



# A New Era of Documentation in Psychiatry: Advice on Psychotherapy, Progress Notes

As a practitioner in the behavioral healthcare sciences, I am used to rapid change. This has been especially true for those in a market with a high percentage of managed care patients in their case mix. The greatest areas of change for behavioral clinicians in a managed care market are a drop in reimbursement and the increasing level of documentation. Much of the required documentation is designed to lead to an evaluation of how well a practice complies with the documentation guidelines, eventually leading to bad news at the time to negotiate new reimbursement schedules.

Since implementation of the regulations under the Health Insurance Portability and Accountability Act (HIPAA), much has changed in the way we handle transactions, security and especially privacy. For the behavioral clinician, privacy rules represent a tremendous challenge. The provision that presents the greatest challenge is CFR Section 164.508 (a)(3)(iv)(A), defining the psychotherapy note.

By Peter B. Gillman, Ph.D.

The proposed rules defined psychotherapy notes as “detailed notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Such notes are to be used only by the therapist who wrote them, maintained separately from the medical record, and not involved in the documentation necessary for health care treatment, payment, or operations.”<sup>1</sup>

There was additional clarification that the term would not include medication prescription and monitoring, counseling session start and stop times, or the modalities and frequencies of treatment furnished, results of clinical tests, or a brief summary of the diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

In the final rule, the initial definition was retained in whole. Text was added to the regulation stating a requirement that, to meet the definition of psychotherapy notes, the information must be separated from the rest of the

individual’s medical record.<sup>2</sup>

The items that have not been included are known as the “Exclusions to the Psychotherapy Note.” They are not considered a part of the psychotherapy note, are not protected under the provisions of the HIPAA regulations, and may be disclosed without your agreement, knowledge, or authorization if used and disclosed for the purposes of treatment, payment or other health care operations. This is the progress note — the document that a clinician must put in the patient’s medical record after each encounter.

This leads to the question, “How does this change my current practice?” The bottom line here is that it changes everything.

Most practitioners have a choice of documentation systems to represent their thoughts regarding a patient’s clinical encounter. These choices come out of the field known as medical informatics. A well-known system established early in the development of the field of medical informatics by Lawrence Weed (1968) is the Problem Oriented Medical Record (POMR).<sup>3</sup> This was a part of an effort to structure the way clinicians organize their ideas and experiences about their patients, and how to represent these ideas and experiences in a medical record.

As part of this effort, Weed created what is known as the SOAP Note.<sup>4</sup> This component of the POMR extended the problem-oriented model by providing more structure and a standard approach to recording information under a problem.<sup>5</sup> Since the POMR’s inception, many limitations have been noted. These limitations have inspired many efforts to improve upon the ways clinicians document their clinical encounters.

The remainder of this article will introduce a new way for behavioral clinicians to organize and structure their experiences of the clinical encounter. It is based on the Exclusions to the Psychotherapy Note, governing what we can put in the medical record related to what we learn during the clinical encounter.

When the Exclusions to the Psychotherapy Note are viewed in the order presented above, one may see the addi-

tional burden to the existing schemes for clinical documentation for psychiatry and the behavioral healthcare sciences. However, when the same federal requirements are reorganized to reflect a smoother conceptual flow through the clinical encounter, this becomes an opportunity for a superior method of documentation to emerge from the clinician's experience in the clinical encounter.

I have reorganized the items as follows into what has come to be known as the Gillman HIPAA Progress Note:

- Counseling session start and stop time.
- Modalities of treatment furnished.
- Frequency of modalities furnished.
- Medication prescription and monitoring.
- Results of clinical tests.
- Summary – Symptoms.
- Summary – Functional Status.
- Summary – Progress.
- Summary – Diagnosis.
- Summary – Treatment Plan.
- Summary – Prognosis.

Now think of a 10-minute training simulation where you absorb this new schema by listening to the following statements:

What symptoms did my patient bring to me today?

