Documentation

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Aetna policy statement

The Golden Thread

is the consistent presentation of relevant clinical information throughout all documentation for a client. The Golden Thread begins with an intake assessment that clearly identifies an appropriate clinical problem and corresponding diagnosis. Next, the treatment plan should reflect a clear series of goals for helping the client through the identified problem. Each goal should have specific interventions prescribed that reflect best practices and evidenced-based treatments to help guide the client along the path to recovery. Finally, the Golden Thread includes progress notes that demonstrate that the services you deliver match what was prescribed in the treatment plan. Each note should lead into the next, creating a comprehensive story of the client's progress through treatment (https://blog.therapynotes.com/the-golden-thread-your-key-to-complete-documentation).

Key things to remember:

1. **If you do not write it down, it didn't happen.**
2. **If the documentation is illegible, it's not useable.**
3. **Your documentation is the story you are telling others who are not present. Can your co-worker pick up where you left off based on your documentation?**
4. **Devil is in the details: who, what, when, where and why; onset, frequency, intensity, duration.**

SUBSTANCE USE TREATMENT:

Level of care 1 through 3.7

Substance Use Treatment: Initial Details

- **Why is this person presenting to treatment (all levels of care)?**
  - What triggered their interest at this time?
  - Who referred the member to/for treatment?
  - What changed in their life that motivated them to seek treatment at this time?
  - How long have they presented with said symptoms or feelings to seek treatment?

- **Substance use history (all levels of care)**
  - Substance, Age of Onset, Age of Current Pattern, Frequency of Use, Quantity of Use, Date of last use and amount used
  - If there is a gap in usage from date of admission, ask the member how were they able to abstain from using during that time. Also discuss/evaluate if they can be treated at a lower level of care first.
  - If a member tests positive for other substances but does not disclose in the Substance use section, you should ask them about that use and document.

- **Establish Baseline Functioning (all levels of care):**
  - When was the last time the member was “at their best?” For example, in 2012 member was employed as a carpenter, had stable housing with/without someone, in a relationship, good relationship with family, children in their care, etc.

Substance Use Treatment: Initial Details

- **Member has NEVER engaged in any level of treatment**
  - If referring to any level of care outside of ASAM LEVEL 1, discuss why this member cannot safely start at level 1.
  - Court ordered: if a member does not meet medical necessity, it is all our responsibility to ensure they are placed in the appropriate level of care to meet their needs.

- **Member has been in level 3.5 Residential treatment within the last 90 days.**
  - What are we going to do differently?
  - How will you establish what did or did not work since their last admission/discharge?
  - Will member sign a Release of Information (ROI) for the previous provider?

- **Member has not used substances in days, weeks, months since admission to level 3.5 Residential**
  - Discuss how member was able to remain sober without level 3.5.
  - Discuss why this member cannot begin in a lower level of care

Substance Use Treatment:

Dimension 1 Acute intoxication/withdrawal potential:

- **Member has NEVER engaged in any level of treatment**
  - If referring to any level of care outside of ASAM LEVEL 1, discuss why this member cannot safely start at level 1.
  - Court ordered: if a member does not meet medical necessity, it is all our responsibility to ensure they are placed in the appropriate level of care to meet their needs.

- **Member has been in level 3.5 Residential treatment within the last 90 days.**
  - What are we going to do differently?
  - How will you establish what did or did not work since their last admission/discharge?
  - Will member sign a Release of Information (ROI) for the previous provider?

- **Member has not used substances in days, weeks, months since admission to level 3.5 Residential**
  - Discuss how member was able to remain sober without level 3.5.
  - Discuss why this member cannot begin in a lower level of care

Substance Use Treatment:

Dimension 2 Biomedical Conditions/ Complications

- **Describe medical conditions: COPD, Congestive heart failure, seizure do, diabetes, high blood pressure, pregnant, etc.**
- **Describe the impact medical conditions would have on treatment if any. How are medical conditions being addressed on the unit?**
- **Discuss treatment interventions or psychoeducation groups to increase knowledge related to medical conditions and/or unsafe practices in the community?**
- **Also discuss medication list, compliance status and PCP information**

Substance Use Treatment:

Dimension 3 Emotional/ Behavioral/ Cognitive Conditions and Complications/SI/ HI/AVH/abuse and trauma history:

- **What is the members Mental Status Exam (MSE)? For example, alert and oriented x4, calm, cooperative, anxious, depressed, tearful, lethargic, goal oriented, linear thought process, poor insight/judgment/impulse control, etc.**
- **Does the member currently present with suicidal ideations (SI), Homicidal Ideations (HI), Auditory/Visual Hallucinations (AVH)? Is there a plan/intent? Last ideation, frequency, duration?**

- **History of Mental health diagnosis: Major depression, Schizophrenia, Bipolar, etc; year/age of diagnosis. History of OP/IOP/PHP/IP admissions and reason for treatment. Medication list and compliance status.**

