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IOS Compliance Training Part I

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Behavioral Health Compliance Manager

Objectives

- Identify documentation best practices at Housing Works
- Describe the purpose of documenting
- Identify & use examples to demonstrate the electronic health record(EHR) the program utilizes to document client encounters
- Discuss what is documented in the client record
- Identify important elements of a comprehensive intake process
- Identify essential elements required in a treatment plan & other areas of clinical documentation
- Describe the documentation process for effective progress notes
- Discuss creating effective discharge plans to support clients as they transition out of outpatient therapy

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Documentation is mandatory for all client contacts, assessments, and the delivery of services.

Documentation should be completed and locked in eCW within 48 hours after the encounter.

All documentation should be entered in the electronic health record (E.H.R)

Documentation should be clear, concise, and organized

Good documentation ensures accountability, service improvement, and reimbursement for services rendered.

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E-Clinical Works (ECW) and E-ICARE used to document scheduling of services & billing

Not every program uses the same E.H.R.; OMH – e-icare; CONNECT – e-icare; OASAS – e-icare; Article 28/IOS - ECW

Documentation in the Client Record/EHR

Electronic Health Records

- IOS uses electronic health records (EHR) e-clinical works (ECW) to document services delivery with clients.
- This is the same EHR where you can find documentation for other Article 28 clinic services, such as primary care, psychiatry, pain mgmt, etc.
- Services can be rendered via in-person, televisit or telephone (in special circumstances)
- All documentation is expected to be completed and locked within 48 hours.

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Documentation in the Client Record/E.H.R

- Documentation should address:
  - Who
  - What
  - When
  - Where
  - How
  - And next steps

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- **Who:** client, social worker, and any additional individuals present

- **What/Why:** issue/concern, reason for visit, task to be addressed, purpose; describe the service being provided

- **Where:** location of service, client, clinician/provider, modality (telehealth/in person)

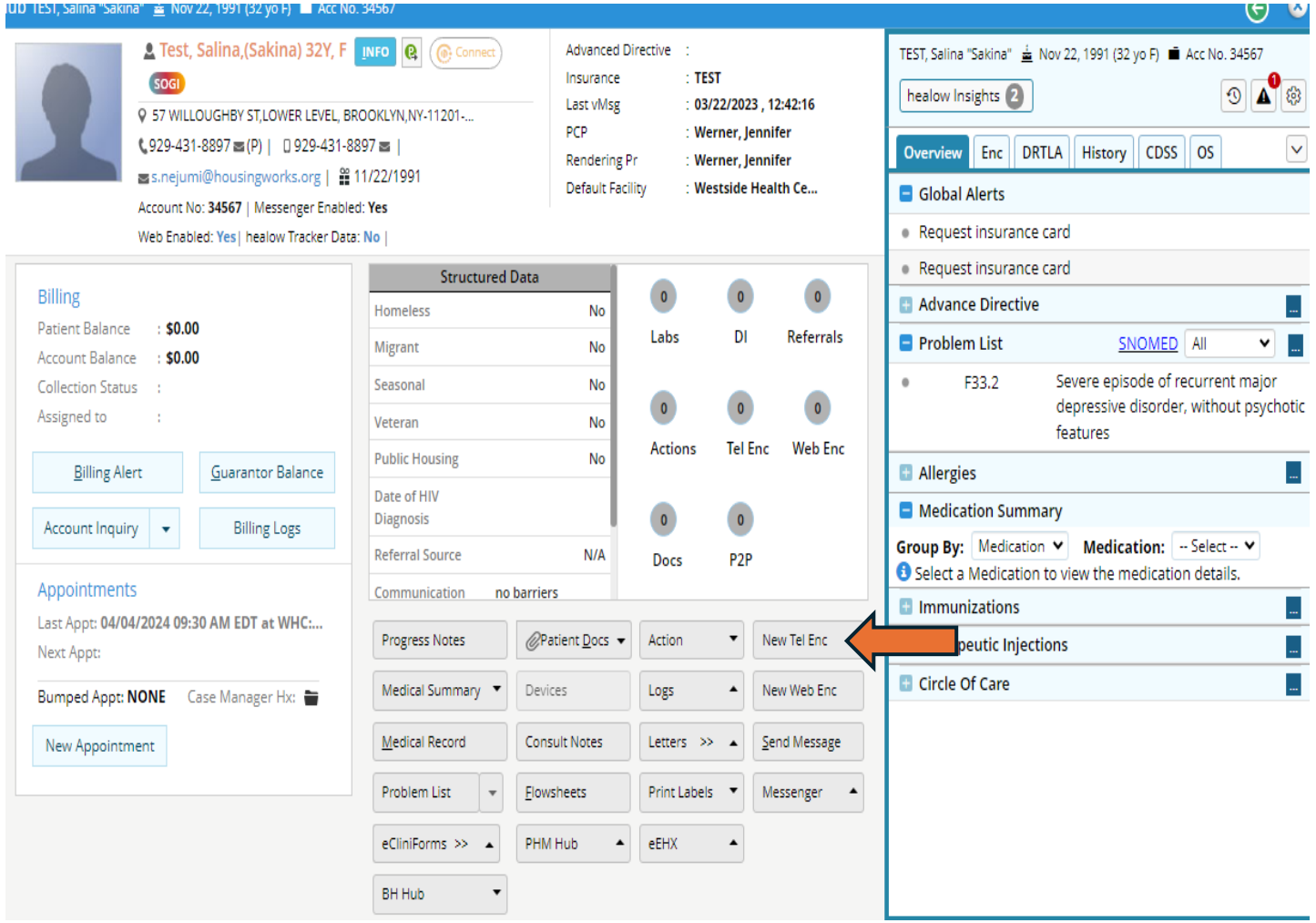
- **When:** date of service, time of visit, length/duration

- **How:** intervention, modality and frequency
- **Next Steps:** plan of action next visit

Telephone Encounters (TE) in eCW

Telephone Encounter

- Telephone encounters (TEs) are a way to have conversation between providers within the EHR & can also be used to capture administrative info that needs to be documented in the client record.
- You may also receive TEs from other HW providers so be sure to check your jellybean daily

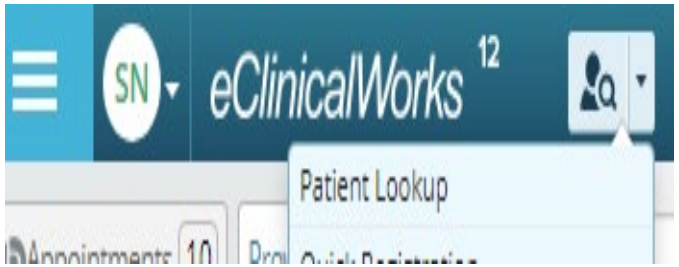


Components of a TE

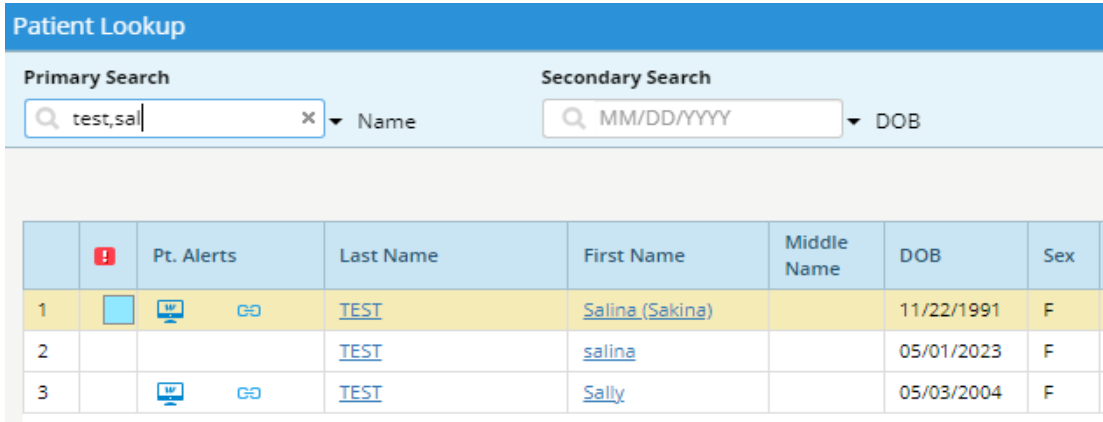
- **Reason:** This should be a succinct statement of the purpose/content of the TE e.g. "IOS care coordination"
- **High priority:** you can select this box, located under reason, if this is an urgent communication
- **Assigned:** This is selecting the person who will be following-up on the identified issue or to whom you are wanting to communicate with
- **Provider line:** Change the provider to the behavioral health supervisor (e.g. remove the current provider and then add BH "supervisor's name)
- **Facility:** Best practice is to change this to the facility you are operating in but is not required for most TEs
- **Messages:** In this area is where you will have the meat of your message. Should include summary of conversation/the issue you are addressing
- **Action taken:** In the initial message, you are simply going to select *Time stamp* to indicate when you are sending this message. Further conversation between providers would continue within this action taken section, with a time stamp for each time that you make an entry

Documenting a Telephone Encounter

- Select patient look up

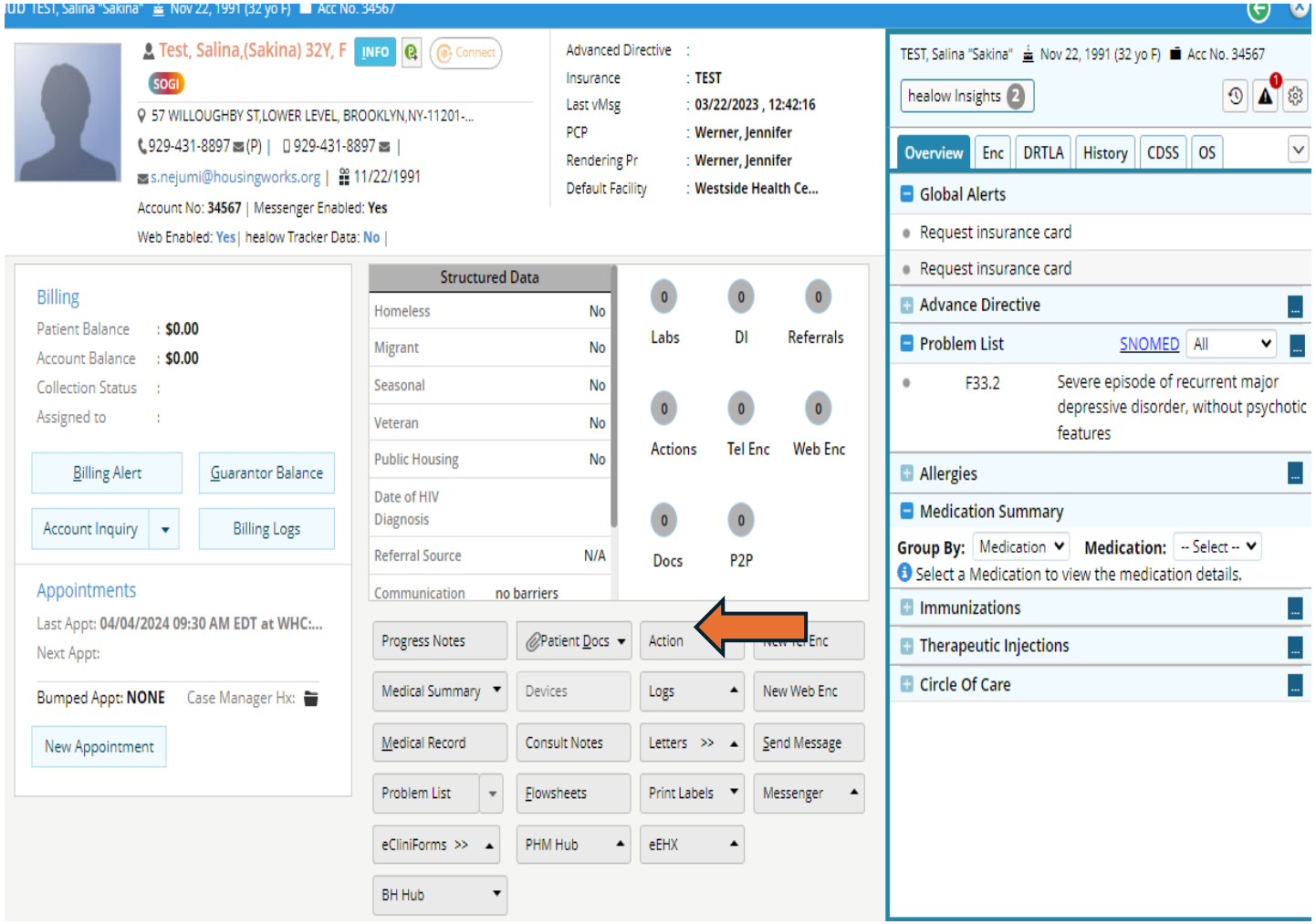


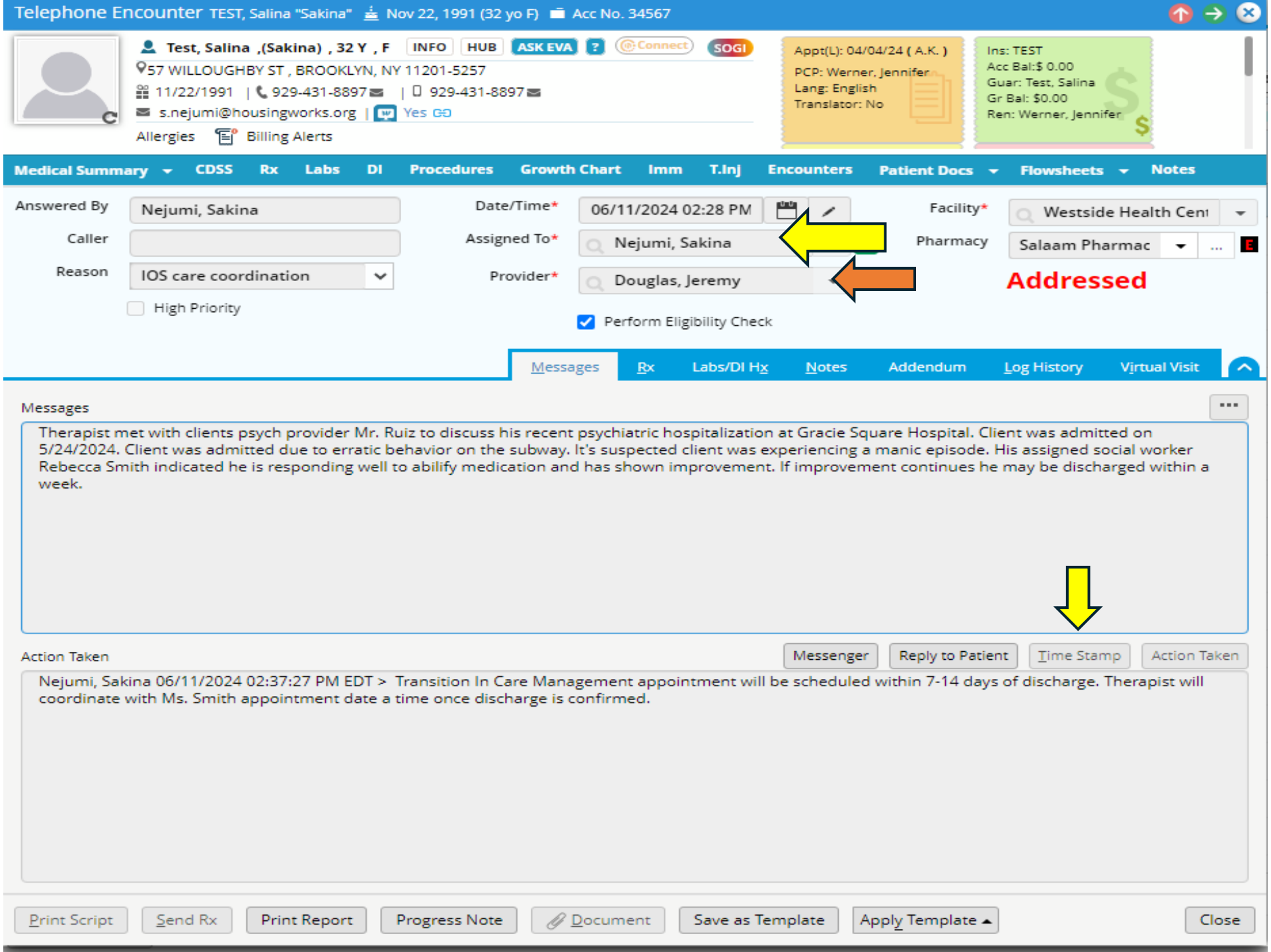
- Primary search by last name, first name or Secondary search by Date of Birth
    - If you know the Medical Record Number (MRN) you can also use that to search directly



