

Writing Clinical Notes

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This program is designed to be educational and should not be construed as legal advice.

Learning Objectives

1. Learn some of the legal and ethical parameters of clinical documentation
2. Understand the content of documentation essential to an effective defense of a malpractice lawsuit or licensure board complaint
 - General risk management guidelines
 - 2019 Florida law changes re/ confidentiality and privilege re/ dangerous pts./clients that could impact documentation practices
3. Opportunity to share styles of documentation that support one's particular practice setting.

Clinical Documentation

The client record is comprised of the physical or electronic folders or files, sometimes referred to as the chart or treatment record, in which protected health information (PHI) pertaining to the care of the client is maintained. The contents typically contain:

- Client contact information
- Dates of service (start/stop time)
- Participants (in attendance)
- Informed consent (signed/dated)
- Financial charges and payments (may be stored separately)
- Clinical assessment and/or Dx
- Authorizations to release confidential information
- Session notes (chart notes, progress notes, process notes)
- Treatment plan
- Prognosis and progress tracking
- Collateral information (testing results, letters, reports, emails, court and legal documents, information obtained about the client from others (including past clinical records and communications from third parties)
- “Psychotherapy notes” (HIPAA)

Psychotherapy Record (Fla. Stat. 491/Rule 64B4)

Rule 64B4-9.002 Definitions.

Psychotherapy records are chronicles of a dynamic psychotherapeutic relationship and are to be accorded the dignity and respect due such a relationship. Psychotherapy is for the client and all records constructed shall respect the integrity and privacy of that relationship.

- (1) **Psychotherapy report** is a summary of information derived from the psychotherapy records which addresses a specific request as authorized by the client.
- (2) **Psychotherapy record** shall contain basic information about the client including name, address and telephone number, dates of therapy sessions, treatment plan and results achieved, diagnosis if applicable, and financial transactions between therapist and client including fees assessed and collected. A record shall also include notes or documentation of the client's consent to all aspects of treatment, copies of all client authorizations for release of information, any legal forms pertaining to the client, and documentation of any contact the therapist has with other professionals regarding the client.
- (3) Regardless of who pays for the services of the psychotherapist, a client is that individual who, by virtue of private consultation with the psychotherapist, has reason to expect that the individual's communication with the psychotherapist during that private consultation will remain confidential.

Rulemaking Authority 491.004(5), 491.0148 FS. Law Implemented 491.0148 FS. History—New 12-11-91, Formerly 21CC-9.002, 61F4-9.002, 59P-9.002, Amended 2-11-98.

Psychotherapy Notes - HIPAA

Notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separate from the rest of the individual's medical record.

Psychotherapy notes exclude **medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, financial data,** and any summary of the following items: **diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.**

Therefore, all information about the client/patient excluded from Psychotherapy Notes is included in the client's record.

42 C.F.R. Part 2

- Original regulations were drafted over 30 years ago; substantial revisions were made effective in March 2017
- New terminology (e.g., “Substance Use Disorder Patient Records) and attempted relevance in present era of electronic records
- Consent (authorization) forms are now somewhat different; they must include an explicit description of the substance use disorder information to be released
- Electronic signatures are now permitted
- Look for further future “guidance” documents from SAMHSA
- As with “psychotherapy notes” under HIPAA, records from substance use disorder programs that receive federal funds have specific requirements

Standards for Records – Psychologists (FL)

Rule 64B19-19.0025 Standards for Records.

To serve and protect users of psychological services, psychologists' records must meet minimum requirements for chronicling and documenting the services performed by the psychologist, documenting informed consent and recording financial transactions.

- (1) Records for chronicling and documenting psychologists' services must include the following: basic identification data such as **name, address, telephone number, age and sex; presenting symptoms or requests for services; dates of service and types of services provided**. Additionally, as applicable, these records must include: **test data** (previous and current); **history including relevant medical data and medication**, especially current; **what transpired during the service sessions; significant actions by the psychologist, service user, and service payer; psychologist's indications suggesting possible sensitive matters like threats; progress notes; copies of correspondence related to assessment or services provided; and notes concerning relevant psychologist's conversation with persons significant to the service user.**
- (2) & (3)
- (4) Records shall also contain data relating to **financial transactions** between the psychologist and service user, including fees assessed and collected.

