

Clinical Documentation

Psychotherapy Notes

Psychotherapy Notes or Process Notes are defined as being notes recorded by a mental health professional which document or analyze the contents of a conversation during a private individual, group, joint, or family counseling session. These notes are kept physically separate from the rest of the individual's medical record. As long as they are separated, psychotherapy notes are given special protection under HIPAA. Clinical social workers are exempt from releasing psychotherapy notes without patient authorization, and psychotherapy notes also are excluded from the provision that gives clients the right to see and copy their health information.

Progress Notes

Progress notes are used to record the progress of treatment and are the substance of a client's case record. They are part of the medical record as defined by HIPAA. These notes include assessment, diagnosis, and treatment interventions, referrals to community resources, preventive services, and coordination of care with other health care providers. Progress notes should also include documentation of any unusual struggles or dilemmas the client experienced during the therapeutic process and how they were resolved.

Progress notes should contain the following:

- Session date, start and stop times of session
- Medication and prescription monitoring
- Modalities and frequencies of treatment
- Results of clinical tests
- Summary of progress to date
- The purpose of the contact
- What occurred during the session, including specific interventions used
- Any problem areas noted by the social worker
- Observations and assessment of the client's status
- Plans for further intervention
- Signed and dated by the social worker

There are numerous formats one can utilize for progress notes. Below are a few options.

Summary or Narrative Format

This is the most common format, the social worker summarizes the content of the intervention in paragraphs. The summary note provides a sense of what took place during the session with the client.

Structured Formats

There are numerous formal structures for progress notes. These include SOAP, SOAIGP, and DAP.

S.O.A.P. Notes

Subjective includes the client's subjective information (information from the client's point of view), such as the client's description of the problem for which they are seeking help and symptoms they describe, and the effect it has on their functioning. This section may include a summary statement or direct quote from the client or from significant other(s).

Objective includes observable data or information that relates to the subjective section. This would include observations of the client's affect, appearance, body language and other signs supporting the diagnosis. These are behavioral observations.

Assessment is the clinical analysis and interpretation of the problem and how the problem impacts the client's functioning. It can include progress (or lack of progress) between sessions, and prognosis.

Plan includes what the worker and client will do next – interventions, frequency for the treatment, plan for future sessions, homework, referrals, follow up needed, and date of the next session.

SOAIGP

An alternative to SOAP, SOAIGP provides more detail and includes the following elements:

Supplementary data base information: This is information provided by the client and significant other(s).

Observations: These are observations provided by the social worker. This would include observations of the client's affect, appearance, body language and other signs supporting the diagnosis.

Activities with and on behalf of the client. These include a summary of client tasks, social worker tasks, and events or topics covered in the client's session.

Impressions and assessment made by the social worker, tentative impressions and hypotheses are stated.

Goals: This includes goals that are being worked on, progress being made on the goals, and any necessary revision to goals are noted here.

Plans for next actions by the worker and client. This includes additional plans for future

actions.

D.A.(R.)P. Notes

This format collapses the SOAP format into three categories or leaves it at four if inserting R into the format. D (data) combines information found in SOAP's subjective and objective categories, whereas the A (assessment) and P (plan) sections are the same as in a SOAP note.

Data includes subjective and objective information about the client, the clinical social worker's observations, and the general overview of the session.

Action describes the interventions used or actions taken in the session.

Response includes how the client responded to the interventions, clinical impressions, and progress noted.

Plan reviews the treatment plan and any needed revisions as well as homework, referrals, and date of the next session.

Claim Clarification

Clinical social workers should carefully consider whether to integrate psychotherapy notes and progress notes into one document. Doing so does not transform the non-protected progress notes into the protected psychotherapy notes. For reimbursement purposes, should both need to be combined as one, it is the clinical social worker's responsibility to extract the necessary information required to process a claim. The best practice is to keep the psychotherapy notes separated from the client's record for heightened privacy protection under HIPAA. This also permits smooth processing of reimbursement through the use of proper progress notes. (NASW, May 2005 [Clinical Social Work Practice Update](#)).