Telephone Encounter

- From patient hub, Select "*New Tel Enc*"





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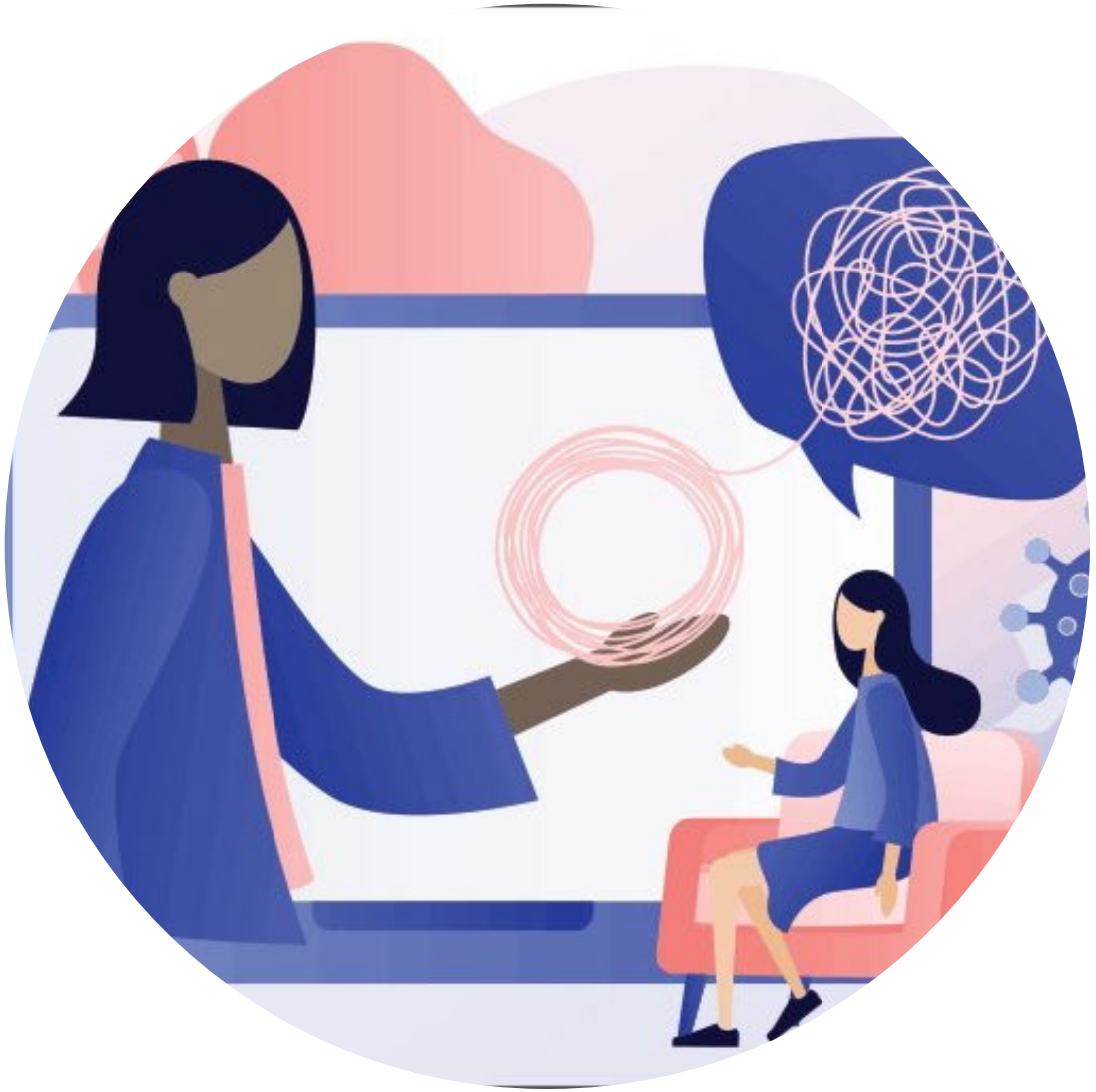
If TE will be shared with provider, change *assigned to* to provider name

Ensure Provider is a BH supervisor

Document next step and remember to time stamp



Documenting The Intake Process

The Intake Process: Setting the stage

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- Through the intake and engagement process, the clinician strives to develop a rapport with the client that will help to facilitate the client's commitment to work together on their identified goals
- When first meeting the client….
  - Provide a short description of your role and function within the organization setting
  - Share information about confidentiality [including being a mandated reporter], the helping process, the type of treatment services offered and expectations for entering services and during treatment
  - Discuss release of information for collaterals and treatment providers or a referral if they don’t meet program requirements or are no longer interested.

Intake Process cont.

You can check out the IOS Admission & Intake policy for more details

- The information obtained during the intake process will help to formulate the assessment
- The process is a collaborative relationship to engage & build rapport with the client
- It's important to be respectful, thoughtful, genuine & non-judgmental
- Help the client understand the next step in the overall treatment process and /or help with an identified referral

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Intake Process cont.

See Disclosures HIPAA training for more info on ROIs

- As part of initiating treatment, you will also want to
  - Review consents/intake packet & document in the progress note that consents were reviewed with the client
  - Obtain and review Release of Information (ROI) to collaborate with collaterals
    - Particularly in IOS, collaboration with other treating providers is a focus & would be helpful to talk through with client the benefits of having full treatment team involved in their care
  - Remind client that engagement in services is voluntary

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Intake process cont.

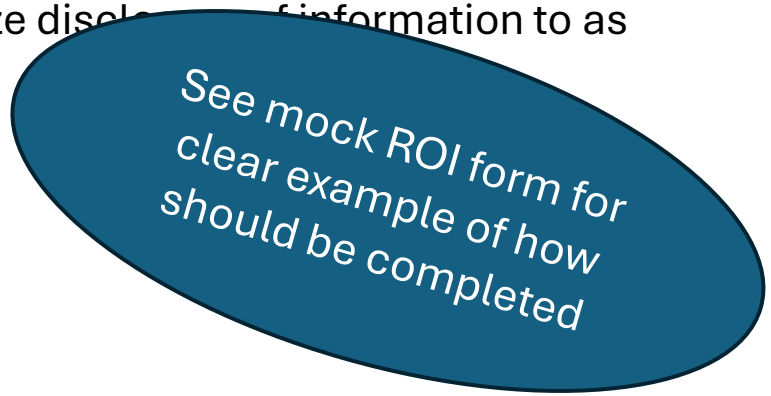
- Intakes are generally scheduled within 2-4 weeks of receiving the referral
- Those assessed as high risk must be scheduled within 5 business days
- If a client does not show for their intake appointment, outreach should still be documented
  - Best practice: if referral source is known, referral source should be notified of the client not attending & may be able to assist with re-engaging for a new appt

See A28/IOS Wait list for Admission policy for more info

Consents

Consents

- In the first session, provide informed consent of treatment, including limitations of confidentiality
- For majority of clients referred to IOS for therapy, they are already seeing another HW medical or psychiatric provider, so there are not new consents to complete/review for therapy
- The exception to this is we should be asking clients who they want to authorize disclosure of information to as part of their care
- For consents to be valid, the following must be present:
    - Client has signed & dated, where indicated
    - Staff/witness signature & dated, where indicated
    - At least 2 forms of identifying info (combo of name, DOB, or MRN/eCW #)



- If you do review consents in client's Patient Docs folder, note that it should be absent of any blank/unsigned consent forms
    - If not signed, please alert the Patient Service Representative &/or Health Center Director for correction
- Intake/consent packets are maintained by the operations staff
- If consents are completed through electronic registration, consents will be automatically added to the patient docs in eCW
    - Clinician should include a note in the pre-admission note that the consents are in eCW folder

Third Party Authorization to Disclose PHI form

Also known as Release of Information (ROI) form

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[A litigation version of this form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
John Doe	01/01/1990	NA or MRN
Patient Address 123 ABC Street, New York, NY 10030		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item

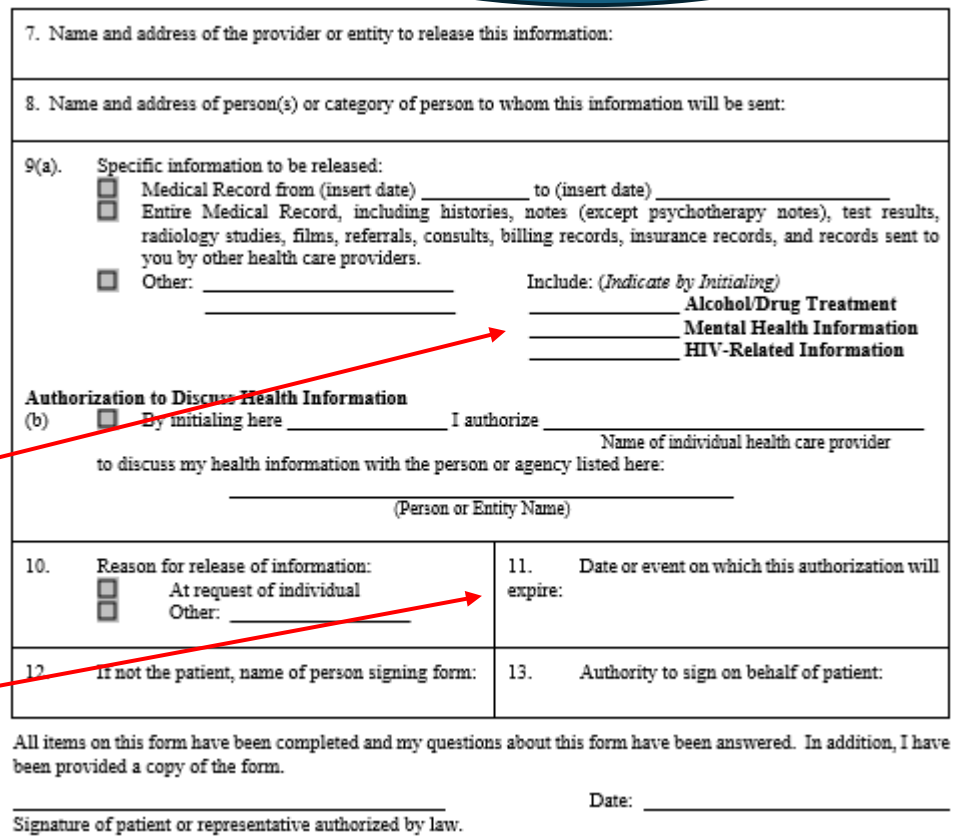
Authorization to Disclose PHI

See HIPAA Disclosures training in LMS & Medical records release policy for more details

PHI Release of Information (ROI) requests must be responded to **within 5 and no more than 10 calendar days**.

- Patient must complete the Authorization for ROI Form
- **If authorizing disclosure, EACH section must be completed**. The patient must:
  - **indicate** exactly which records are being requested.
  - **initial** the ALCOHOL/DRUG section, as applicable.
  - **initial** the MENTAL HEALTH, as applicable
  - **initial** the HIV-RELATED section, as applicable

  Redact any Alcohol/Drug, Mental Health, or HIV-Related information if these boxes are NOT initialed
- Expiration (item #11) must be indicated, or the form is **INVALID**
- Patient information should only be released by the Patient Care Coordinator, Med Record Coord, or Health Center Director by hard copy, PDF file transmittal, or electronic fax, adhering to the records request workflow.



7. Name and address of the provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:
- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including histories, notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)
- _____ **Alcohol/Drug Treatment**
- _____ **Mental Health Information**
- _____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Name of individual health care provider
to discuss my health information with the person or agency listed here:
_____
(Person or Entity Name)

10. Reason for release of information: ☐ At request of individual ☐ Other: _____	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

What's in the consent packet?

- Client registration form
- Notice of Privacy Practices + Consent for treatment form
- Client code of conduct
- Advance directives
- Advanced Beneficiary Notice (when applicable)
- Patient's rights/grievance form
- Healthix
- Psyckes consent
  - Only applicable to those who have Medicaid, Medicare
- Release of info form
  - This is optional but should be completed for anyone client wants involved in care

Intake Assessment

IOS Intake Process

Referrals are scheduled for intakes within 2 weeks – 30 days of initial contact/referral from provider

Intakes can be scheduled as either one 60-minute initial visit or two 30-minute sessions.

If client is deemed High risk intakes are scheduled within 5 business days of screening date*

If referrals cannot be scheduled within 30 days, clients will be provided with alternate scheduling options – at another site - or be placed on a waitlist

Key dates & factors

- Generally is a 2 Part Intake Process; can be completed in one, if able
  - Intake/Comprehensive Assessment completed in first intake/visit and signed and submitted for approval by supervisor **within 2 business days of appointment**
  - If it takes 2 sessions, **you pull in what was completed in the first intake into the 2nd note;** submit assessment in eCW to supervisor at once complete
- Client is admitted by the 4th intake appointment or completion of the intake assessment, whichever is first
  - The completed intake assessment should be submitted to the supervisor within 2 business days
  - While supervisors do not have a specific timeframe for review/approval, supervisors should make an effort to provide feedback in a timely manner
  - Keep in mind that your supervisor may submit edits for you to make & these must be done timely
- Note that due to more flexibility in IOS regulations, clients may or may not be admitted for care & may have up to 4 ad hoc therapy sessions

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Referrals/Priority referral

- Most referrals will come from internal providers, case managers, & other HW programs. However, clients can engage in therapy in IOS w/o any connection to another HW program or provider
- Calls, walk-ins or referrals for services will be directed to the Operations Assistant or assigned supervisor who will screen for risk to assess if referral is categorized as a priority referral
  - Recipients referred from inpatient, forensic, emergency settings or those at high risk are scheduled for an initial assessment within at **most 5 business days.**
- For all referrals, an effort will be made to schedule the first intake appt for **full 60 min time** slot. If schedule does not allow for that, **two 30 min sessions** will be scheduled, the first initial within a one week period.
- Source of referral should be captured in the progress note/intake assessment to document where client was referred from for care.

