Consulting

IBH DOCUMENTATION

When: When we document is not as easy question; some of us feel strongly that we should never document (write/type) during a session, while others feel limited, intentional documentation during session is acceptable. The following is a grid of considerations in this individual decision.

	No documentation during sessions	Limited documentation during sessions	Documenting/ typing/writing throughout session
Reason(s)	It is not possible to engage in high quality listening, while also writing. High quality listening is the cornerstone evidenced-based practice in our field and the single biggest indicator to patients of whether we have empathy for them.	When intentionally, skillfully done, typing/ writing for a few minutes at particular points during sessions can 1) indicate to patients what they are saying is important 2) cut down on total documentation time at the end of the day, improving clinician wellbeing.	Never recommended
Considerations	If patients need something specific during the session, such as information that is in their chart, or a letter written, then using a computer during session makes sense.	It is very important to narrate what we are doing when we type during sessions 'I'm just going to write some of this down while you are talking…' this is vitally important on video or phone sessions as well.	
Cautions	A good sense of one's own memory is important; documenting immediately after session helps with this.	Never turn away from patients to document (computer should be on our lap). If patient is demonstrating feelings (crying, shame, anger, worry); stop documenting and turn full attention on patient.	

Why: Many of us were trained how we were supposed to document, without knowing the purpose of what we were documenting. This has often been responsible for over-documenting (writing too much, for no apparent reason or audience, resulting in a very high documentation burden on clinicians).

Purposes of documentation:

1. **For the patient:** if and when they need it in order to support applications for benefits, such as SSDI or supportive housing, immigration proceedings or other.
2. **For the clinician:**
   - To guide and monitor treatment outcomes.
   - To assist in the therapeutic relationship- helping the clinician to remember important information about the client between visits, or if there has been a long period between sessions.
   - To assist in reflection; for some counselors, the process of writing and making decisions about the language, the wording, of the documentation is a way to reflect on the session and the client, in the spirit of continual improvement. Looking back through multiple visits, patterns may surface, or ideas about future strategies to assist the client might come to mind.
3. **For the other healthcare team members who might see this client at a later time:** in this way documentation is a tool to communicate to others on the team, who may help the client in the future.
4. For **insurance/payor** to justify payment for services.
5. **Legal and risk management.** In the case of adverse outcomes and/or legal action, documentation can be protective of the organization, when it clearly demonstrates competent clinical care.
6. **To document quality of care** For others, such as peer reviewers or supervisors, who may be reviewing our notes to assess the quality of care we are providing.

The following are guidelines, intended to provide support and clarity. These are not rule:

Documentation is ideally done within hours of the session.

There is significant evidence that the memory degrades steadily every hour. This makes documentation less useful for the above reasons if a day or more has passed between session and documenting.

For one session, strive for no more than 10 minutes in documenting.

While some counselors may want to write more, having the artificial constraint of 10 minutes can support the practices of deciding what is most important, focusing on key areas, and writing immediately after the session. *It is very important to avoid the trap of traditional health/social services, where the documentation burden is very high, and the benefit of the documentation to the client or counselor is very low.*

Documentation is focused where the client is focused.

Counselors primarily document where the client is at and what their presenting difficulties and goals are. While we do typically ask in first or second sessions enough to get a provisional diagnosis and assess risk if it is indicated, other specific demographic information, family history, medical information, or social information does not need to be asked during a first session, and thus, does not need to be documented in the first session note.

Avoid using stigmatizing words in documentation:

Robust research indicates that the use of stigmatizing words to describe particular people and/or their characteristics or actions, directly causes worse health outcomes. This is because words we use shape how we think of people, and vice versa. As counselors, we want to be leaders in anti-stigma, including in written form. Because language, social conventions and research are all constantly evolving, we continually become aware of words or phrases that are less empathic and more stigmatizing. Referring to the language suggestions at the end of this document can be helpful.

Avoiding diagnostic mental health jargon:

As with stigmatizing words influencing our thinking, so too does pathology-jargon influence us. This type of language objectifies the client, is not strength-focused, and assumes a power-differential. Even though we must diagnose to get paid, t, this is problematic. While we can use words like 'depression' or 'anxiety' or 'substance use' as those are words in the common lexicon (and often clients use those words), we want to avoid, for example, words or phrases like: 'personality disordered; 'sociopathy'; 'parentified'; 'enmeshment' or 'infantilized'. A good guideline is not to use any words your client wouldn't understand or use themselves. This is especially important as most organizations move toward open notes (for client viewing).

The discipline of summary and generality:

It is unnecessary to write specifically, about almost anything. It is time consuming and not helpful to the client (or to other care providers) to write how many times a week someone has panic attacks, what the symptoms are, and how long it has been happening, and what the precursors are to it. We can instead write: 'daily panic attacks. Writing too much can also be detrimental to the client, if the records are subpoenaed; if write extensive specifics about their substance use, their anger at an ex, or their suicidal thoughts, it can be used against them, in many scenarios. Summarizing is a very specific skill in documentation, lifting us out of the linear documentation of everything that happened in the session, and instead, summarizing generally.

