Clinical Documentation

ENGAGING IN EFFECTIVE AND APPROPRIATE TREATMENT PLANNING

Housing Works
Continuing Education
October 2022

Course Information

- Attendance: Please type your full name in the chat
- Recording: Please be aware that this course is being recorded
- Continuing education hours: 1.5 hours (awarded to LMSW's and LCSW's upon successful registration, full attendance, completion of learning assessment and course evaluation).
- Learning Assessments and evaluations: This form includes an attestation as a component; there will be a QR code at the end of this presentation and they will also be sent by email to registered individuals following the end of the course.
- Certificates of attendance with CE hours: will be sent by email to eligible registered participants within 2 -3 weeks following the course
- Questions or comments: Feel free to leave comments in the additional comment section of the evaluations specific questions can be sent by email to a.peterkin@housingworks.org

About Me

- Alcia Peterkin, LCSW, SIFI. Alcia holds a master’s degree from Smith School for Social Work and a post-graduate certificate in psychoanalytic training from the Training Institute of Mental Health. Alcia’s clinical experiences include both community mental health and private practice settings and focuses on collaborative treatment with individuals with varying presentations including mood disorders, substance use, anxiety, trauma and psychotic presentations. Alcia has worked with clients individually and in group settings at organizations such as Brooklyn Community Services, Catholic Charities Brooklyn and Queens as well as Housing Works. Alcia is currently operating as the Director of Clinical Training at Housing Works and is focused on supporting clinical training and clinical supervision needs of licensed staff around the agency

Course Objectives

a) Discuss the role of clinical documentation in various treatment settings.

b) Identify the different components of a treatment plan

c) Create a basic treatment plan using S.M.A.R.T goals and objectives

d) Evaluate examples of effective treatment plans.

Clinical Documentation

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What is and Why do we need clinical documentation?

Defn: " the capturing and recording of clinical information." (Segen's Medical Dictionary, 2012)

This includes:

Screening	Assessments/ Intakes/ Psychosocial	Progress Notes	Treatment Plans	Discharge summary/Plans	Referrals

Oversight and Accountability

- State/ Federal Accountability
  - Professional responsibility
  - Insurance/contract program
  - Client accountability/ transparency

Treatment Guide

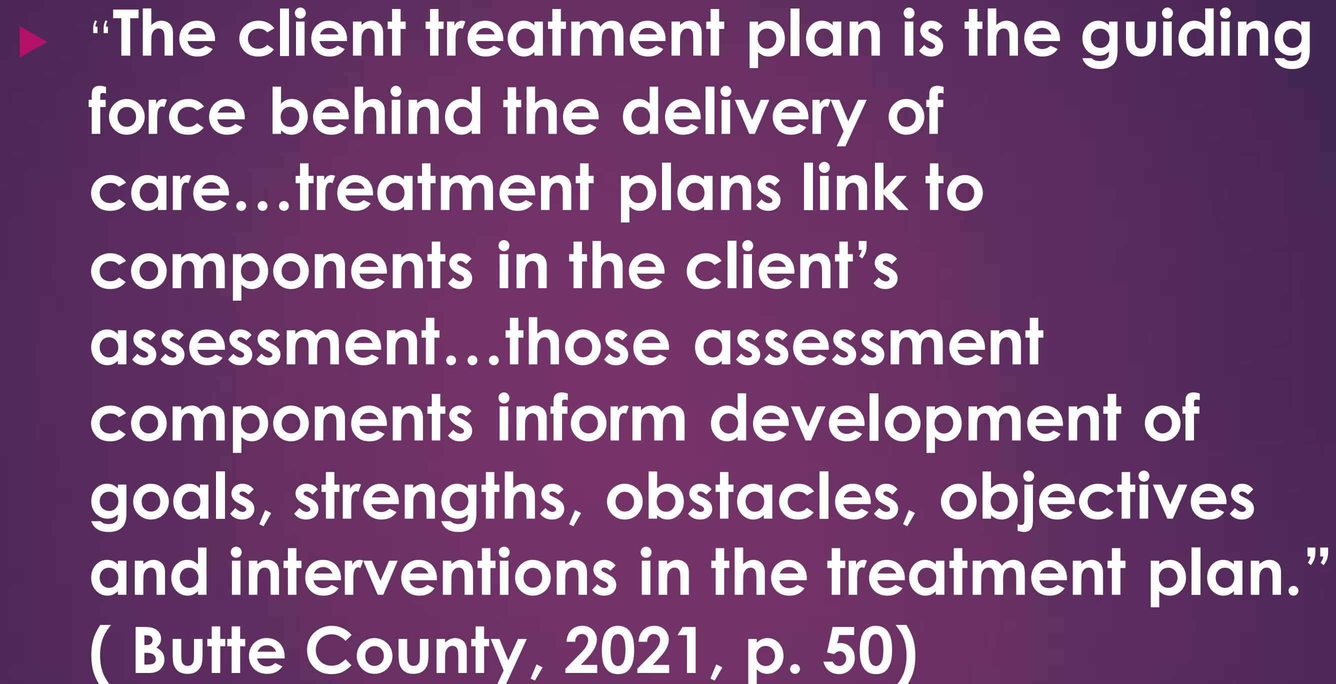
Client agency and empowerment (Linhorst, et.al, 2002)

The Treatment Plan & Treatment Planning

What is Treatment Planning ?