Priority admissions

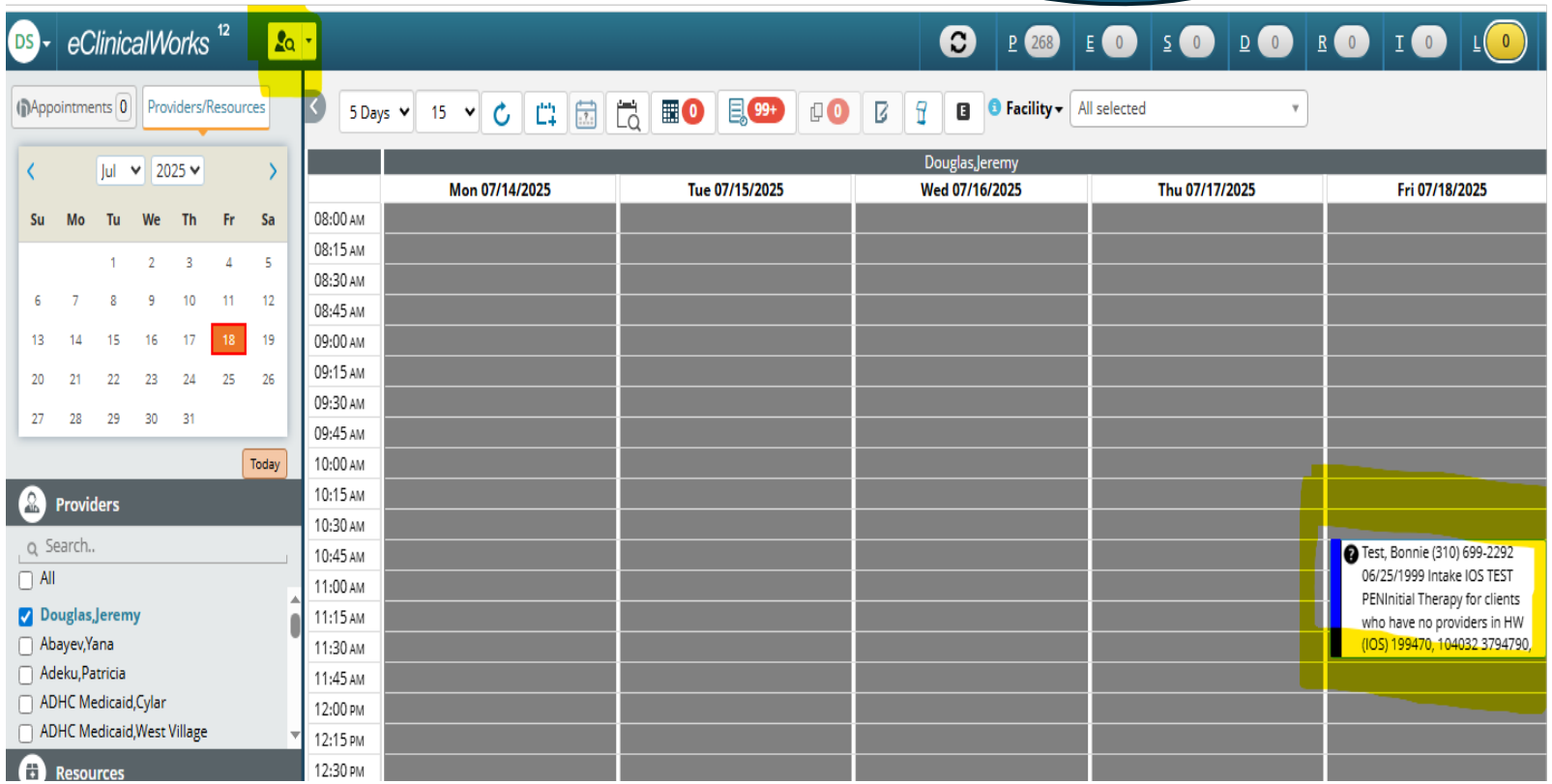
See IOS Wailtlist policy for more info

- These are persons who are identified as required to be provided an **intake appointment within 5 business days**
- This assessment is determined by the Director and/or Assistant VP
- Priority admission are clients who were referred from…
  - Are referred from inpatient hospitalization/treatment
  - Are transitioning from an ACT team
  - Are enrolled in AOT
  - Were recently released from a forensic setting (last 6 mo)
  - Are assessed to be at high risk
  - Or anyone determined to be in urgent need by the Director and/or Assistant VP
- This should be documented in the intake assessment in history of presenting illness (HPI) section

Intake assessment

See eCW training resource for more details

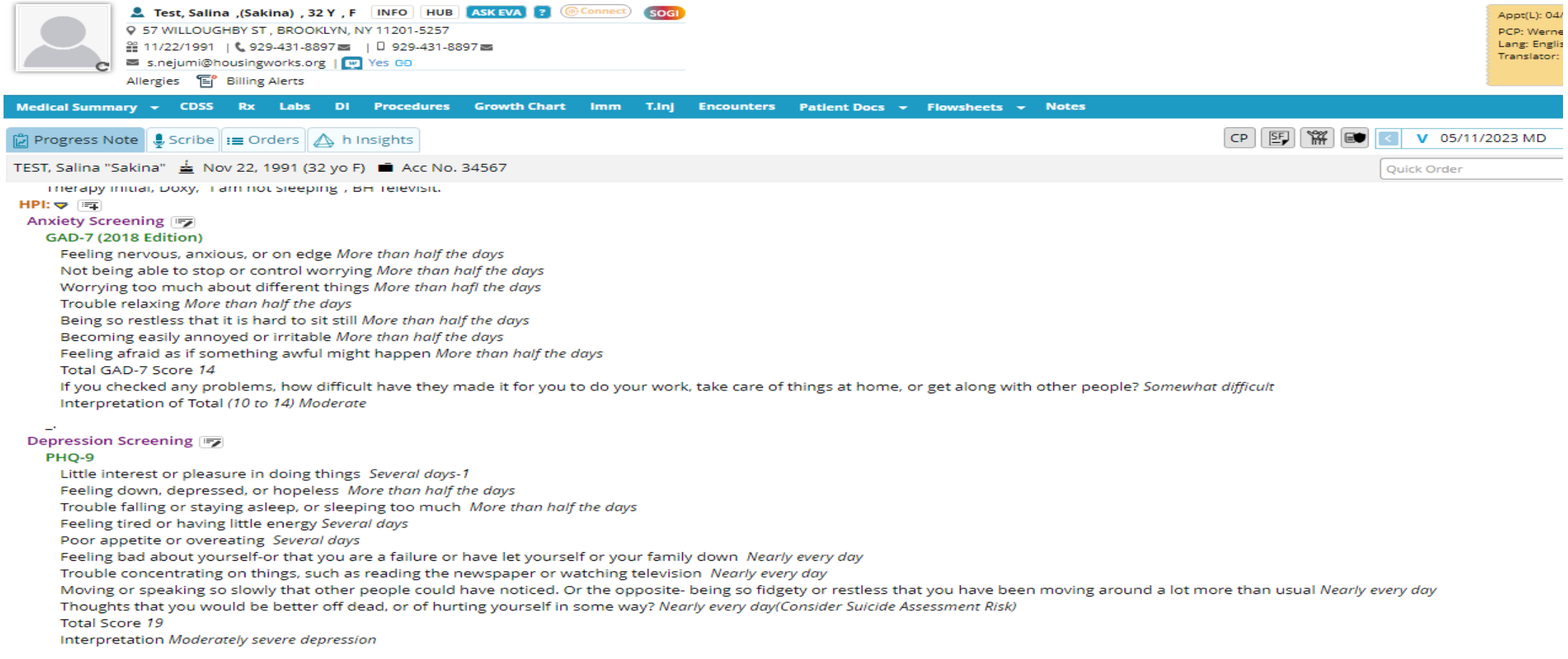
- You can search for the individual patient & find your appointment there. Or you can go to your panel in "Resource Scheduling" in eCW to select the visit/client that you are initiating the intake appointment with
- From encounter: right click > switch to "Classic" > select "View progress note"



Elements assessed at intake

- Presenting problem/history of present illness
- Mental health screening (PHQ9, GAD7) & hx
- Substance use screening (DAST, AUDIT, Fagerstrom) & hx
- Assessment of risk for SU & mental health
- Current Family and Social situation (patient/family current strengths, supports, and stressors; family and significant others social function, education history, employment history, finances, housing, culture, & language)
- Medical hx
- Family & social hx
- Cultural/religious info
- Justice involvement
- Concrete service needs (unhoused, benefits, food insecurity, case mgmt needs, etc)
- Mental status evaluation
- Collateral Information, when appropriate/available
- Patient DSM-5 diagnosis

Example of an Intake



Test, Salina ,(Sakina) , 32 Y , F INFO HUB ASK EVA ? Connect SOGI
57 WILLOUGHBY ST , BROOKLYN, NY 11201-5257
11/22/1991 | 929-431-8897 | 929-431-8897
s.nejumi@housingworks.org | Yes
Allergies Billing Alerts

Appt(L): 04/
PCP: Werne
Lang: Englis
Translator:

Medical Summary CDSS Rx Labs DI Procedures Growth Chart Imm T.Inj Encounters Patient Docs Flowsheets Notes

Progress Note Scribe Orders h Insights CP SF V 05/11/2023 MD

TEST, Salina "Sakina" Nov 22, 1991 (32 yo F) Acc No. 34567 Quick Order

Therapy Initial, Doxy, "I am not sleeping", BH Televisit.

HPI:

Anxiety Screening

GAD-7 (2018 Edition)

Feeling nervous, anxious, or on edge *More than half the days*
Not being able to stop or control worrying *More than half the days*
Worrying too much about different things *More than hafl the days*
Trouble relaxing *More than half the days*
Being so restless that it is hard to sit still *More than half the days*
Becoming easily annoyed or irritable *More than half the days*
Feeling afraid as if something awful might happen *More than half the days*
Total GAD-7 Score *14*
If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people? *Somewhat difficult*
Interpretation of Total *(10 to 14) Moderate*

Depression Screening

PHQ-9

Little interest or pleasure in doing things *Several days-1*
Feeling down, depressed, or hopeless *More than half the days*
Trouble falling or staying asleep, or sleeping too much *More than half the days*
Feeling tired or having little energy *Several days*
Poor appetite or overeating *Several days*
Feeling bad about yourself-or that you are a failure or have let yourself or your family down *Nearly every day*
Trouble concentrating on things, such as reading the newspaper or watching television *Nearly every day*
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual *Nearly every day*
Thoughts that you would be better off dead, or of hurting yourself in some way? *Nearly every day(Consider Suicide Assessment Risk)*
Total Score *19*
Interpretation *Moderately severe depression*

Referral and Chief Complaint

General HPI

(History of Present Illness)

- Includes a prompt to include the following info in a summary statement
  - **Referral Source**: Who referred the client and why.
  - **High Risk Status**
  - **Demographics & Identification**: Age, ethnicity, gender identity, pronouns, sexual orientation.
  - **Presenting Problem**: Clinician's impression of the issue.
  - **Context of Symptoms**: Onset, duration, and triggers.
  - **Functioning Impact**: How symptoms affect daily life, relationships, or health.
- Example of HPI
  - *Hispanic, 26-year-old cisgender, heterosexual male (he/his) who has presented for initial assessment for therapy referred by…for….).*
  - Kelly is a 38 y/o African American cis-gender woman (she/her) who identifies as heterosexual and is presenting for an initial therapy session after referral by their PCP."

Chief Complaint

(Client's Own Words)

- Ask the client their reason for seeking treatment
- Example:
  - "I'm looking for consistent mental health treatment and monthly psychiatric medication."
  - "I'm trying to just get things right…I wanna see or understand what has me going through what I'm going through."
  - "Belinda referred me for therapy."

Referral and Chief Complaint Cont’d

- Examples of Clinician's Impression of the Problem:
  - “Client is a military veteran with a history of depression, anxiety, trauma, substance abuse, chronic homelessness, and incarnations . Client currently is seeking mental health service for additional support for his depression, anxiety, and to work through his past trauma history, and addiction. Client demonstrates insight into his mental health. Client is motivated for positive change.”
  - "Client demonstrates insight into need for treatment to manage PTSD sxs and for additional support in his recovery. Client is motivated to engage in ongoing psychotherapy to better cope with mental health sxs."

Documenting an Intake: Screeners

- At intake, you are required to complete a series of screeners to provide a snapshot of information that supports your clinical assessment & diagnostic considerations based on sx that are reported
- Important to know these are diagnostic tools & are used as supportive documentation of clinical assessment of sx that should be included in the assessment
- Required screeners:
  - PHQ9 (depression)
  - GAD7 (anxiety)
  - DAST-10 (substance use)
  - Fagerstrom (tobacco)
- Additional screeners that you may use:
  - Columbia Suicide Severity Scale (CSSRS – suicidality)
    - Note this available tool to support your assessment of risk & is not necessarily required
  - MDQ (bipolar)

Documenting an Intake: Screeners

IMPACT

DAST-10

Have you used drugs other than those required for medical reasons? *No = 0*
Do you abuse more than one drug at a time? *No = 0*
Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes") *{...}*
Have you had "blackouts" or "flasbacks" as a result of drug use? *{...}*
Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No". *{...}*
Does your spouse (or parents) ever coplain about your involvement with drugs? *{...}*
Have you neglected your family because of your use of drugs? *{...}*
Have you engaged in illegal activities in order to obtain drugs? *{...}*
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? *{...}*
Have you had medical problems as a result of your drug use? *{...}*
Score: *00*
Interpretation: *{...}*

Suicide Severity Rating Scale

Have you wished you were dead or wished you could go to sleep and not wake up? *No*
Have you actually had any thoughts of killing yourself? *Yes*
have you been thinking about how you might kill yourself? *No*
Have you had these thoughts and had some intention of acting on them? *No*
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? *No*
Have you ever done anything, started to do anything, or prepared to do anything to end your life? *No*

Tobacco Questionnaires

Tobacco Use

Are you a: *Never Smoker*

Tobacco Initial - Patient Interview

How soon after you wake up do you smoke your first tobacco cigarette? *{...}*

Medical history

- This section is exploring client's physical health hx & needs
- **Medical conditions (any pertinent details & length of time)**
- **Prescribed medical medications**
  - Include dosages & reported adherence
- **Are you engaged in primary care (within last 12 months)?**
  - If client is not engaged with a primary care provider and/or has not received a physical evaluation in the last year, want to work with client to refer them to a PCP, internally or externally
  - Request an ROI for any provider that is identified & include refusal of ROI if client is not willing or able to provide

Medical history

Total Score: *Low to Moderate Dependence (3 - 4)*
Age patient started smoking: *12*
Is the patient currently using any NRT/MAT? *No*
Have you ever attempted to stop or reduce smoking tobacco cigarettes? *Yes*
How many times did you try? *3*
What have you tried to help you? *Acupuncture, Cold Turkey*
Are you interested in reducing your use of tobacco cigarettes? *Yes*