What is the impact on their functional status?

What progress did the patient make since the last session?

How does this change my diagnostic thinking?

What is my treatment plan and recommendation for the next treatment period?

What is the prognosis for this period of time?

In the HIPAA course I have been teaching for the past two years, when I share this with my students, their response is usually universally supportive of this schema. They are also very careful to write down the correct way to implement the note. The logical flow creates an opportunity for the clinician to create superior documentation about the encounter while maintaining HIPAA compliance with the federal documentation standards. This level of documentation is far superior to the SOAP or DAP note formats.

There are a number of reasons worth consideration in supporting this assertion:



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1. It requires the clinician to think in more behavioral terms.
2. It requires the clinician to focus on presenting symptoms.
3. It requires the clinician to think about the functional environments that the patient finds it meaningful to express his/her psychopathology.
4. It requires the clinician to think about the progress made since the last session.
5. It requires the clinician to think about how the above data might change his/her diagnostic thinking.
6. It requires the clinician to think about changes to his/her treatment plan and recommendations.
7. It requires the clinician to think about the prognosis until the next treatment session.

Once this is implemented, the clinician will find it easier to document to the medical record without taking copious notes during the session. It will also be possible to complete the documentation prior to seeing the next patient. In essence, all your documentation can be completed by the end of the day, so you can go home and have dinner with your family.

This schema can be implemented manually. The attached progress note on this page offers an example. It is best implemented when used with an Electronic

Medical Record.

I have been using ChartEvolve, which allows me to register my patient, print out all the necessary HIPAA forms for distribution and signature, schedule my patient, complete the accounting and billing functions, and complete the entire clinical encounter. What is so helpful about ChartEvolve is that it automatically separates those items that must be in the HIPAA progress note from the psychotherapy note and consult.

It is very important to understand that all initial evaluations and assessments, all addenda to them, and all re-evaluations and assessments go in the patient's medical record. Because the Mental Status Examination is the result of clinical testing, it can be documented in the HIPAA progress note.

There is no provision that requires the clinician to actually prepare a psychotherapy note. This addresses the issue of keeping two files. However, if you insist on preparing a psychotherapy note, you *must* keep this note separate from the patient's medical record. Not in the same file, same drawer, same cabinet — preferably not in the same room.

If you have been commingling progress note and psychotherapy note data in the same note between April 14, 2003 and today, don't panic. My recommendation to my students has been to staple them together. They are not to be disclosed. It will be a violation of the HIPAA regulations if you do. You may deal with this situation by writing a Treatment Summary of the encounters in question.

What you can do starting tomorrow is to use the Gillman HIPAA Progress Note Format to write *all* of your encounter progress notes. ☺

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**References**

<sup>1</sup>Federal Register, Vol. 64, No. 212, Nov. 3, 1999, p. 59938  
<sup>2</sup>Federal Register, Vol. 65, No. , Dec. 28, 2000, p. 82497  
<sup>3</sup>Weed, L.L. Medical records that guide and teach. *New Engl J Med*, 278: p. 593-539 and 278: p. 652-657  
<sup>4</sup>Weed, L.L. Medical records, medical education, and patient care; Press of the Case Western Reserve University, 1969  
<sup>5</sup>Salmon, P., Rappaport, A., Bainbridge, M., Hayes, G., and Williams, J. *Proceedings of the American Medical Informatics Association*, 1996, p. 463-467.

PROGRESS NOTE

Counseling session start and stop time: \_\_\_\_\_  
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 Modalities of treatment furnished: \_\_\_\_\_  
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 Frequency of modalities furnished: \_\_\_\_\_  
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 Summary – Progress: \_\_\_\_\_  
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 Summary – Diagnosis: \_\_\_\_\_  
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 Summary – Treatment Plan: \_\_\_\_\_  
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 Summary – Prognosis: \_\_\_\_\_  
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