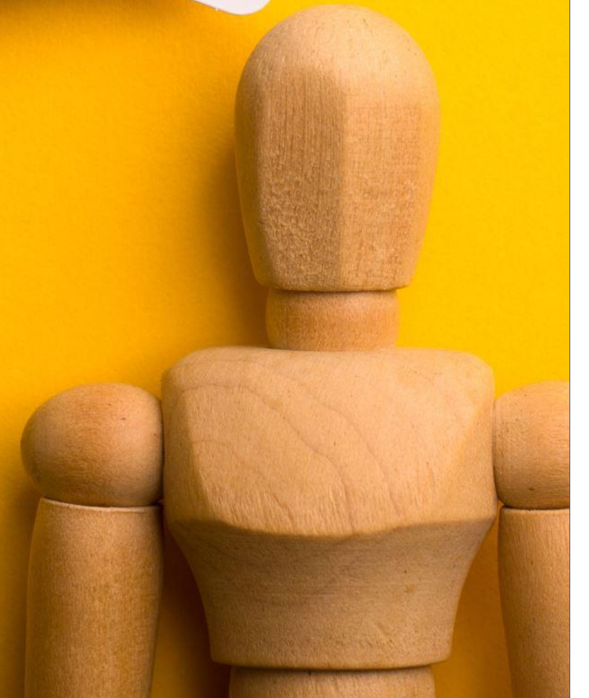
- **"The process whereby clients' life goals are explored and established, goals are prioritized and then written as short-term and long-term treatment and rehabilitation goals, and treatment and rehabilitation activities are selected to support goal achievement." (Linhorst, et.al, 2002, p. 427)**

- **"An ongoing process of assessing mental health status and needs of the individual, establishing his or her treatment and rehabilitative goals, and determining what services may be provided…to assist the individual in accomplishing these goals. The treatment planning process includes, where appropriate, a means for determining when the individual's goals have been met to the extent possible in the context of the program, and planning for the appropriate discharge of the individual…" (Office of Mental Health, 2021, p. 18)**


"The client treatment plan is the guiding force behind the delivery of care…treatment plans link to components in the client's assessment…those assessment components inform development of goals, strengths, obstacles, objectives and interventions in the treatment plan." (Butte County, 2021, p. 50)

Important Aspects of a treatment plan Initial/Otherwise

- Presenting Issue/Problem/:
- Goal
- Objective
- Participants: Client (supports, therapist, etc)
- Intervention/ Services/frequency
- Evaluation/Outcome
- Additional: Strengths, barriers



Presenting Issue/Problem/Need:

- Connect to your assessment/ Why are they here
- Impairment in an area of their lives

Goals :

- Collaborative and elicited from the client
- Identifying only one or two based on each problem area

Issue: Client has poor treatment attendance and engagement due to lack of safe and stable housing.

Goal: To obtain permanent housing

Issue: Client is not consistent with medication regimen for their chronic health issue which causes frequent hospitalizations
Goal: To increase consistency of medication use to stabilize medical symptoms.

Issue: Client has continuous employment and relationship difficulties due to chronic substance use.
Goal: To reduce substance use to be able to show up for work consistently

Specific
Achievable
Timely
SMART
Measurable
realistic

Developing S.M.A.R.T Objectives

- Objectives

  "an ideal objective is one that meets both the client's needs in working towards the goal and is specific and measurable enough to be able to chart progress." (Marin Health and Human Service, 2022, p.19)

  Specific- is this connected to my problem in a targeted, clear way

  Measurable – need some way to be able to measure this.

  Achievable - is this something that the client can achieve

  Realistic – does this make sense for this individual in this situation

  Timely - what's the length of time for this objective to be accomplished

- WHO will change the issue/impairment/need as seen by the measure from baseline or current level to identified target by timeline
- Client will increase consistency of medication regimen as seen by increased scheduling and attending DOT appointments from 2 times per month to 4 times per month by three months time.

Examples

Client will increase psychiatric stability of schizophrenic symptoms especially auditory hallucinations by increasing attendance to scheduled psychiatric medication management appointment from 0/month to 1/month over the course of the next three months.

Over the next three months, client will decrease anger outbursts that impact his relationship with his partner as evidenced by an increase in identification and practice of 2 mood regulating coping strategies from 0 x per week to 2 x per week.