Medical History

Medical History

Medical conditions (any pertinent details and length of time): *{...} diabetes, hypertension*
Prescribed medical medications: *{...} metformin 50 mg every day Client reports taking her rx pretty consistently - at least 5 days/week*
Are you engaged in primary care (within last 12 months)? *Yes*
Provider at Housing Works clinic location? *No*
Provider Name: *Dr. Jane Smith*
HIPAA consent for provider obtained? *Yes*
Date of last HIV test: *04-2025*
Date of last HEP C test: *04-2025*

Social and Family Hx

Social & Family History

- This section is exploring historical & current factors in these areas
- **How does the client describe their family growing up? How do they describe the familial dynamics?**
  - Put as much or as little as client is able to provide. Want to specifically document any important, key relationships such as parents, siblings, etc
- **Any known family medical/mental health/substance use diagnosis?**
  - It is okay to also include informal diagnosis of issues reported
- **Describe your current familial relational dynamics (children, partners, etc)**
- **Any family/relational dynamic issues of concern for therapy (ACS, IPV, ruptures)?**
- **Educational background & highest level of learning/certification**
  - Select highest level of education from the list; are able to select more than one option if needed
  - May also be a place where you capture goals related to education but there is a prompt for this later
- **Any known learning challenges/disability**? y/n If yes, expand with provided info
- **Does the patient report any challenges with reading and/or writing?**
  - This question is assessing for any literacy needs that would need to be taken into consideration when providing forms/documents & may consider referral to resources to support

Social & Family History continued…

- **What is the client's cultural/ethnicity identity? What role does this play in their life?**
- **What is the client's spiritual/religious identity? What role does this play in their life?**
- **Summary of work experience**
  - Include industries of work, challenges & successes in the work space
- **Current voc/educational activities or needs:**
  - This can include goals they have in this area
- **Where is the client currently living?**
  - Type of lodging, location, etc
- **Who is the client living with?** This can include any pet(s)
- **Current income source(s)**
- **Client reported strengths & abilities**
  - May sometimes need additional prompting to support identification. Consider prompting with things they like about themselves, things they do well, achievements they have made
- **Community resources & needs assessment** (Hierarchical needs: food stability, housing stability, bills/arrears, safety)

Social & Family History

Social and Family Hx

How does the client describe their family growing up? How do they describe the familial dynamics? *{...} Client grew up with bio mom and maternal grandmother as primary caregivers; lived with them along with her 2 siblings - younger brother, younger sister. Stated that growing up she did not have a good relationship with her siblings as they often engaged in bickering/fights and would lead to them getting into trouble with grandmother. Described feeling closer to her grandmother, which made her death in 2023 quite hard for client to navigate. Client describes bio father as absent and someone who she never developed a relationship with.*

0/0

To D

Any known family medical/mental health/substance use diagnosis? *Yes paternal gf - depression brother - depression*

Describe your current familial relational dynamics (children, partners, etc): *{...} Client lives with a roommate. Has one son who is 19 y/o. Describes a healthy relationship with the son. No issues with roommate. Still has a good relationship with her mom. Is not currently dating anyone seriously but is seeing someone casually who she started seeing in the last 2 months*

Any family/relational dynamics issues of concern for therapy? (Ie ACS/IPV/Ruptures) *Yes Client reports when her son was 12 y/o ACS was involved due to concerns with truancy. Her son was missing 1-2 days of school a week for a period of 3 months. Client stated that the ACS case was unfounded for neglect but did find it helpful as it was what got her started to going to therapy and her son into therapy which helped with the truancy issue. Client does not that relationship with her mom, though now okay, does have hx of emotional abuse.*

Educational background and highest level of learning/certification: *Bachelors Degree, {...} May be interested in pursuing a graduate degree in the future but currently has anxiety about taking on more debt for school*

Any known learning challenges/disability? *No*

Does the patient report any challenges with reading and/or writing? *No*

What is the client's cultural/ethnicity identity? What role does this play in their life? *{...} Identifies with the Jamaican culture since that was the culture that her mother and maternal gm raised her in. Sees this in her life with large gatherings for family, more collectivist mindset, close relationship with cousins who also live in NY. Sees this as a strengthner to her community supports*

Behavioral Health Treatment

- **Client identification & diagnosis (self reported, provider dx):**
  - Indicate what source the dx is coming from i.e. "Client was psychiatrically hospitalized in 2020 & received dx of Bipolar I. Client does not agree with this assessed diagnosis."
- **Symptoms as described by client**
- **History of sx (onset/length of time/frequency/intensity)**
  - This section may include more of your clinical assessment of sx. If it contradicts client's description of sx/presentation, be sure to include rationale/observations that support your assessment
  - Areas you may want to specifically assess to support differential dx: sleep, appetite, energy & concentration levels, mood, interpersonal relationships
- **Identify any experience of perceptual disturbances, psychosis, mania (past or current experience, onset, length of time)**
  - This may include info provided by collateral documentation from another provider or hospital visit. Be sure to include source document of info and that document is scanned into client's record for future reference.

Behavioral Health Treatment continued…

- **History of substance use** (substances used, route of administration/MAT/MOUD current/history)
  - No matter the substances or patterns indicated, should specify whether you assess or not that the client meets the diagnostic criteria
  - e.g. "Client endorses drinking ETOH 2-3x a month but does not endorse any impact on function or daily living. Client does endorse periodic use of cocaine which has negatively impacted work functioning and relationships and meets diagnostic criteria.
- **Currently in any treatment program(s)**
  - Open text box to identify any outpatient or inpatient treatment client may have been involved with over course of their lifetime.
  - Prompt for as much detail as possible
- **Prescribed psychotropics** – may also include previously prescribed rx, challenges with side effects, what was not/helpful for prescriptions
- **Past BH treatment:** Psychiatrist/psychologist/social worker/LMFT/substance use counselor
- **Did patient consent to ROI for coordination with previous/current provider?** y/n
  Include rationale of refusal of ROI if client is not willing or able to provide

Keep in mind that simply because someone endorses use of a substance, does not mean that they qualify for a diagnosis

Behavioral Health Treatment

Behavioral Health Treatment

Client identification and diagnosis (self reported, provider dx): *{...} Client describes herself as depressed. Reports hx from previous outpatient therapist as diagnosed with Major depression, single episode in 2023.*

Symptoms as described by client: *{...} Describes anhedonia; low motivation "just not wanting to do anything;" periods of sleeping 10+ hours which is more than usual amount of 6-7 hours of sleep; fluctuations in appetite that look like binging food in the evenings but having little to no appetite in the day; isolating from friends and having more callouts from work on "real tough" days which she expanded to describe are times when she has no energy, motivation or desire to go to work.*

History of symptoms (onset/length of time/frequency/intensity): *{...} states these sx started around age 22 when she was finishing college. Since then, has had periods of no sx but doesn't describe this occurring for more than 6 months at a time. Describes a moderate level of intensity (identified 5-6 sx associated with depression)*

Identify any experience of perceptual disturbances, psychosis, mania (past or current experience, onset, length of time): *{...} none reported*

History of substance use (substances used, route of administration/MAT/MOUD current/history): *{...} Client reports occassional use of THC gummies when she is feeling tired & wants to get better sleep. Started using cannabis when she was in college around age 18/19 and would smoke occassionally, now tends to use more edibles for modality. Drinks ETOH socially. Consumes no more than 2-3 glasses of wine or cocktails in one sitting Does not identify any challenges with either of these substances.*

Currently in any treatment program(s)? ----- *never been engaged in SU tx*

Prescribed psychotropics: *{...} previously had been prescribed Zoloft. Took it for a year but stopped taking in 2024 when she felt her depression sx were better managed. Is open to idea of returning to psychotropics for additional support*

Past BH Treatment: Psychiatrist/psychologist/social worker/LMFT/Substance Abuse Counselor/ other(specify)/ Reason for leaving(specify): *{...} Saw Aviva Epstein, NPP at HW from 2021-2024 was in outpatient therapy at New Horizon from 2019-2022*

Did patient consent to release of information for coordination with previous/current providers? ----- *Client did not provide consent for previous*

Behavioral Health Treatment (Risk assessment)

See Crisis policy for more info on which policies to consult in risk situations

- This section is still within the BH tx hx but the last set of questi zeroes in on risk assessment
  - **If risk is current or in the recent past (w/in 3 -6 months), must complete safety plan with client**
- **History of psychiatric hospitalization**
- **Any historical experiences of suicidal ideation/attempts (dates/frequency/method)?** y/n If yes, provide details provided
- **Do you have access to lethal means?** y/n If yes, provide details & depending on risk assessment, may initiate discussion of how client can reduce access to lethal means
- **Any historical experiences of homicidal ideation/attempts or assaultive behavior (dates/frequency/method)?** y/n If yes provide details
  - If client endorses current/active ideations with plan, consult with supervisor

Behavioral Health Treatment (Risk assessment)

Past BH Treatment: Psychiatrist/psychologist/social worker/LMFT/Substance Abuse Counselor/ other(specify)/ Reason for leaving(specify): *{...} long psychiatric history in inpatient and outpatient with psychiatrist, psychiatric NPs, case workers, a therapist a long time ago.*
Did patient consent to release of information for coordination with previous/current providers? - - - *Did not offer, Dr. Jonathan Lee, Montefiore Einstein. To revisit.*
History of psychiatric hospitalization: *{...} Patient has several episodes of psychiatric hospialization. Could not clearly remember the dates. Offered to provide them at a future session.*
Any historical experiences of suicidal ideation/attempts (dates/frequency/method)? *Yes Detailed above. History of suicidal ideation since age 14.*
Dates/frequency/method: *last was 4 years ago, (2021.)*
If in the last 6 mo, cue CSSRS/full SI assessment/Safety Plan *Did full assessment and safety plan.*
Do you have access to lethal means (SI)? *Yes Client does not want to kill himself, it is more impulsive, he can't predict it. He said the main means are gun, jumping, pills, cutting. He has no sharp knives, can't open window to balcony, does not have and does not plan to get a gun, has access to but has no stockpile of pills. Wants to live. His wife is his main reason to stay alive. He has few coping techniques today, mostly drugs.*
Any historical experiences of homicidal ideation/attempts or assaultive behavior(dates/frequency/method)? *Yes Client attempted suicide twice as an adult the most recent was 4 years ago, jumping from a fire escape. Prior to that taking a lot of pills. Prior to that he cut his wrist with a piece of glass at age 14, not necessarily to die but he had mixed feelings. When not successful he was mixed feelings of relief and sadness.*
Dates/frequency/method: *Client stated dates are unclear. 4 years ago. Must re assess.*
If in the last 6 mo, cue safety plan *not in the last 6 months*
Do you have access to lethal means (HI)? *Yes He said "I don't plan to buy a gun. They are around. I don't have any sharp knives. I could get pills. I can't open the door to my fire escape anymore."*

Trauma History

- This section is structured towards the end of the assessment to have allowed for time to develop some level of rapport. However, you are able to assess this area (& any others) in any flow that makes sense for you & the client in front of you.
  - Recommend documenting if client is willing to engage in conversation about trauma hx or if they may be more guarded
- This section explicitly prompts for physical, relational, & sexual violence. You may also explore any witnessed or experienced trauma in the following categories:
  - verbal/emotional
  - Community
  - Immigration
  - Elder
  - Financial
  - Combat/military
  - Anything else the client identifies as traumatic for them

Legal involvement

- These are pretty straightforward questions assessing current involvement in the justice system
- **Legal history** (any arrests, charges, periods of incarceration
- **Pending charges** y/n If yes, provide details on current charges & court date. May also want to inquire if reports of their care may be required or requested by the Court
- **Current parole/probation** y/n If yes, inquire about a ROI
- **Current orders of protection** y/n
  - May also include info of previous OOP
- **Current attorney/public defender** y/n If yes, inquire about a ROI

Initial goals for treatment

- **Appropriate for admission?** y/n
  - If you are assessing no, rationale & clinical reasoning should be clearly documented
  - Strongly recommended to discuss with supervisor before assessing not appropriate for tx
  - If not appropriate, provide options &/or support for referral to appropriate level of care
- **Schedule for treatment frequency**
  - Within IOS, this is typically every 2 weeks. May identify weekly, bi-weekly, once monthly
- **Identified initial treatment goals**
  - Think of this as your informal txp outline. What are some initial areas client identifies as wanting to address or need support with over course of treatment

Example of last sections

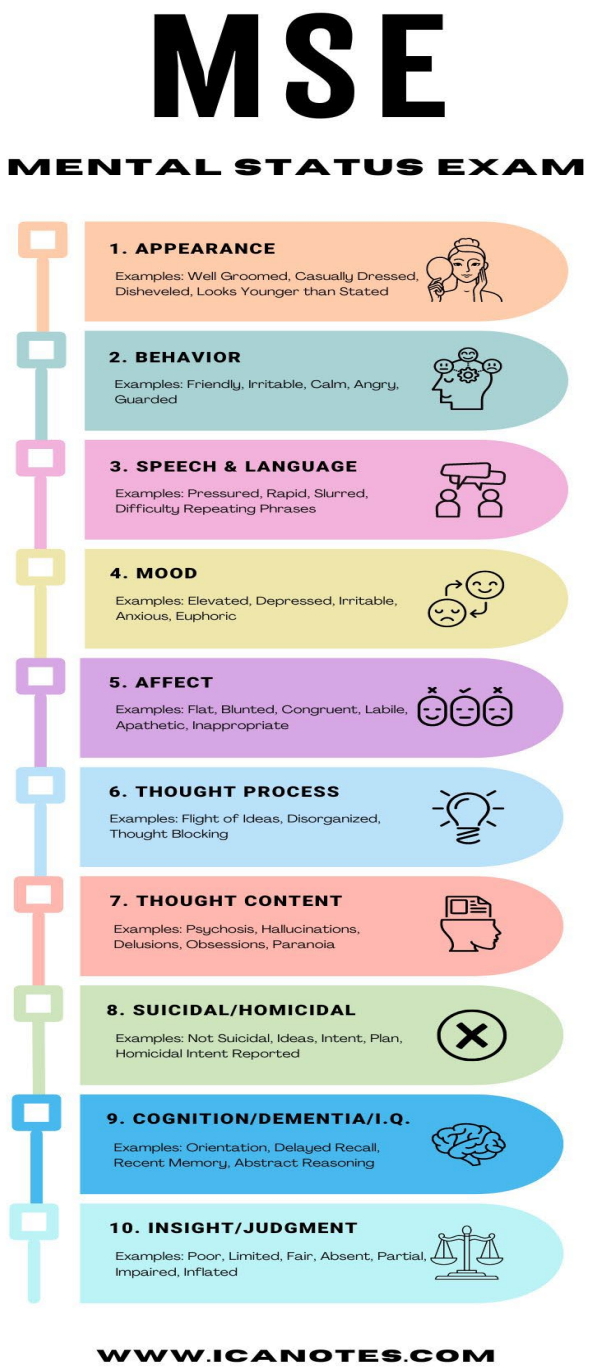
Experiences of Trauma. Clients parents died in 2024. Client's cousin died. Client's friend was shot and died and he was shot at. Client experienced sexual abuse as a child.