- **History of trauma or abuse: indicate type (physical/sexual/emotional abuse, witnessed abuse/violence, death/loss, domestic violence, medical complication, etc) onset, frequency/duration and impact on functioning today.**

- **Cognitive conditions or complications: Traumatic Brain Injury, Developmental delays, history of Learning disorder diagnosis, etc**

- **Family history of Mental Illness or Substance Abuse**

Substance Use Treatment:

Dimension 3 Emotional/ Behavioral/ Cognitive Conditions and Complications/SI/ HI/AVH/abuse and trauma history:

- **Discuss treatment interventions, psychoeducation groups, assignments, and progress/barriers towards goals.**

- **Discuss how you will address any symptoms/behaviors identified. Members with identified Mental health concerns will need Mental health treatment while on the unit. For example, psychiatric evaluation, medication management, 1:1 Mental health therapy, additional assignments (specify)**

- **Discuss how member demonstrates repeated inability to control impulse; would member be at risk of relapse due to unstable mental state and requires stabilization, if so as demonstrated by; demonstrates antisocial behavior.**

- **If a member is refusing mental health treatment, how are you going to assist in their recovery? What interventions will you use to ensure they are stable and effectively engaged in treatment. Discuss how you will address any concerns identified in the initial review or observed since admission.**

Substance Use Treatment: Dimension 4 Readiness to Change:

- **Treatment History (hx) (detox, residential/IP, PHP, IOP, OP; dates of service) and response.**
  - Noncompliant with OP/IOP recommendations (did not engage in intake; only completed X days or hours of recommended treatment, continued to use, continued to fail weekly/biweekly drug tests; Sober eight months after completing which LOC, etc.

- **Longest period sober (outside of a structured environment):**
  - How was the member able to remain sober, if applicable:
  - If sober while in a controlled environment, such as jail, discuss why member cannot begin at a lower level of care.

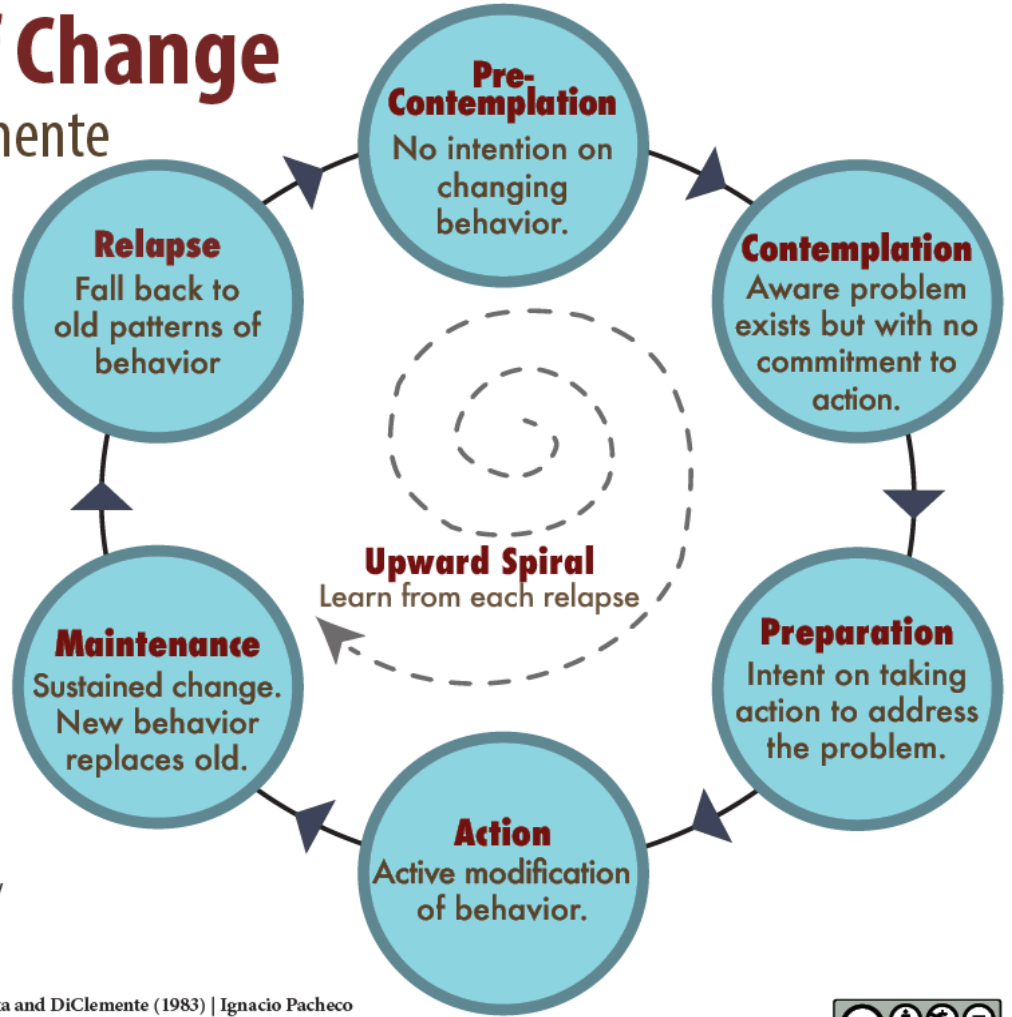
- **Stage of change _____ as evidenced by _____**