The discipline of remembering it is the client's perspective:

When a client tells us his husband is an alcoholic, his last supervisor mistreated him, and that he was physically abused as a child, we document this from his perspective: 'Client shared husband has alcoholism' and 'client shared supervisor is unsupportive' etc. We don't write 'client's husband is an alcoholic' or 'client was physically abused as a child'. This helps us remember that all our information comes from the client; it is how they see things.

Make note of specific names of people or facts about the client that are important to them, to help us remember.

If we have seen a client 3 times for relationship difficulties and we don't recall their partner's name, or if we ask about their relationship with their mom, forgetting the client told us she had died, these missteps can be very wounding. Alternatively, using their beloved cat's name, remembering the client was adopted or recalling what country they were raised in can create a deeper trust in us, in our care of them as people.

Optimize team care and the shared EHR:

Ensure the diagnosis is added to the shared diagnosis/shared problem list, so it appears with the medical problems/diagnosis. Utilize EHR-based communications (in accordance with whatever agreements the BH, Dental, Social Care and Medical departments have made).

Nuts and Bolts

Blue = good clinical practice

Red = mandatory for most payers (MediCaid/MediCare/Commercial)

Green Check indicates what can be radial button or picklist

- **Presenting problem:** What the patient said they are there for. *Example: Patient reports they are here because PCP referred them, states they are unsure why' or 'patient states their presenting problems are uncontrollable worry and depression, and conflicts with husband causing high levels of distress'*

- **Assessment:** Assessment is ongoing, not a one-time event; **first visit should always be treatment,** with concurrent assessment. This section will be longer for a first visit.

  Must include:

  - **presenting problem**
  - **symptoms that support diagnosis**

Should include:

- **assessment of patient strengths, beliefs, preferences**
- **relevant family history, SUD, trauma**

Example: *Patient reports she is here due to long term depression and anxiety. Depression symptoms depressed mood, short term memory and concentration impairment, low desire to engage in activities, and insomnia for the last 8 years, worsening over the last month. Patient reports anxiety NOS symptoms, including, insomnia, uncontrollable worry, startle reflex, intrusive images, anxious mood, and nightmares. Patient reports she was sexually abused as a child and has a history of domestic violence with current partner, although states it has been over 5 years since she has been physically abused by partner. Patient does not endorse any regular use of substances; states her mom and aunts all had anxiety. PHQ-9 is 15, GAD7 is 14.*

Intervention: What did you as a therapist do, example *'intervened to build rapport and trust, elicited patient beliefs about their depression and anxiety, discussed past self-management and treatments, what has been helpful, what has note; elicit patient preferences about treatment, past history with counseling; intervened to give patient basic feelings mngt information, re: identification and expression of feelings; discussed first line depression/anxiety treatments, re: counseling, medications, daily exercise, daily contact with supportive others, etc. explored patient's early childhood history, including family patterns and impact on current functioning'*

Patient strengths: Examples: *'patient reports strong bond with adult children' or 'patient has a history of seeking help, and a history of self-management with depression and anxiety'' or 'patient reports a strong support system including regular AA attendance and close friends' or 'patient reports an active spiritual life, strong faith, engagement in religious practices that she finds comforting' or 'patient has a history of health changes including successful weight loss and recovery from amphetamine addictive disorder'*

Functional impairment: mild, moderate, severe for symptoms. Example: *'Patient reports moderate impairment in daily life from symptoms'*

Patient goals for course of therapy: Important clinically, to focus us on eliciting from patients what they want to accomplish with a course of therapy- in other words, how will they, and we, know if therapy is helpful. Example: *Increase in energy and motivation to play with grandchildren; lowered conflict with husband; relief from constant worry'*

Plan: Includes both patient goals before next visit, and also clinicians' recommendations/ referrals before next visit. Example: *'Patient states she will increase assertive communication with adult children; begin leaving house once a day to get the mail; clinician referred back to PCP for medication evaluation; refer to case management for help with housing instability; follow up appointment in 2 weeks'*

Diagnosis: Example, adjustment disorder; depression NOS (should be from a pick list)

Example, First Visit

(Some of below would be captured in radial buttons or picklists, in the EHR)

***Presenting concerns**: patient states their presenting problems are uncontrollable worry and depression, and conflicts with husband causing high levels of distress'*

***Assessment:** Patient reports she is here due to long term depression and anxiety. Depression symptoms depressed mood, short term memory and concentration impairment, low desire to engage in activities, and insomnia for the last 8 years, worsening over the last month. Patient reports anxiety NOS symptoms, including, insomnia, uncontrollable worry, startle reflex, intrusive images, anxious mood, and nightmares. Patient reports she was sexually abused as a child and has a history of domestic violence with current partner, although states it has been over 5 years since she has been physically abused by partner. Patient does not endorse any regular use of substances; states her mom and aunts all had anxiety.*