Legal Involvement:

- Legal Involvement History
  Legal History (any arrests, charges, periods of incarceration): *Unknown*
  Pending Charges: *No*
  Current Parole/Probation: *No*
  Current Orders of Protection: *No*
  Current Attorney/Public Defender: *No*

Initial Goals for Treatment:

- Initial Goals for Treatment
  Appropriate for admission? *Yes Client is appropriate for admission, and would benefit from coordinated psychotherapy, psychiatry and group therapy.*
  Schedule for treatment frequency: *_Therapy 1x weekly, group therapy will consider after 30 days, periodic care coordination*
  Identified initial treatment goals: *_develop coping skills to reduce anxiety/panic symptoms, , manage bipolar, decrease depression symptoms, enhance motivation to live, enhance knowledge of the role of substance use disorder and substance use on wellbeing*



Mental Status Exam

- On this page, you are documenting your assessment of the client's presentation in the pre-admission session(s)
- If the client's presentation is different across multiple pre-admission sessions, indicate the discrepancies in the comment box
- This may be a page that you do outside of your face-to-face time with the client

Mental Status Exam

Mental Status:

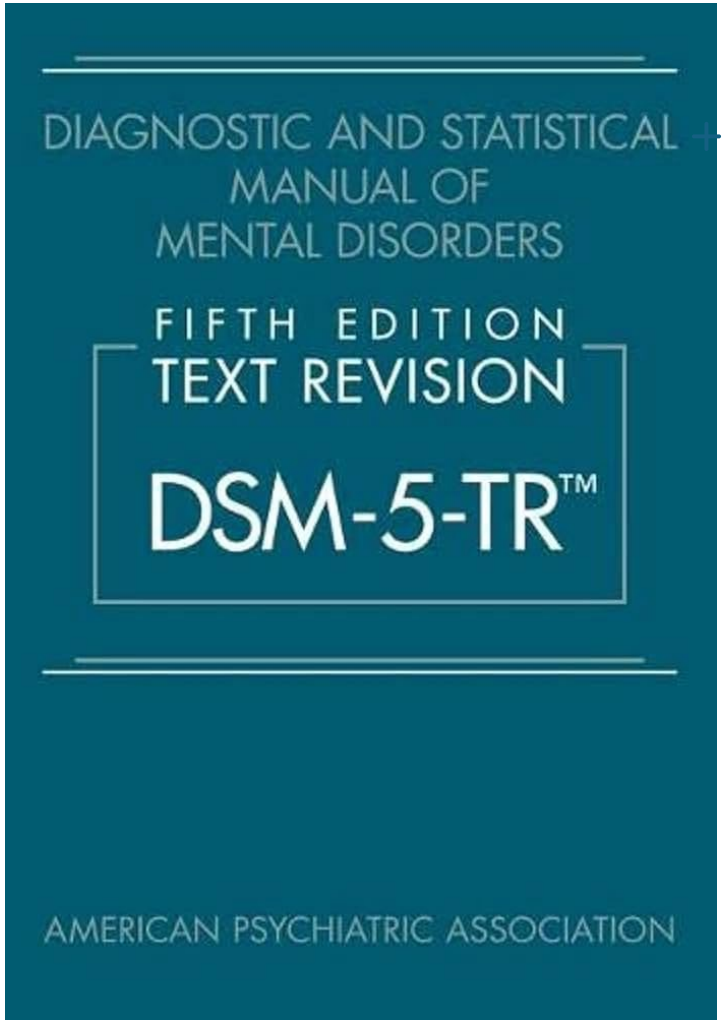
- Appearance Well dressed, well groomed, neatly kept..
- Attitude WNL.
- Affect WNL.
- Motor Activity Normal.
- Eye Contact apropriate.
- Mood euthymic.
- Speech normal rate and speech and volume.
- Thought Process orgnaized and alert.
- Thought Content coherent.
- Disturbances of Perception no Delusion and Hallucination noted. .
- Memory Intack.
- Cognitive Function 3x oriented .
- Abstraction WNL.
- Judgment FAIR.

Mental Status:

- Appearance Unkempt, "I still didn't shave.".
- Attitude Cooperative, Mistrustful.
- Affect Constricted.
- Motor Activity WNL, tense.
- Eye Contact Average.
- Mood Anxious, Depressed.
- Speech Clear.
- Thought Process Logical.
- Thought Content Paranoid, Depressive.
- Disturbances of Perception Command in the past, denies at present, Olifactory: reports being able to smell his father from miles away as a child at school.
- Memory Poor.
- Cognitive Function Poor concentration.
- Abstraction to be further assessed.
- Judgment Impaired, to be further assessed.
- Insight Poor insight regarding impact of substances on mental health, multi substance use including methadone with occasional injected heroin and cocaine with prescribed antipsychotic, antidepressant, stimulant, sedative..
- Reliability to be further assessed.
- Delusions Possible persecution.

Diagnoses

- The intake assessment should include elements that support the clinical rationale of whatever diagnoses that you are identifying. **This may also include substance use dx but SU dx cannot be the primary dx.**
- If you pull your diagnosis from an internal or previous provider, this should be indicated in your assessment and may include a note that you are still assessing and/or ruling out diagnoses
    - Note that this should only be a temporary note for a handful of sessions. After a few encounters, you should be able to confirm or modify the dx that best aligns with presentation of sx that you identify
- **Remember that the screening tools are not diagnostic tools.** They can be referenced to support diagnostic assessment but are not standalone verification of diagnostic sx
- Diagnoses should match across your clinical documentation
- **Diagnoses can, & should be when needed, changed at any point in treatment.** Whenever there is a change, the progress note should support whatever changes was assessed and identify new/changing sx that support the diagnosis change
- If client works with another HW provider who has a different diagnostic assessment, may be beneficial for care to collaborate with this provider to discuss different assessments



Diagnoses documentation example

Assessments

1. Anxiety, generalized - F41.1 (Primary)
2. Major depressive disorder, recurrent - F33.9

Diagnosed by attending therapist based on PHQ-9: Client meets Criteria A (depressed mood and loss of interest or pleasure. Feeling bad about herself like she is a failure, psychomotor agitation/retardation, feeling worthless and excessive guilt, diminished ability to focus and concentrate. Criteria B (the symptoms are causing client distress, especially when client is at home). GAD-7 Client meets Criteria A (excessive anxiety and worry occurring more days than not for at least 6 months), B (client finds it hard to control her worry). C (client's anxiety and worry are associated with restlessness and feeling on edge, difficulty concentrating and client's mind going blank, and irritability. Client's worry is causing significant distress and impairment in important areas of functioning (ADLs).

Client [redacted] presented in person for f/u therapy with writer, and writer used open-ended questions to inquire about [redacted] welfare [redacted] reported continued AH of "neighbors" who are "saying" they are going to "kill me." Client reported rx adherence to 1mg resperidone but had no change in sx and was sleeping very little due to AH. Brooklyn respite housing did not have availability when case manager worked with client on application. Writer used socratic questioning throughout to improve insight, and [redacted] was open to suggestions and help. Writer was informed prior to visit that [redacted] was given new rx of 2mg resperidone at night which [redacted] could pick up after visit which [redacted] agreed to do. Writer assessed client's feelings of safety, and [redacted] said she did not want to go back to her apartment. Writer looked up CPEP in [redacted] zipcode and discussed voluntary hospitalization and explored [redacted] hx with hospitalization to avoid retraumitization, and [redacted] said she would rather go to hospital than return home. Writer invited case manager (HIPPA consent on file) into office to work collaboratively on other respite housing options. Writer provided new list, and [redacted] and case manager submitted new application following visit to SUS Respite Housing at 1719 Montrose Ave in Brooklyn. Writer reviewed and signed off on application (uploaded to pt documents) and was informed client could be accepted the following day. [redacted] stated goal to pick up medication and either go to respite housing or CPEP if feeling unsafe. Client stated she would try increased dose of resperidone and asked for clarity which writer provided by looking up rx in [redacted] chart. Client verbalized strategy to "drown out voices" by using music if she returns to her house to pick up clothing prior to going to respite housing. Writer provided print out of upcoming Housing Works appts to present to anyone as confirmation of receiving MH and PC services.

Client was cooperative and open to tx and has re-engaged in psych care and resuming rx. [redacted] reported no change since last visit and plan to provide temporary safe environment for client and to try increase dose in resperidone. More frequent f/u appts scheduled during this period for continued monitoring and support. F/u scheduled 1 week.

Assessments

1. Paranoid schizophrenia - F20.0 (Primary)
2. PTSD (post-traumatic stress disorder) - F43.10
3. Gender dysphoria in adult - F64.0

dx per previous treating psych provider Aviva Epstein, PA, endorsed by new psych provider Syesha Anderson, NP, and endorsed by counselor. Counselor changed primary MH dx to schizophrenia based on presentation.

Clinician Impression

- This is not formally prompted in the template but should be entered within the notes box in the MSE
- This is a summation of your key assessment areas/findings from the clinical interview
- Summarize any key risk areas, symptomology that supports diagnosis(es). This may also include:
  - Possible therapeutic interventions client would benefit from in therapy
  - If client has active substance use or wants this included, harm reduction focused intervention. Indicate if client endorses use and whether they are assessed to meet diagnostic criteria
  - Client identified housing/social needs

Clinician impression

- Delusions Possible persecution.

_The client is a 42 year old caucasian heterosexual man (he/him) arrived in person after being referred to therapy by Robin Blaize for suicidal ideation anxious and depressed affect, neglected hygiene, to get help to feel better. He said "I am still having panic attacks and now they make me nauseous." He completed the GAD-7, PHQ9, DAST-10, trauma,b ehavioral health, Social and family, medical, tobacco, and legal involvement history.
The client was alert, engaged and cooperative. He is primarily seeking medication to alleviate symptoms. He expressed frustration about knowing that a medication works but not being prescribed. He said he wants to improve his panic episodes, cope with anxiety, reduce depression, eliminate suicidal thoughts, restore wellness and get support to feel better.
The clinician will further assess and explore client thoughts and motivations regarding substance use.
The client requested a letter for social security stating reasons why he can't work at present.
The patient expressed hope that treatment may improve how he feels and functions, and will explore attending a group in the future (a month) and agreed to come for his next appointment in one week.

Required Signatures

- The clinician completing the intake assessment must electronically sign the assessment
- The supervisor will electronically sign when the assessment is final approved & this officially locks the assessment & indicates as completed
- If there is feedback/edits to be made, the expectation is that changes are made within 2 business days & resent to the supervisor review/approval

HOUSING WORKS
CLINICAL LEARNING INSTITUTE

IOS Compliance Training Part II

Deena Smith, LCSW

Behavioral Health Compliance Manager

High risk admissions

High risk admissions

See IOS Determining Risk Status & Management of High Risk policy for more details

- For IOS, there are certain clients who may be assessed [illegible] priority access to treatment
- These populations are:
  - Referred from an inpatient or emergency setting
  - Referred by a priority who indicates the person at urgent risk due to SI/HI or may be at risk to harm self or others
  - Acute psychiatric decompensation
- The initial assessment must be scheduled within **5 business days of referral**
- **Completion of intake in no more than 30 days or the first day that comes after the 4th session**, whichever comes first
- May review this case with a supervisor & assess a need of referral to a higher level of care
- Note that risk is continually assessed throughout treatment

High Risk example

Suicide Severity Rating Scale

Have you wished you were dead or wished you could go to sleep and not wake up? *No*

Have you actually had any thoughts of killing yourself? *Yes Patient reported he thought about death when he was 19 and first learned of his HIV diagnosis.*

have you been thinking about how you might kill yourself? *Yes Patient thought about ingesting poison when he was 19.*

Have you had these thoughts and had some intention of acting on them? *No*

Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? *No*

Have you ever done anything, started to do anything, or prepared to do anything to end your life? *No*

This section was completed on 2/20/24.

High risk/safety planning

Risk Factors: Suicide

- **Distal Risk Factors – Chronic and longstanding risk factors**
  - Demographic factors- death by suicide, previous suicide attempts (past year, past 3 months), psychiatric hospitalizations
  - Family hx of suicide or violence
  - Adverse childhood experiences
  - HX of Psychiatric Illness & symptoms – Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Substance Use Disorders, Eating Disorders, Posttraumatic Stress Disorder, Borderline Personality Disorder) (Suicide Prevention Resource Center, 2018)
  - Chronic Pain

Proximal Risk Factors- acute or current factors that identify more imminent risk

- Current and active psychiatric sxs
- Current substance use
- Stressful life conditions
  - COVID -19 Pandemic
  - Job loss, etc
- Direct access to lethal means
- Exposure to suicide in community, social circles or the media

- Other Risk factors
  - Some cultural or religious beliefs

Mental health risk factors

See the Behavioral Health Orientation training for more info on Suicide risk & safety planning

Routine Follow-Up to continually assess MH Risk Factors

Identify any discrepancies in assessments , for e.g. PHQ 9- rendorse SI but denies in general intake

Risk Areas should include NSSI, SI, HI, IPV/DV

Safety Plan Creation and Reassessment

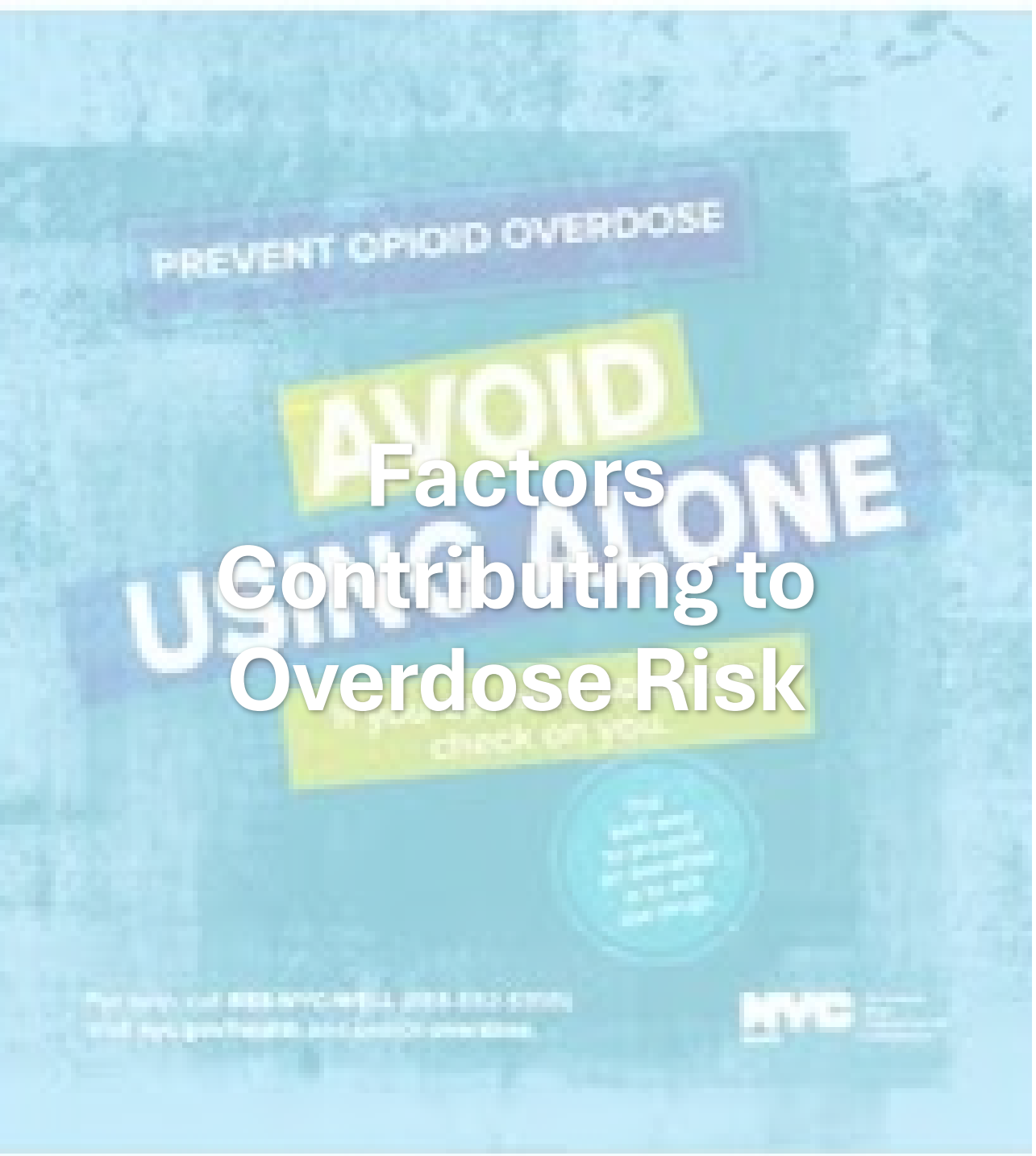
Documentation in EHR and also shared with patient (i.e. also note in documentation if patient declined copy)