Standards for Records – Psychologists (FL)

Rule 64B19-19.005 Releasing Psychological Records.

- (1) Any licensed psychologist who agrees to provide copies of psychological records to a service user, a service user's designee, or a service user's legal representative, shall be accorded a reasonable time, not to exceed thirty (30) days, to make final entries and copy the psychological records, and may condition release of the copies upon payment by the requesting party of the reasonable costs of reproducing the records.
- (2) Any licensed psychologist **who opts to issue a report rather than provide copies of psychological records** to a service user, a service user's designee, or a service user's legal representative, shall issue the report within thirty (30) days of the request, and may charge a reasonable fee for the preparation of the report and may condition the issuance of the report upon payment of the reasonable fee.
- (3) The **psychologist's notes pertaining to psychological services rendered may be considered raw data** as provided by subsection 64B19-18.004(3), F.A.C., at the discretion of the psychologist and therefore can be released only (1) to a licensed psychologist or school psychologist licensed pursuant to Chapter 490, F.S., or Florida certified, or (2) when the release of the material is otherwise required by law.

Health Records (Fla. Stat. 456)

Fla. Stat. Section 456.057 – This section has broad requirements for ownership and control of records. This section, along with 456.058, also discusses disposition of records upon death, relocation, retirement or other termination of practice. The various licensed health care practitioners covered by this law (including mental health counselors) must offer patients an opportunity to obtain a copy of their health care record.

Under Fla. R. 64B4-9.001, records must be maintained for at least 7 years after the last date of contact with the client. When a practice is terminated, the mental health counselor must provide notice via newspaper of greatest circulation in the county where the practice is located and an address where records are available to the client. Records must be kept for at least 2 years after termination of practice or death of practitioner (see details in rules).

Risk Management

Documentation of Dangerous Situations

At-risk situation – Document what the client did or said that suggested that he or she was considering engaging in, or was actively engaging in, a high-risk behavior.

Assessment – On the basis of your clinical experience and knowledge of the client, document the severity level of this threat.

Options – List the options you consider to be appropriate responses. By listing the options, you demonstrate that you were thinking broadly and that you considered a range of alternatives before reaching a decision.

Rule out – Describe what options you ruled out and why each was determined to be inappropriate. These descriptions demonstrate your clinical decision making.

Consultation and/or supervision – If feasible, obtain and document any colleague consultation or supervision you received.

Actions taken – Describe the options you chose, including what you said or did. This process helps clarify how you implemented the options you chose.

Follow up – Document what happened – what you did – and how things progressed until there was resolution.

Important Change to Fla. Stat 491

Confidentiality/Privilege

Fla. Stat. Sec. 491.0147 (and similar confidentiality/privilege statutes for mental health disciplines other than counseling) was amended in 2019, with important implications for documentation when a client poses a specific threat to cause bodily injury or death to an identified or readily available person

Under revised law, privilege “must” be waived, and licensed mental health counselor “shall” disclose client communications necessary to communicate specific threat of serious bodily injury or death to law enforcement where licensee makes a clinical judgment that the client has the apparent intent and ability to imminently or immediately carry out the threat. (Law enforcement “must” then take action to prevent risk of harm, including notifying intended victim or initiating a risk protection order.)

Consider importance of documenting what was told to you by client and why, based on your clinical judgment, you believe client has intent/ability to execute the threat. Also document consultation obtained and what actions you considered but ruled out and why.

Your Real World of Charting

Let's stop and talk about how you do it.

Clinical records modality

- Handwritten in folders
- Electronic (but not with EMR software)
- EMR (Therapy Notes, Simplepractice, Therasoft, Other...)

What case note format do you use?

- SOAP
- DAP
- Other

Does anyone keep two separate records

i.e., Psychotherapy Notes (HIPAA)?