Client will reduce substance use in order to improve ability to attend work on time and increase his income.

Client will increase meetings with his case manager from 0 per month to 2 meetings for month over the next 4 months to submit applications for temporary or permanent housing possibilities.

INTERVENTIONS

- "Services/modalities a provider anticipates providing to assist the client in attaining the objective in each goal" (Butte County Behavioral Health, 2021, p. 60)
- "**What is the service + why is the service needed = How this will help the client"**
- **Examples:**
  - **Cognitive Group treatment to assist client in increasing socialization and developing strategies to decrease unhelpful and intrusive thought patterns associated with anxious feelings**
  - **Monthly Care management services to connect the client to substance use group treatment and additional community resources to reduce isolation and boredom and increase efforts to reduce alcohol use at home which impacts employment and earning potential.**
  - **Medication Management and Health Education to increase client's adherence to HIV medication which will assist in decreasing client's viral load and reduce additional physical health complications**

Interventions: What is that you as the provider, clinician, or case manager will be doing to support this objective and goal.

Frequency: how often is this intervention/ service- ~~as needed~~

Strengths and obstacles/ barriers/ difficulties

Signatures: collaborative, copy to client

Treatment Planning as an Ongoing Process

Progress Notes

- Treatment plan/review are not specific documents, but treatment planning included in the progress notes.
- Treatment plan/review exists but maintains the "golden thread of documentation" within progress notes
  - Esp. when able to be completed w/out the client

Considerations

- Provide a guide as to how to structure my progress notes – recounting meeting vs connecting interventions to goals and objectives
- Creates a need for more objective language and observation (supporting service necessity as opposed to subjective interpretation or vague/distant knowledge
- Provides a way to "close loops" between sessions especially as it relates to goals and objectives and creates continuity.

DSM-5 Diagnoses and ICD-10-CM Codes

F17.10 Nicotine use disorder, mild ✕ F10.10 Alcohol use disorder, mild ✕

Content of the Session*

Client attended follow-up counseling session using Doxy.me platform however session was scheduled for in person. Client was located at home address on file throughout duration of visit and counselor working from office 1751 Park Ave 3rd fl, NY NY 10035. The client has signed a telehealth consent. Counselor briefly discussed the importance of the need for privacy during individual sessions to protect the confidentiality of the client. Client presented as oriented x3, with euthymic mood and mood-congruent affect and linear thought process. Counselor utilized Motivational Interviewing reflective listening techniques and open-ended questions throughout visit to address client's substance use patterns and client goals while in treatment. Client disclosed she continues to drink alcohol to manage stressors relating to her boyfriend's health and living situation. Client continues to disclose concerns about the living conditions and how independent living in the facility appears to be more concerning than it was in the nursing home. Counselor redirected client to her goal of spending more time in her sessions focusing on herself, health, and substance use. Counselor brought awareness to how client had agreed to in person 1:1 sessions on Mondays however has consistently requested telehealth the day of these appointments. Counselor asked client if she wants to continue with telehealth and if so, appointments be switched to Fridays. Client agreed to this for next week however this prompted discussion of client needing more support around her substance use. Client refused a higher level of care stating "I can't leave him" referring to her boyfriend. Counselor offered to increase 1:1 sessions to 3x/week including Harm Reduction group, and two of the 3 sessions in person. Client identified that her health has declined, especially with muscle mass in her legs. Client identified that the last time this occurred was years ago when first entering treatment. Client shared awareness that she needs to get out of the house more. Client created a goal for this week: for every one thing she does for her boyfriend, she will do something for herself to support her health and goals. Client has agreed to increase her schedule starting next week, and at the end of each week determine if she wants to continue to meet with counselor 3x/week.

Case Examples

Client with Housing and or service provision needs

- Client is presenting to your Care Management program due to lack of stable housing. Client reports that they were living with a significant other for two years but due to changes in the relationship and possible IPV that they have been staying with friends for a period of three months. However, client shared that for the past two months they have been staying on the streets and over the past two years have steadily lost most of their possessions. Client also noted that they are HIV positive and have had difficulty keeping medication and often lose track of it sometimes between transitions. Client remembers being undetectable about 3 years ago and notes some pride with this. However, they are unsure as to what their viral load is and feel somewhat fearful of even finding out about this.