Warning Signs & Protective Factors

- *Warning Signs – changes in behavior and new behavior that highlight imminent risk*
  - **Threatening to hurt or kill self or talking of/wanting to kill oneself**
  - **Recent increase in suicidal thinking/planning**
  - **Making preparations**
  - **Feeling burdensome**
  - **Hopelessness, no reason to live, feeling trapped or being in unbearable pain**
  - **Increase in social isolation/social withdrawal**
  - **Increase in substance use or differing behaviors as it relates to substance(s) and types of use**
  - **Insomnia/sleep disturbance**
  - **Rage/revenge seeking behavior**
  - **Verbalizing "not being around"**
  - **Recent and intensive changes in mood**

Protective Factors

- **Coping strategies**
- **Problem Solving skills**
- **Help-seeking behavior**
- **Family (close, supportive, sense of responsibility)**
- **Spirituality**
- **Fear of consequences**
- **Fear of death**
- **Minimize access to Lethal Means**
- **Social Support/Sense of Belonging**
- **Strong therapeutic relationship with a trusted provider**



Factors Contributing to Overdose Risk

- Recent Use of Opioids/Other substances high potential for overdose (Within past 12 month period)
- Past Hx of overdose
- Health and Life Stressors:
- Any personal factors : explore and solicit from the individual
- Process of Substance use: (the what, how and when)

See the Behavioral Health Orientation training for more info on Harm reduction & overdose prevention

Best practices for requesting HIPAAs while Safety Planning

- Risk for harm to self, others and/or overdose
- While making safety plan, also make plan for activation
  - “Who can I reach out to if…..I don’t hear from you X times…..If you miss X sessions without contact .”
- Obtain HIPPA for safety plan contacts if possible
  - Safety plan contact should be relevant to potential scenario
  - If client cannot identify emergency contact, discuss potential for wellness check
- Telehealth and Risk
  - If client typically meets with you over Doxy and is high risk or decompensating, consider if client needs to be assessed or seen more regularly in person

Safety Plan

- In eCW, there is not a built-in safety plan. You can complete a paper version of a safety plan & add it to the "Patient docs" folder in the client's chart
- The version we tend to use is the Stanley-Brown
- Safety plans can be completed at any time in treatment & are meant to be living documents – meaning it is something you & the client can refer back to & make updates/adjustments, as needed
- Best practice is to also offer a copy to the client

Documenting Progress Notes

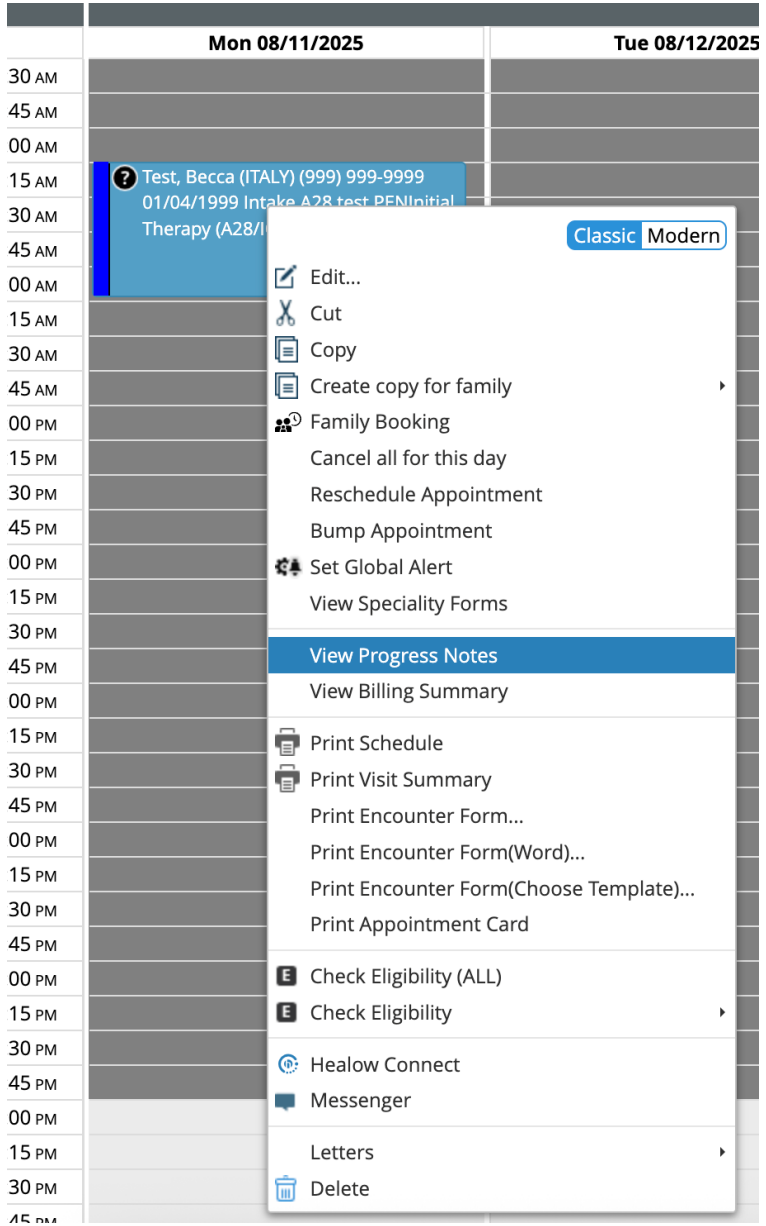
Progress notes

- Your notes are a key element to documenting each individual's progress, challenges, needs, strengths, and clinical necessity that supports continued engagement in treatment
- Notes should be completed for any billable encounter that you have with a client
- Notes should be consistent with the individualized treatment plan & report advancement or lack thereof toward goals, symptom reduction & functional improvement
- Provide documentation to **demonstrate that services are delivered as defined in the treatment plan that supports medical necessity & billing,** including clinical interventions that are used
- Progress notes must be dated & signed by a clinical member of the clinical program staff
- Non-LCSW staff will need to have their notes co-signed by supervisor/LCSW
- Notes should be completed in locked in eCW within 2 business days
  - Supervisors should make an effort to review & co-sign notes within the same time frame

How to create a progress note

- From resource scheduling view, right click on the appt for which you are looking to create a progress note
- Select the "Classic" menu option > select view "progress note"
- This will open the progress note for the corresponding encounter

See eCW billing training resource for further details



Content of session

- Notes need to include the **type of session** (i.e., intake vs follow up) and **how it was conducted** (in person or telehealth)
  - If you do the session by **telehealth**, you need to include:
    - The **type** of telehealth (i.e., doxy, zoom, telephone)
    - Where the **patient is located** for the session (i.e., their specific location and the state they're in)
    - If the patient is in a potentially public space (like a park), document the conversation you have around **potential risks to privacy** and patient's consent, if they consent, to proceed with the session
- Who was present in the session
- The progress note should overall contain at least 3-5/7 sentences that discuss the overview of main content/goals discussed in session. The patient's **treatment goal that is being addressed** has between this session and the next session
  - **Example**: Addressed patient's goal to reduce harm by reducing alcohol use
  - Please note that you should **periodically circle back to goals** in the following domains: **substance use, medical, mental health, areas of assessed risk, as well as any other client-identified goals**
  - This should also include identification, incorporation of client's **strengths and resources** that they are able to utilize to support them in addressing goals

Content of the session (cont)

- The **therapeutic modality** **you're using and what you're using it to address**
  - **Example**: Writer used CBT to assess triggers for substance use and coping skills to address triggers. Writer introduced the ABC model to assist pt in identifying situational and emotional triggers; pt reported triggers are getting into arguments with others and feeling disrespected. Writer and pt practiced deep breathing coping skill in session.
- The **patient's perception/response**
  - **Example**: Pt reported the deep breathing skill was helpful in this moment and expressed concerns about utilizing it in the moment. Writer and pt discussed practicing skill when pt feels calm so that it is easier to use when pt is activated
- *Plan:* Their **next appointment date** and any other next steps that may need follow up on

Example

- Insight Good.
- Reliability Fair largely due to challenges at times articulating specifics of events; ongoing assessment with criminal offense history .

Client (CT), 49 yo African American heterosexual male (he/him) arrived in person for follow up therapy, and therapist asked open questions. [redacted] said he didn't have anything specific he wanted to bring up that day and was open to therapist guiding session. Therapist shared that he received an email from his previous mental health hygiene attorney who shared documents of his criminal conviction history and clarified that there were no records involving any male victims. Therapist and [redacted] processed emotions for him with having a severe allegation on the registry and how it affected his mood and depression. Therapist asked [redacted] what he would like to do, and [redacted] said he would like to correct it if possible. Therapist asked what it would be like for him if he put in a considered effort and did not get that result, and [redacted] acknowledged he didn't know the outcome but wanted to try anyway. Therapist encouraged [redacted] to take the steps on his own with some guidance and support from others, and therapist provided print out of email/contact number where he could inquire about a correction/amendment to the registry. He said he checks in with the registry once a month although he didn't know the person's name or have contact information so a HIPPA consent was not done. He said he would ask the person the next day when he saw them. Therapist asked what he might do if [redacted] request is dismissed as [redacted] acknowledged that sometimes he is ignored. Therapist and [redacted] identified language and strategy he could use to advocate for himself with this need.

[redacted] was receptive to communication skill building, strengths-based perspective to advocate for himself to try and resolve challenge which affects mood d/o. Client's activities of daily living affected with impacting employment, limited social support, intermittent SI/HI, and difficulty managing finances; client additionally is on social security due to mental health condition and has history of psychiatric hospitalizations. Plan to monitor psych engagement, rx consistency, promote self-efficacy with appointments, and continue working on consistent engagement across all areas of care.

[redacted]rrent Medications

- Delusions None reported .

Client is a 42-year-old, African-American, straight, cisgender woman (she/her pronouns) presenting for f/up in person. Client presented in good spirits despite reporting a recent fibromyalgia flare-up. Client used the session to process her experience of chronic illness, noting that her life currently feels defined by fluctuating "good and bad moments," rather than good or bad days. Client described the flare-ups as debilitating, depressing, confusing, and unpredictable. Client reflected on her first flare-up about ten years ago and the emotional distress it caused, particularly due to the lack of support from past partners who struggled to understand her physical limitations.

Therapist provided space client's emotional expression and validated client's lived experience with chronic illness. Therapist used supportive reflective listening and normalization to help client explore the emotional and functional impact of her condition. Therapist reinforced client's resilience and commended her for attending the session in person despite discomfort. Psychoeducation was offered around the mind-body connection and chronic illness-related depression. Therapist helped client identify supports in her environment and acknowledged her daughter's helpfulness as a protective factor.

Client was engaged in session. Client provided multiple examples of how fibromyalgia affects her daily life and family dynamics, including how her daughter assists her at home while her son, who has ADHD, is less able to contribute. Client remained grounded and open throughout the discussion, demonstrating insight into her needs and strengths and reported feeling motivated to continue to manage her sxs and remain positive despite any setbacks she may experience.

Key areas to enter progress note data

- Reason for appointment should capture a quote from client that demonstrates chief complaint for the encounter
  - You may also include a note about what the type of encounter it is i.e. "therapy f/u"
- General HPI
- Mental status exam
  - In the open text box under this section, this is where you type your main body of your progress note summarizing the context of the session
- Assessment – diagnosis(es)
- Treatment - diagnosis & ICP/Txp
- Telehealth questionnaire – must be completed only for telehealth sessions
- Note that medications are incl

Example Progress Note part I

Reason for Appointment

1. Therapy F/U 14 (Doxy)
2. "I thought people thought I was weird."

History of Present Illness

General HPI:

- General HPI Patient identified as a 29-year-old white, cisfemale (she, her, hers or they pronouns). Patient identified as bisexual. Patient was referred by her Behavioral Health Medical Provider (BHMP), psychiatrist, Aviva Epstein.

  This section was completed on 12/1/23. It was updated for f/u session use on 1/30/24. Updated on 5/24/24 to account for patient's age change in April.

TeleHealth:

- TeleHealth Questionnaire
  Client consent obtained for telehealth visit? *Yes*
  Visit occurred via telemedicine interface? *Yes*
  Mode: *Doxy Video*
  At least 50% of encounter spent counseling/coordinating care? *Yes*
  Provider at Housing Works clinic location? *Yes*
  Patient at Housing Works clinic location? *No*
  Client's current permanent location? *NY State*

Mental Status:

- Appearance Kempt.
- Attitude Positive and ego syntonic.
- Affect Broad.
- Motor Activity WNL; no concern for, indication of, or disclosure of intoxication or catatonia.

Example Progress Note part II

- Eye Contact WNL.
- Mood Euthymic, but patient started to cry toward then end as she exprerssed feelings of loss and grief.
- Speech WNL.
- Thought Process Thought ordered.
- Thought Content Patient denied any recent or current, active or passive SI, HI, auditory/visual hallucinations, mania, psychosis, delusions, delirium, paranoa, and/or psychiatric Emergency Department (ED) visits/hospitalizations.
- Cognitive Function AOx4.
- Judgment Good.
- Insight Good.

Clinical Supervisor (CS) met with patient via Doxy. Patient continued to focus on the relationship that she was experiencing and how it ended differently than she hoped. When speaking about this, CS and patient began to explore her her thoughts and feelings regarding shame. Patient explored how vulnerability is connected to these feelings. Patient and CS then spent some time discussing shame resilience techniques and how they could be beneficial for patient's anxiety in relationships.

Current Medications

Taking

- Calm , Notes to Pharmacist: PRN
- Lexapro 5 MG Tablet 1 tablet Orally Once a day
- Melatonin , Notes to Pharmacist: PRN
- Lexapro 5 MG Tablet 1 tablet Orally Once a day

Vital Signs

Assessments

1. GAD (generalized anxiety disorder) - F41.1 (Primary)

Treatment

1. GAD (generalized anxiety disorder)

Notes: Patient was scheduled for 30-minute F/U appointment. Patient was seen for 26 minutes (4:08PM to 4:34PM).