- Documentation should discuss members participation in groups, progress in each group, assignments and progress with each assignment, treatment interventions, psychoeducation groups. Discuss insight, blaming others for their addiction problems, passive or active opposition to treatment, expresses little interest in changing, despite consequence doesn't understand how Substance use and MH problems impact these consequences, etc. You want to discuss how you will address any barriers identified.

The Cycle of Change

The Cycle of Change
Prochaska & DiClemente

- **Precontemplation:** A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists
- **Contemplation:** The person becomes aware that there is a problem, but has made no commitment to change
- **Preparation:** The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client is convinced that the change is good) and increased self-efficacy (i.e. the client believes s/he can make change)
- **Action:** The person is in active modification of behavior
- **Maintenance:** Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional
- **Relapse:** The person falls back into old patterns of behavior
- **Upward Spiral:** Each time a person goes through the cycle, they learn from each relapse and (hopefully) grow stronger so that relapse is shorter or less devastating.



SOCIAL WORK TECH

The Cycle of Change
Adapted from a work by Prochaska and DiClemente (1983) | Ignacio Pacheco

Version 3.4 Updated 09 September 2018

Chemical Dependency Treatment:

Dimension 5 Relapse, Continued Use or Continues Problem Potential

- **Current legal and history of legal involvement (all levels of care)**
  - This includes DCFS involvement. Discuss dates of legal involvement and consequences; if DCFS involved-where are the children, reason for involvement and current status. Will the member sign a Release of Information (ROI) to include Probation Officer and DCFS in treatment? If not, discuss barriers.

- **Imminent danger of relapses as demonstrated by**
  - Unable to recognize relapse triggers and lacks insight; Cravings (rate the cravings 1-10, discuss onset/frequency/duration of cravings); Difficulty coping with cravings; Drug seek/drug glorification behavior

- Documentation should discuss members participation in groups, progress in each group, assignments and progress with each assignment, treatment interventions, psychoeducation groups. You want to discuss how you will address barriers/symptoms/behaviors identified.

Chemical Dependency Treatment:

Dimension 6 Recovery Living Environment

- Living/community environment-what is their housing status (homeless, resides with family/alone/etc); If residing with others, are they also using substances; are substances easily accessible in the community; limited services in their area, etc?

- Who is their support system- can they ID a sober support; does their social network lead to significant social isolation/withdrawal; social network includes regular users?

- Are they using to cope? Describe what they trying to cope with.

- Employment status/hx

- Documentation should discuss members participation in groups, progress in each group, assignments and progress with each assignment, treatment interventions, psychoeducation groups and attempts to include family/support system in their treatment. You want to discuss how you will address barriers/symptoms/behaviors identified.

- **Discharge planning**
  - Tentative discharge date
  - Discuss potential referrals to Mental Health and Substance use Treatment and attempts to secure appointments.
  - Include efforts to secure housing (who was contacted, how often, status, etc).
  - Should discuss back up options if Recovery/Sober Homes are not available.

Substance Use Treatment: Notes

- Individual Notes: documentation should include members symptoms (depressed, angry, daily, several times per day, rated 1/10), presentation (calm, cooperative, disheveled, guarded, etc), goal/objective for the session, progress/barriers and plan moving forward.

- Family/Support Session: documentation should include efforts to contact family/support system; barriers to including family/support system in treatment; if family/support system is included, who, how often, and goals for family sessions; “family sessions” can also consist of PO, DCFS, CW involvement

- Assignments: documentation should clearly reflect assignments in each group as well as with individual therapist. What are the assignments, when are they due, their objectives related to the members treatment plan and progress.

- Group Notes: documentation should clearly speak to the purpose of the group, members response, participation level, insight, ability to apply new information, barriers, progress, assignments, daily or group goal and plan moving forward.

Substance Use Treatment: Treatment Plan

- **Consider S.M.A.R.T goals: Specific, Measurable, Attainable, Realistic and Time limited**
  - For example,
    - Will develop relapse prevention plan:
      - Will identify/utilize three-10 coping skills
      - Will develop three-10 triggers
      - Will ID 10 healthy activities
    - Will develop sober support network by:
      - obtain three phone numbers from support meetings
      - attend three support meetings
      - identify a sponsor
    - Medication compliance
      - Comply with medication regimen 7 days a week
      - ID medications, purpose and dosages, etc.

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QUESTIONS
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