HIPAA /HITECH Breach Notification

- You lose your Smart Phone or your computer is hacked. What are your obligations under HIPAA/HITECH?
- HITECH identifies four factors to consider in analyzing and deciding whether to notify individuals
 1. nature and extent of PHI, including types of identifiers and likelihood of re-identification;
 2. who the unauthorized person was who used or received the PHI;
 3. whether PHI was actually acquired or viewed; and
 4. extent to which risk has been mitigated.

HITECH Breach Notification

- **Examples of breaches possibly requiring notice**
 - Laptop, phone or other device with PHI is lost/stolen
 - Paper medical records dumped (MA example)
 - Psychiatrist who “lost” phone at airport
 - Therapist’s administrative assistant who sent email to all patients with “reply all” activated
 - Counselor whose client’s ex-spouse allegedly broke into office and stole records
- **Problems for LPCs, LMHCs, LMFTs, and SWs are real!**
 - Do you use a laptop, digital copier and/or flash drive with PHI?
Do your supervisees use them?
- **Wall of Shame**

https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

Penalties

- Potential for criminal and civil penalties
- Willful neglect *will* lead to compliance review by U.S. Dep't of Health and Human Services; other behavior *may* lead to review
- HITECH authorizes State Attorneys General to bring civil actions on behalf of state residents for HIPAA violations.
<http://www.hhs.gov/ocr/privacy/hipaa/enforcement/sag/>
- Additionally, some states have enacted their own privacy breach laws.

Review - Purpose of Documentation

Clinical Management

Legal Implications for Client

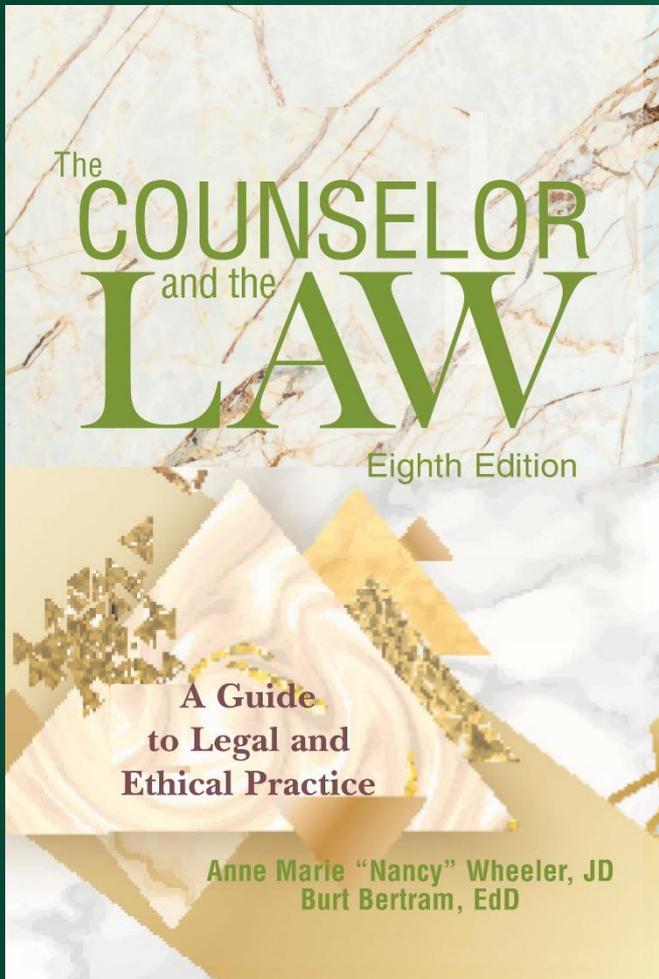
Compliance: HIPAA, State Statute & Ethics

Risk Management (Practitioner Protection)

Wheeler & Bertram, *The Counselor and the Law* (8th ed) 2019. pp 158-164

Triad Conversation

1. Describe to your partners, your clinical note style/process.
2. Record any questions that surface during your conversation to share with everyone.



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