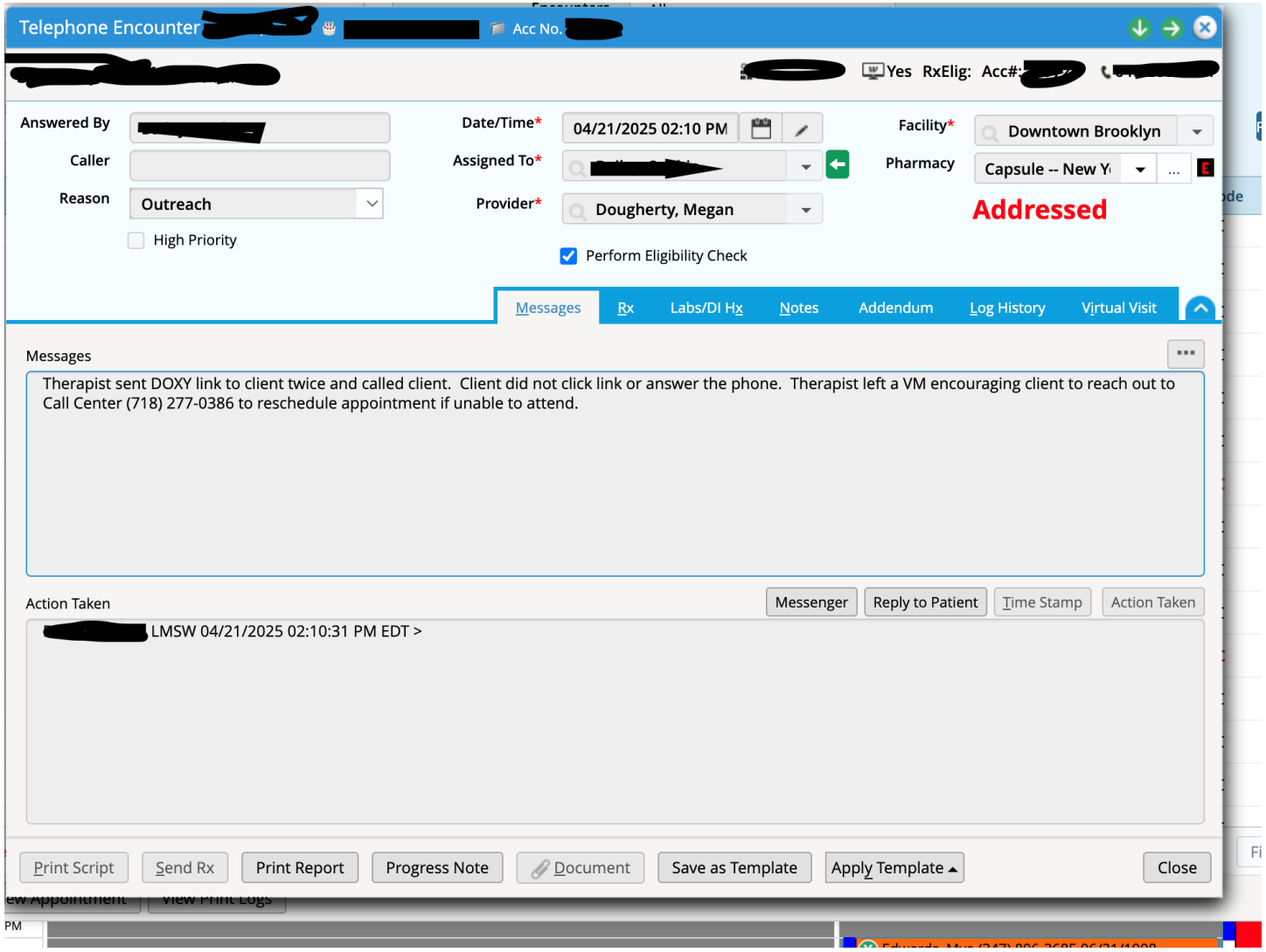
Clinical Notes: CS utilized Open-ended questions, Affirmations, Reflections, and Summarizing (OARS) techniques and psychoeducation to explore how shame impacts patient's feelings of anxiety.

Behavioral Health Objective: Patient would like to develop three new self affirming neural pathways that reduce her cognitive blockades to living authentically by 1/30/25.
Progress: Patient and CS explored how the use of self-affirmastions will help patient with developing new neural pathways.

Admin notes

- There is no formal administrative note in eCW. Admin notes are to be captured in telephone encounters (TEs) in eCW
- These notes are meant to capture any non-billable encounter or important information or event that is relevant to client's care and/or goals
- This may include:
  - Outreach for a missed session
  - Outreach to a collateral
  - Compliance issues that have been identified and indicated to include a note in the record
    - This is typically completed by the supervisor
- It is best practice to document any time you review records in eCW for a psych or medical provider- could be added as part of a collaborative note or integrated into the next progress note with client
- Though not billable, these notes should still be completed in a timely manner, signed, & locked by the writer

Admin note for outreach



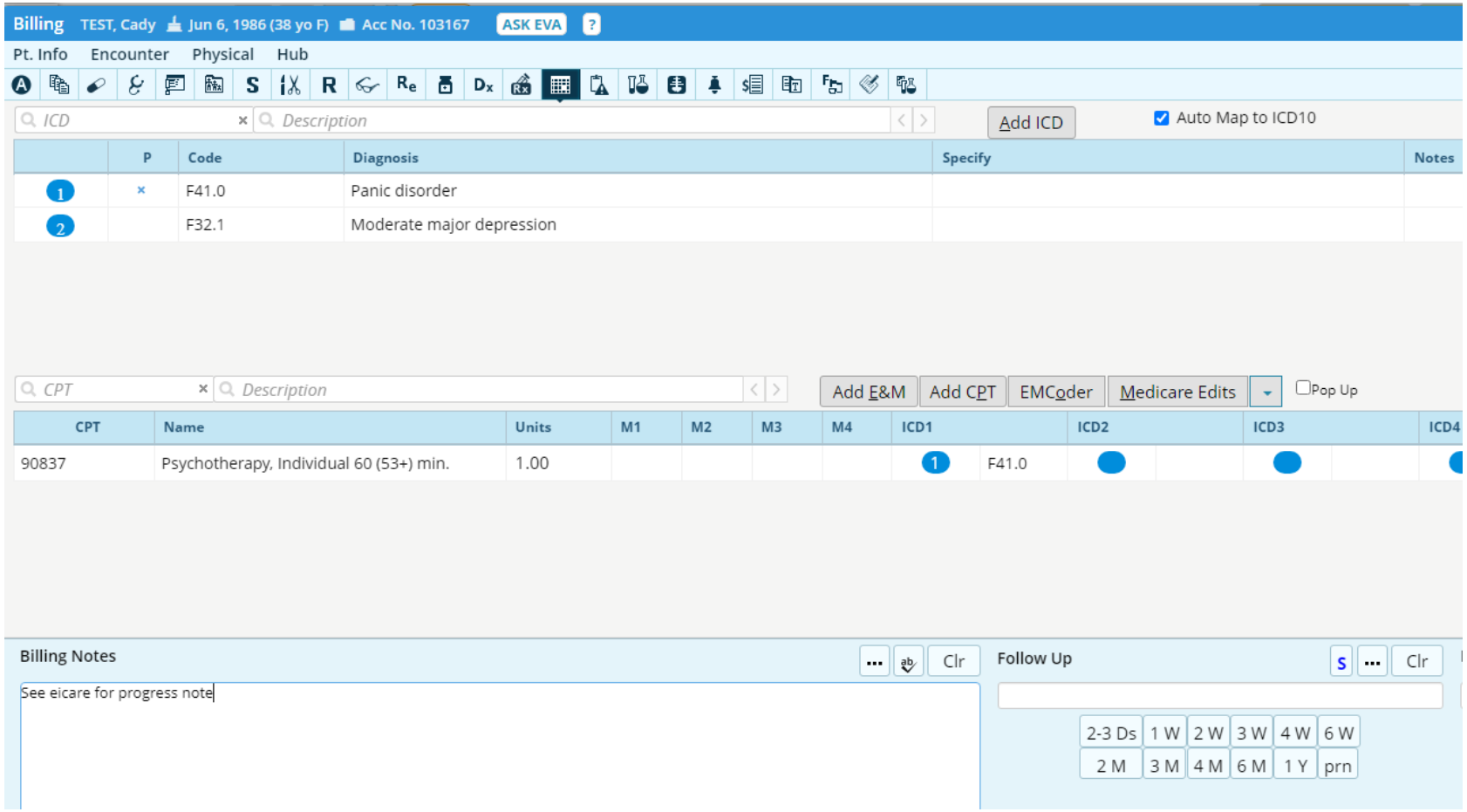
Billing in eCW

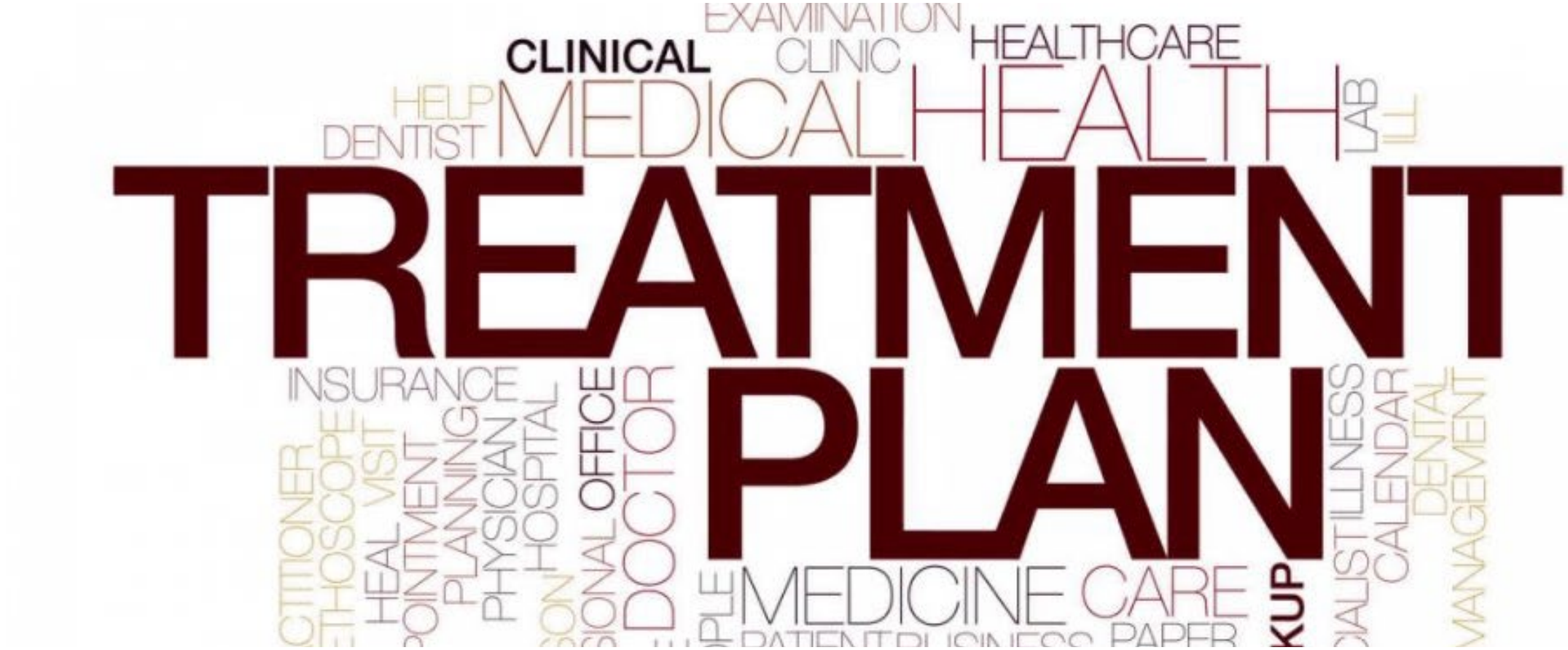
Billing

- Billing is captured in the same EHR as the clinical documentation: eCW
- What's included:
  - All assessed diagnoses – both MH & SU
  - Telehealth questionnaire for telehealth visits
  - CPT/billing code
  - Additional modifiers
  - Signature of clinician providing services
  - For non-LCSWs, a co-signature by an LCSW must also be obtained

Example of billing

Review further with your supervisor





Documenting Treatment Plans

Treatment Planning

Treatment planning is a collaborative process between clinician and the client: how they will work to develop a plan to address an issue or meet a need. The plan outlines a roadmap of how they will work together to help the client achieve their goals and objectives. The treatment plan includes a statement of the clinical problem, the interventions and room to measure client's progress.

When developing a treatment plan it is important to consider the client's strengths, their circumstances, and what they hope to achieve. It's important to set goals using patient centered statements/goals that are measurable and adjusted as the client progresses in treatment.

Periodic review of the treatment plan keeps the plan accurate and up-to-date; allows for adjusting the interventions by determining what is working ; the review may highlight areas of strength that can be used to increase positive outcomes in other less successful area; May uncover other barriers to treatment success that may not have been identified; offers opportunities to brainstorm areas that are a concern and create a plan for next steps.

Treatment plans are reviewed and updated every 90 days or the first encounter after, unless indicated for a sooner review.

