis of that material.** This material is often helpful to the therapist in treating the patient over time, but is not necessary to assure continuity of care in the absence of the therapist. This material is also not necessary to document adequately the patient’s diagnosis and prognosis and the basis of

those assessments, the evaluation and treatment of the patient, the services provided, the necessity of those services, and the treatment plan, all of which can be accomplished using the information contained in the general medical/clinical record. Process recordings are one of the most common forms of a “psychotherapy note” as that term is defined in HIPAA.

### **Organizing the Patient Record**

The patient record should be organized into various sections. This has been and remains the manner in which records are kept in hospitals, clinics and other health care agencies, as contrasted with the manner in which records have been kept in individual practices, particularly by behavioral health practitioners.

The practice of maintaining patient records in spiral notebooks, looseleaf binders, or composition [bound] notebooks, either one for each patient, or combining patient records on various pages of the same notebook is inappropriate. **Each patient should have his or her own record maintained in a file folder (preferably one which has fasteners) exclusively for that patient.** The reason for using folders is that the clinical record should be arranged in sections and can be easily secured in a locked filing cabinet. Using spiral or bound notebooks makes it difficult to keep materials received in the patient’s clinical record, and looseleaf binders tend to be bulky and consume extra space.

The following sections are suggested for a patient’s general clinical record:

- 1) patient contact and basic information: a page with basic contact information, demographic data (birthplace, birthdate, marital status, emergency contact, etc.) health insurance information (updated from time to time as this information changes), the patient’s primary physician and other treating practitioners and how they may be contacted, and a copy of the patient’s health insurance card;
- 2) intake materials: including the initial intake history, evaluation and assessment and any referral materials received (if any);
- 3) progress/session notes, initial and interval treatment/service plans and closing/termination summary: as detailed above **(notes of group, family or conjoint therapy that are placed in a patient’s record should be kept separate from, and written on a separate page than any notes relating to his or her individual therapy sessions. In this manner, if a patient’s clinical record must be disclosed, this can be accomplished easily without disclosing information regarding other persons with whom he or she is receiving group, family or conjoint therapy)**;
- 4) referrals made and consultation reports and testing results obtained: copy of any consultation request (i.e., medical evaluation to rule out organic illness) or request for testing, reports of such consultations and of any psychodiagnostic or other tests;

- 5) communications with other practitioners: Correspondence and documentation of contacts with other practitioners regarding the patient (i.e., to obtain information about prior or concurrent treatment, to coordinate ongoing care, etc.), requests for records made to other practitioners and the material received in response; and any other communications of a clinical nature (other than treatment reports, pre-authorization or continuing authorization requests submitted to a health plan and responses thereto);
- 6) correspondence with the patient or non-clinical collateral contacts: Correspondence with the patient or non-clinical collateral contacts (i.e., parents of a child patient)
- 7) billing records: copy of all bills sent, all insurance claim forms submitted, and other correspondence regarding payment and health insurance financial matters (including initial and periodic treatment reports, requests for pre-authorization or further treatment authorization, and the correspondence and responses related to those requests made to third party-payors), and a ledger itemizing dates and types of services, charges made and payments received.
- 8) HIPAA privacy related documents and other consents/authorizations: informed consents for treatment, consents and authorizations to use and/or disclose clinical information/records, receipt for HIPAA notice of privacy practices and other similar documents, requests received for patient records/information/psychotherapy notes (and the consents/authorizations related to those requests) and the practitioner's response to those requests (i.e., cover letter transmitting the requested materials);

**IF A PRACTITIONER MAINTAINS PSYCHOTHERAPY NOTES AS DEFINED ABOVE, THESE NOTES SHOULD BE MAINTAINED PHYSICALLY SEPARATE FROM THE PATIENT'S GENERAL CLINICAL RECORD, IN A FOLDER OR BINDER LABELED WITH THE PATIENT'S NAME AND IDENTIFYING THE MATERIAL IN THIS FOLDER OR BINDER AS PSYCHOTHERAPY NOTES.**

**In addition to the clinical record, there should be a separate HIPAA Compliance Folder for each patient in which: (1) a copy of the receipt for notice of privacy practices, (2) accounting for all disclosures of health care information other than to other practitioners or to health plans, (3) all complaints from the patient and responses and materials related to such complaint(s), (4) all requests by the patient for access to or amendment of clinical records and the responses to those requests, (5) all requests by the patient for accounting of disclosures and the responses to those requests, (6) any incident reports relating to erroneous disclosure of protected health information and the action(s) taken regarding the disclosure, and (7) any other HIPAA compliance related materials. This HIPAA Compliance Folder should be maintained separately from the patient's clinical record and separate from any "psychotherapy notes" as defined by HIPAA Privacy Rules.**

## **CLINICAL DOCUMENTATION & RECORDKEEPING IN GROUP / FAMILY / CONJOINT THERAPY**

Even when a patient is being seen in group, family or conjoint therapy, the patient must have his or her own patient record. The practice of writing one note for each group, family or conjoint session and then placing a copy of that note in the chart of each patient who participated in the session is not appropriate, even if each patient is referred to only by his or her initials in the one note. Additionally, notes of group, family or conjoint therapy that are placed in a patient's record should be kept separate from, and written on a separate page than any notes relating to individual therapy sessions. In this manner, if a patient's clinical record must be disclosed, this can be accomplished easily without disclosing information about other persons with whom he or she is receiving group, family or conjoint therapy.

For documentation of a group, family or conjoint therapy session, a note which reflects the information that should be documented in a general progress note as indicated above should be written and should be supplemented by addition of comments about the patient's functioning in the group/family/couple session and his or her reactions and responses in the context of the group/family/couple process. **The progress/session note for each person in the group, conjoint or family therapy, should focus on that individual's mental status, behavior, participation and functioning in the session, and their reactions and responses to the themes and processes that arose during the session. It should avoid, to the extent possible, mentioning any identifiable material from or about other particular members of the group, couple or family, unless this is necessary for clarity. In writing an individual group therapy note for each group member, only the name of the individual group member whose note is being written should appear in that note.**

In this regard, in the case of group therapy the number of patients attending the group session should be documented in the progress/session note, along with the initials of the other patients who attended. A separate attendance list of the patients in each group, by session (date of service) should be filed in a group therapy record folder so that there is a record of which patients attended which group and when.

In this regard, in the case of family and conjoint treatment, the very nature of the treatment involves specific identifiable persons. Thus, to protect the privacy of those persons as much as possible in case a patient's record must be revealed at some point, the persons, other than the patient in whose chart the progress/session note is being placed, should be referred to without using their names. **The note written for each patient in the family or couple should focus on the family/couple dynamics as they impact on that individual patient.** Before such a family/conjoint therapy record is disclosed, the practitioner should obtain a HIPAA compliant informed consent ***from each person age 12 or over who is identified as a patient***, even if only by their position in the family/relationship, before disclosing the family/conjoint therapy record kept for the patient in question.

It should be noted that with regard to authorizations by children and adolescents for disclosure of their clinical records, the New York State Public Health Law §18(3)(c) provides, in pertinent part that, “[a] **subject over the age of twelve years may be notified of any request by a qualified person to review his/her patient information, and, if the subject objects to disclosure, the provider may deny the request. In the case of a facility, the treating practitioner shall be consulted.**”