TREATMENT PLAN AREA	DESCRIPTION
Presenting Issue/Need/Problem	Lack of stable and safe housing
Goal 1.	“I want my own place” _ To obtain stable housing “I want to get back on track with my medication.” – To provide access and support to increase consistency with medication usage to improve physical health
Objective 1	“The client will complete an intake session to enroll in case management program within the next month.” or “Over the course of the next three months, the client will meet with his assigned case manager twice per month to submit applications for temporary or permanent housing possibilities.”
Intervention (include duration and frequency of services)	Over the next three months, the program will provide bi-weekly hour-long case management meetings during which the case manager will identify housing possibilities and assist client with completing and submitting four applications to increase the client's chances of obtaining permanent housing .
Client strengths	The client is resilient and expresses a desire and motivation to work towards obtaining housing.
Obstacles/barriers	The client is currently living on the streets

Client with mental health diagnosis

- A client is presenting to your outpatient mental health program after being referred and accompanied by his older adult parent who has suggested that client engage in treatment. Client has diagnoses of depression and anxiety that often prevent him from leaving the house. Client notes that he feels anxious about going outside since the start of the pandemic and identifies fears of getting sick and dying. Client noted that despite getting the COVID -19 vaccine this fear is still "very real and present". Client has lost several family members and friends as a result of the pandemic. Client also notes that they were working in a small part time role prior to the pandemic and lost the job. Client notes that they are unable to go out for work and is completely dependent on their older adult parent. Client wants to manage the anxiety but has a hard time engaging in treatment due to having to travel.

TREATMENT PLAN AREA	DESCRIPTION
Presenting Issue/Need/Problem	Anxiety and fears of getting sick and dying that impact overall well- being (ability to go outside by oneself, ability to work)
Goal 1.	"I want to be able to manage my anxiety so I can work or do other things" – To decrease experiences of debilitating anxiety to improve and increase capacity for daily functioning
Objective 1	Over the next 6 months client will increase his attendance to telehealth psychotherapy sessions from 0 per week to 1 per week to develop strategies to reduce his intense experience of anxiety. Over the next 6 months client will increase his practice of two behavioral strategies for anxiety management from 0 times per week to 2 times per week to decrease intense experiences of anxiety and improve daily functioning
Intervention (include duration and frequency of services)	Over the next 6 months, the program will provide weekly 45 minutes psychotherapy sessions via tele-practice. Therapist will provide psycho-education regarding anxiety and utilize evidenced based practices to assist client in developing two anxiety reducing strategies.
Client strengths	Previous work history, desire to decrease anxiety
Obstacles/barriers	Fears of getting sick due to COVID-19, loss of several family members and friends, difficulty leaving the house

Client with substance use and medical diagnosis

- Client is mandated to attend your outpatient substance use program as an alternative to incarceration. Client presents with severe alcohol use and reports frequent cannabis use as well. Client reports that he has been engaging in alcohol use for a long while and that he grew up in a family where drinking "was big." Client noted that he does not want to stop drinking but knows he must attend the program. Client shared a history of experiencing physical abuse as a child and experiences with community-based violence. Client reports having two children that he has not been able to see due to having been inebriated and aggressive in a past visit. Client noted that he wants to improve his relationship and be a better father than he had. Client reports living in a shared residential setting but would like to get his own independent housing.

TREATMENT PLAN AREA	DESCRIPTION
Presenting Issue/Need/Problem	Alcohol use, cannabis use. Poor relationship with children
Goal 1.	"I want to finish the program". – To meet requirements and complete attendance for mandated program "I want to improve my relationship with my kids."
Objective 1	Over the next 3 months client will increase his compliance with program requirements as evidenced by increasing his program and group attendance from 0 times per week to 1 time per week to complete attendance." Over the next 3 months client will comply with his mandated requirements by decreasing his alcohol use from 6 alcoholic drinks per day to three alcoholic drinks per day." Over the next 3 months client will increase his telephone communication with his children from 0 per week to once per week in an effort to increase contact to improve his relationship with them.
Intervention (include duration and frequency of services)	Over the next 3 months, the program will provide weekly 30-minute individual substance use counseling with licensed substance use professional to support client's compliance with program requirements and to support client's substance use reduction. Program will also provide 45-minute weekly group treatment sessions on harm reduction to provide client with the psychoeducation and behavioral tools to reduce harmful engagement or unhelpful impacts of substances.
Client strengths	The client is motivated to complete the program. Client reports a great desire for improved relationship with his children.
Obstacles/barriers	The client expresses a lack of desire to stop drinking. The client shares that he does not have frequent in person contact with his children

Adjusting Treatment Plan Goals/ Objectives?

How do we know when to update/review goals and objectives?

- Accomplishing objectives or making improvements towards objectives
- Change in circumstances/ situations
- Client request for change in goals/objectives and focus
- Length of time in treatment/with same goal and objective
- Change in diagnosis

NICABM, 2020

In closing

- Treatment plans are a dynamic tool that can:
  - Guide the treatment
  - Empower the client
  - Provide accountability

- Using Clear Goals and Smart Objectives provides a structure to the treatment process that supports the client and clinician

- Keep in mind that as a dynamic and evolving tool we want to check in with the goals and objectives and ensure that these continue to align and fit with the client's needs.

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