Writing Effective Treatment plans

- In addition to what the client identifies, you may also consider incorporating information from the intake assessment. Assesses the client's needs, set goals, and determines the most effective treatment methods.
  - If the client is not able to participate in the development of the initial txp, you should use the intake to develop or recent progress notes for txp reviews
- Use client quotes of what they want to work on for their goals
- Important to also consider client's strengths & explore how those can be utilized in goal development
- Have measurable objectives to assess the client's progress. Use SMART goals to identify the plan to address the presenting problem or need.
- Periodically review client's progress and update the treatment plan as needed. This allows you to track progress, make changes to the plan as needed, and ensure that you are on track to meet your objectives. The review may offer an opportunity to brainstorm problematic area and make determinations for next steps.
- Adjust objectives if no progress in treatment

Treatment plans should include…

- **A behavioral health, medical, & social service needs goal are the minimum goals that must be identified**
  - If client is not engaged with a primary care provider, part of treatment may include focusing on linkage to PCP
- Additional goals could be identified under each area. If identified, this goal must be explored over course of treatment
  - Substance use may be an additional goal area
- **Goals can also be deferred.** A client may identify a goal they are interested in achieving but not willing or ready to work on it at this point in tx. If so, this can be a good opportunity to defer a goal. Reason for deferrment should be captured in the note and/or txp
- **Objectives should be SMART and not continuously carried over**
  - Should not be carried over more than 1 review
- Goals & objectives should also include target dates & frequency of services (treatment schedule)
- Additional services, such as groups, should also be captured within txp
- Measurable discharge criteria
- Signature of client, if able to obtain
  - If client is not able to sign, a note should be indicated in the progress note to specify why
  - i.e. "Client participated in txp development via telehealth session on 8/21/24 and therefore unable to provide signature."
- Signature of clinician
- Signature of supervisor

Creating a Goal Statement

- Clinical statement of the condition you expect to change
- The goal is tied to the assessment and presenting problem/issue
- The goals are written in a way that they are reasonable and achievable
- When reviewing goals, it may be helpful to explore the client's perception on progress or lack thereof on stated goals; explore if current goal could benefit from a slight adjustment to better setup the client for success in achieving the goal
- Goals and objectives are often confused in treatment plans so keep in mind there is a difference.
- If you **can see the client do something** (i.e.-complete a journal entry, attend AA, etc.) then it is an objective.
- If you **can't see a client do something** (i.e.-reduce anxiety, accept powerlessness), it is a goal.
- Examples:
  - Client will reframe negative self-talk and feelings of worthlessness as demonstrated in at least 3 consecutive sessions
  - Client will remain abstinent from alcohol for 6 months
  - Client wants to maintain medication (Wellbutrin 300mg, Vyvanse 30 mg, Naltrexone 50mg) to reduce cravings for methamphetamine so he can stay abstinent
  - Client will identify 3 persons that they can outreach for additional suport during times of increased depression symptoms

SMART GOALS:

Use SMART goals to identify the plan to address the presenting problem or need. SMART stands for Specific, Measurable, Attainable, Realistic, and Time

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Make objectives	
Specific	Goals and objectives are more easily accomplished when they are clearly stated. Answering the 5 “W” questions (who, what, when, where, and why) is helpful in setting specific goals
Measurable	Establishing concrete criteria for measuring progress can help motivate continued effort to achieving the goal. How will we know when the goal is accomplished?
Attainable	Goals should be reasonable and achievable. Trying to do too much in too little time is not the best way to succeed.
Realistic	A goals is probably realistic if the person believes that it can be accomplished. To be realistic, a goal must represent something a person is willing and able to do.
Timely	Goals are more grounded when there is a time frame attached to them. Identifying short-term steps within a longer term goal can help to create hope and momentum.

Creating objectives

- Objectives are what the client will do to meet the goals
- Must be stated in behaviorally measurable language and must be clearly stated
- Objectives are the skills developed by the clients and when accomplished will result in achievement of long-term goal
- If a client has had an objective that has recurred for more than one review, it is recommended to adjust this objective to better capture where the client is in relation to that goal or readjusting the goal, if needed
- Examples of objectives:
  - Client will identify 3 persons that the client can outreach for additional support during times of increased depression sx
  - Client will identify at least 2 pros and cons of engaging in cannabis and its impact on the client's mental health
  - Client will report adherence to psychotropic medications at least 4 days out of the week for at least one month

Discharge criteria

- This should capture what the client will see/feel that indicates that treatment has been successful and they are ready for discharge
- **Must be measurable**
  - Consider metrics that you and the client would easily be able to track and monitor over the course of treatment
  - For example, if you are using percentages in your measurement, keep in mind how to track/monitor this progress, change
- This can be updated as you complete reviews if client identifies new parameters or adjustment to previously identified criteria
- Example:
  - "Client will be able to identify 3 coping mechanism to manage depression and consistently engage with them over a 3 month period."
  - "Client will demonstrate adherence to psychotropic regiment 6 out of 7 days for a 6 month period."

Check your work

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- Check your work before you have the client sign…
- Is your goal related to your assessment?
- Do you have at least one clinical treatment goal?
- Are your objectives SMART and do they relate to the goal?
- Are your time frames reasonable and not just matching your authorization?
- Have you described your interventions in a way that accounts for the good work you are doing?
- Do you have more than one goal that accounts for the needs of the client (treatment, case management, etc.).
- Is the treatment plan signed?

Initial Treatment Plan

- Initial txp must be completed within 30 days of admission.
  - Best practice is for the initial txp to be completed within the admission session or the first session after admission.
  - Any client who transfers services from an internal sister clinic must also complete a new initial txp under the new clinic where they are engaging in services
- Treatment plans can be submitted up to 30 days in advance of the txp due date.
  - Treatment plans must be submitted to supervisor and supervising psychiatrist to review prior to or on due date to meet compliance standards.
- These goal(s) should be person-centered & connect to what is being addressed in sessions

Txp Reviews

- Must be minimally **reviewed every 90 days or at the next encounter, whichever comes first**
  - This date is calculated from the date of the most recent txp that was completed
- Goals and objectives should be reviewed & updated at each txp review
  - If a client has had an objective that has recurred for more than one review, it is recommended to adjust this objective to better capture where the client is in relation to that goal or readjusting goal if needed.
- When reviewing goals with client, it may be helpful to explore the client's perception on progress or lack thereof on stated goals; explore if the current goal could benefit from a slight adjustment to better setup client for success in achieving the goal.
- Goals ideally are written in a way that are attainable for client to achieve some progress within the review period. This may mean that goals are written in small clear steps.

Txp review example

Care Plan:

Problems:

- Behavioral Health*

Goal:To address depressive symptoms Objective:Client will attend therapy bi-weekly, will identify at least 3 coping tools/activities and at least 3 triggers for depressive symptoms by 05/09/2025
Notes:, Intervention: On 09/26/2024: Client and therapist updated goal language. Ct reports feeling much better that he had cataract surgery on both of his eyes. Ct stated his depressive symptoms is triggered by being in pain, being alone. Coping tools/activities include adult coloring book, distraction- watching t.v and reading now that he can read again. Ct has selected to continue working on this goal at this time.

- Medical*

Goal:To correct vision with removal cataracts in both eyes Objective:Client will continue to see pulmonologist to monitor oxygen level in blood weekly (100 percent oxygen level before operation), taking albuterol treatment when breathing is labored by 5/9/2025
Notes:, Intervention: On 09/26/2024: Client and therapist updated goal language. Ct completed cataract surgery in both of his eyes on 8/20/2024 and 7/30/2024, This goal is marked as complete.

- Medical*

Goal:To get dentures/dental implants Objective:Client will call his insurance provider and select dentist within 30 days, obtain treatment plan for goal once dentist is selected by 09/26/2024
Notes:

- Social Services Needs*

Goal:"Transportation to and from appointments" Objective:Client will ensure required documentation is submitted and renewed yearly for Medicaid transport, client will ensure he calls a day or 2 before scheduled appointments to ensure availability for transportation by 05/09/2025
Notes:, Intervention: On 09/26/2024: Client and therapist updated goal language. Ct reports this goal is going well. Ct started he has an additional transportation company in addition to access a ride. Ct reports he has submitted all required documentation and attends his appointments as scheduled with transportation assistance. Ct has selected to continue working on this goal at this time.

- Substance Use

Goal:" To stop having drug dreams " Objective:Client will continue to attend NA meetings at least twice a month, identify at least 3 triggers and 2 activities ct can engage in when cravings are present 05/09/2025
Notes:, Intervention: On 09/26/2024: Client and therapist updated goal language. Ct stated he has not been having drug dreams lately. Ct reports he has not been able to attend NA meetings, but have been looking for NA online. Ct identified

Transfers between clinics

Transferring between our clinics

- Although HW has several types of mental health programs, they all operate as different programs
- If a client would like to transfer their care between either of these clinics, there is a slightly different workflow than the typical admission process

Transfers workflow

- No matter which program the client is being transferred to, the client record should include **clinical justification for the transfer** in a progress note or telephone encounter
- If you are transferring **between A28 and IOS sites**, the existing treatment plan may be used if there is documentation that it has been reviewed & updated, as necessary, within 14 days of transfer. You may want to update an intake assessment if it has been more than 12 months and/or if the client identifies significant changes in hx or sx since previous intake was completed
  - Note that if the transfer is to an A28 site, there are additional requirements (referral, have a treating HW provider)
- If the transfer is **from IOS to OMH/OASAS**, the client will need to complete a new enrollment for the program they are being referred to (consents, txp, etc)
  - Note that someone cannot be in both IOS and OASAS & SU cannot be the primary dx in IOS
- The record should include **documentation of communication with other consented service providers & other collaterals**, if applicable; can be captured in an admin note (TE) or within documentation of conversation with client in a progress note
- **Discharge summary** - this currently looks like typing up the referring program, intake appt, summary of goals in tx in a TE

Outreach & Collaboration

Outreach

- It's important that we support clients who may have difficulty with consistent engagement
- If a client is 5-10 minutes late for a scheduled appointment time, it's best practice to outreach the client. Appointment can be rescheduled, if needed, or converted to a telehealth session if client is not able to attend in person but can participate remotely
- For each scheduled encounter, there should be documentation in the record
- Support staff may also engage in outreach for missed appointments
- If arriving late or missing appts appears to be a pattern, discuss & document addressing barriers to consistent engagement in tx

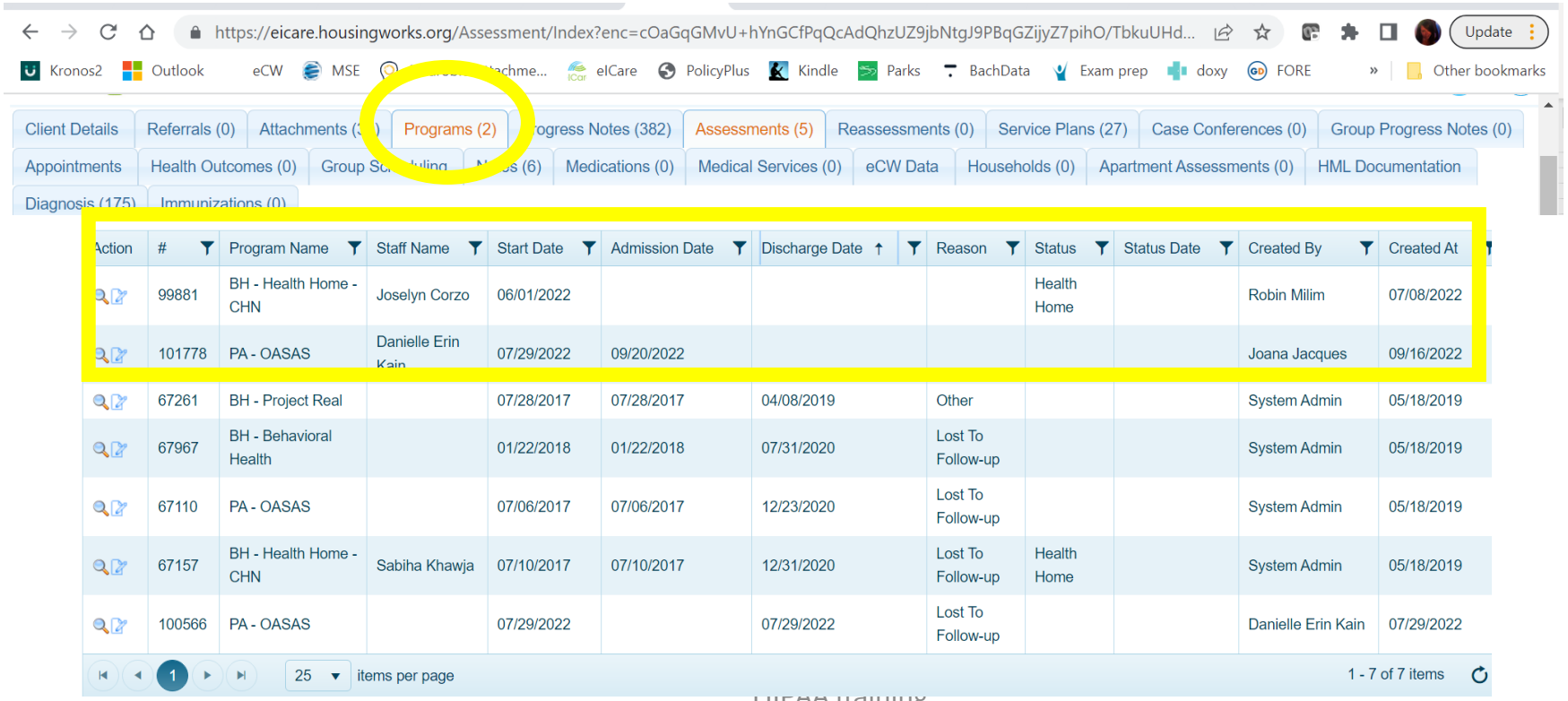
Best practices for requesting HIPAAs at intake

- WHEN do you ask?
- Explain WHY we ask for consent
- Explain WHAT the consent is for
- WHO is important in client's life/ healthcare?

- Remember, HOW we ask matters!
- Considerations with mandated clients
- Document when client refuses consent

Best practices for requesting HIPAAs at intake

- Is client enrolled in internal programs?
  - Before creating assessment, check programs tab in eiCare



Best practices for requesting HIPAAs at intake

- Opportunities from assessment
  - Have extra blank HIPAA's on hand during assessment

Section	Consider:
Referral/Chief Complaint	
Mental Health Tx History	
Substance Use Tx History	
Criminal Justice Involvement	
Family and Housing	

Documenting Discharge

Discharge planning

- Discussion of discharge and discharge planning starts at intake and is an ongoing process
- Intake should document assessment for level of services and criteria for determining when the recipient may be ready for discharged from the program.
- Across documentation starting from the **initial treatment plan**, ongoing **progress notes**, and **treatment plan reviews**, where appropriate, ongoing discussion determining when the client's goals have been met to the extent possible in the context of the program, and planning for the appropriate discharge of the individual from the clinic.
- The discharge plan should reflect individual strengths and level of social support and address psychiatric, substance use disorder, chronic medical, and social needs - as well as consider all available services in the particular community. The plan should also address relevant concerning information obtained from collateral sources of information

Potentially Ready for Discharge:

Completion of Goals: The client has **completed treatment goals.**

Reduction of Symptoms: There has been a substantial reduction in the symptoms recorded in the client's treatment plan and no significant hidden or new symptoms come to the fore.

No longer benefit from treatment: The provider and client agree that continuation of treatment would not likely result in further improvement in functioning.

AOT: Prior to discharge of service of an individual who is also enrolled in an AOT program, the provider notify the individual's case manager and/or relevant director/supervisor.

High-Risk Requirements: Any client determined to be high risk will only be discharged after mobile crisis has been involved and/or other treatment providers involved in the care.

Attendance: The client is not currently meeting the clinic's criteria for continued care due to their level of engagement/attendance. Before discharge, the clinician or support staff will make at **least three documented outreach attempts.**

Alternative Care: It has been determined by provider and supervisor that alternative care is require. The client is referred to the appropriate level of care setting by the provider and discharged from the clinic.

Documenting discharges

- **Planned discharges:** Summary is completed in the final session progress note by the treating clinician, including reasons for discharge, treatment course, risk level, and referrals.
- **Unplanned discharges:** Documented via telephone encounter by the treating clinician including same info specified above.
- **Clients continuing with other FQHC services** but ending psychotherapy: Discharge/referral should be documented in a telephone encounter.

Types Discharge

- **Unplanned Discharge:** If client is discharged due to lack of follow up or attendance. Clinician must ensure that there is documented outreach in client's chart. **At least 3 outreach notes are needed.**

~Best Practice: Would be for client's who are discharged due to loss of contact, a discharge letter be mailed to client informing them of their discharge, the process to re-engaging in services, and referrals provided.

Planned discharge: If client is being discharged for any reason outside of being lost to follow up, a discharge plan/discussion should be documented within client's chart.

References

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