***Interventions:** 'intervened to build rapport and trust, elicited patient beliefs about their depression and anxiety, discussed past self-management and treatments, elicited patient preferences about treatment, past history with counseling, discussed first line depression/anxiety treatments, re: counseling, medications, daily exercise, daily contact with supportive others, etc. explored patient's early childhood history, including family patterns and impact on current functioning*

***Strengths:** patient reports strong bond with adult children, high levels of insight, and a history of self-management with depression and anxiety''*

***Functional impairment:** Patient reports moderate impairment in daily life from symptoms'*

***Patient goals:** Increase in energy and motivation to play with grandchildren; lowered conflict with husband; relief from constant worry'*

***Plan:** Patient states she will increase assertive communication with adult children; begin leaving house once a day to get the mail; clinician referred back to PCP for medication evaluation; follow up appointment in 2 weeks'*

Example of Brief Documentation

(can be used for same-day appointments, brief appointments, follow up appointments of established patients, etc.)

Includes: what patient presents; what therapists did; what is the follow up.

Same Day: Patient referred by PCP due to disclosure of panic attacks, request for anti-anxiety medication, and worries about her son. Patient reports a long history of panic attacks and other anxiety symptoms, including uncontrollable worry (anxious apprehension, global) and difficulty sleeping. Patient reports things had been 'better lately' with anxiety, recently worsened, she thinks, due to son's legal problems and conflictual relationship with him. Intervened with patient to build rapport, trust; acknowledged her long history of self-managing anxiety and normalized/validated current struggles. Suggested 3-4 visits with this ASW; patient agreed. Follow up appt in 1-week, further assessment, and treatment at that time.

Brief Appointment: Short appointment (15 minutes) due to this ASW running late and patient having to leave for a commitment. Patient reports improvements in mood since last session; patient states she thinks the 'weather is helping' and that she was able to walk outside 3 times last week. Intervened to repair with patient over lateness/brief appt; affirmed strengths, especially patient's efforts in outdoor exercise to combat depressive symptoms. Encouraged patient to continue; follow up in 1 week for full appointment.

Follow up with established patient: Follow up with patient, who reports continued partial remission of anxiety symptoms; he attributes this to counseling, cognitive corrective work he is engaging in, and church attendance and prayer. Today patient reports he is using cannabis, to 'help with anxiety and sleep'; encouraged patient to share more on this; elicited from patient his history with cannabis, current use; elicited information about alcohol use and other drug use, which patient says he does not use. Intervened to maintain therapeutic alliance; demonstrate positive regard; Patient does not meet criteria for an SUD with current information; assessment and discussion will continue; validated patients work on cognitive correctives with anxious thoughts, as well as the accomplishment of his goals of returning to church and regular prayer.

Empathy and Equity Language, in Documentation

Avoid these words & phrases	Why it is problematic	Alternative words & phrases
Compliant or non-compliant	This phrase typically denotes insubordination or resistance, implying a power differential. It does not distinguish whether someone is not doing something because they are not able, do not agree, can't afford it, etc.	Activation; adherence.
Substance 'abuse' or substance 'abuser' or 'addict' others: 'dirty' ua; 'drug-seeking'	Any version of the word 'abuse' when referring to those with sud, has been shown to relate to worse care received and worse outcomes. There is a whole 'addictionary' of words and terms that are related to worse quality of care.	Addictive disorder or condition. Substance use disorder or condition. Person with an addictive disorder, or with a substance use condition.
Manipulative	Pathologizes; subjective; judgmental; tends to be used mostly with people with addictive disorders.	No replacement.
Lying	Pathologizes a very common and normal occurrence in healthcare; judgmental.	'Patient reports x, which is inconsistent with x…'
Personality disorder	Misunderstood; applied disproportionally to women; not useful as a label.	List symptoms instead; add to diagnosis list if patient meets criteria.
Chronic pain patient, diabetic; schizophrenic	This is the opposite of 'person first' language.	'Patient has diabetes' 'Person with chronic pain' 'Person with schizophrenia'
Narcotic	This word is a legal term, not a clinical one, indicating a judgment about legality.	Opioid, amphetamine, cocaine, etc.

User	Transactional, de-humanizing.	Patient. People who use our service; person who uses our service.
No-show	Not person first language- can be judgmental.	Missed appointment.
High Utilizer *Frequent Flyer*	Not person first; judgment; transactional.	Person with complex needs. Person with high utilization of health care services.
Disabled	Not person-first.	Person with disability(ies).
Obesity	Pathologizing body size differences.	Larger body; fat.
Demented person/dementia sufferer/senile	Not person centered.	Person living with dementia.
Difficult patient; difficult child	Labels people by their behaviors; doesn't take into account that these are relationally defined (between 2 or more people).	Difficult relationship; difficult interaction.