Documentation Standards and Best Practices
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Introduction

The purpose of this document is to identify and clarify standards and best practices for documentation of services provided to AspenPointe Health Network clients. A provider’s (organization or individual provider) client record (or chart) is a legal document and should follow the concept of the “golden” thread. The Golden Thread is a term that describes the tying together of all the documents in the client record (or chart). The assessment identifies the critical needs of the client. The treatment plan reflects the goals and objectives that address the concerns of the individual, “this is done by the development of measurable, attainable goals and objectives that provide the opportunity for the individual to actively focus on the needs reflected in their assessment in a targeted manner. The progress notes must flow from the treatment plan by specifically reflecting progress towards the identified goals and objectives and the individual’s response to treatment. The progress notes tie to the treatment plan reviews and assessment updates which review the progress described in the notes at particular points in time, reiterate needs and goals, and establish the continuing need for services.

Care should be taken regarding what types of documents are placed in a chart. For example, sticky notes and other small pieces of paper may easily be lost or overlooked and should not be placed in a chart. If such notes are important to include in a clinical record, clinicians should photocopy the pieces of paper onto standard 8 ½ x 11 size paper and include in the chart.

Client records provide the following important functions:

- Help plan and structure treatment
- Documents provide communication with coworkers and other professionals
- Allow provider and supervisor to evaluate treatment outcomes
- Demonstrate proof of amount and type of services offered for funding sources

Information in a client record should logically flow from one document to the next. For example, treatment goals should address problems identified in the assessment. Since treatment interventions are connected to client goals, chart notes should correlate to specific treatment plan goals. Information documented on a monthly summary should reflect progress toward treatment goals and include a brief summary of sessions and activities during the month.
The Treatment Plan

A treatment plan is a written document that:

- Identifies the client’s most important goals for treatment
- Describes measurable time sensitive steps toward achieving those goals
- Documents an agreement between the provider and client

The creation of an individualized treatment plan has been demonstrated to lead to increased retention in treatment that can improve client outcomes. An individualized treatment plan also empowers the provider and client by focusing on measurable goals and objectives – it should be very clear to the client what they must do to progress in treatment.

Providers may choose to use the SMART format for creating objectives and interventions:

**Specific:**
- Address in specific behavioral terms how the client’s level of functioning will improve
- Objectives and interventions should be specific to the goal

**Measurable:**
- Objectives and interventions are measurable
- Achievement should be observable to the client and provider
- Indicators of client progress are measurable:
  - Assessment scales/scores
  - Client report/monitoring results as applicable
  - Behavioral and mental status changes

**Attainable:**
- Objectives and interventions are attainable during treatment
- Focus is on “improved functioning” rather than cure
- Goals are revised when achieved

**Realistic:**
- Client can realistically complete objectives within a specific time period
- Goals and objectives are achievable given the client’s environment, support, diagnosis, and level of functioning
- Progress should require client participation
Time-limited:
- Focus is on time-limited or short-term goals and objectives
- Objectives and interventions should be reviewed within the specified time period

Treatment Plan Reviews and Updates

Treatment plans are generally created at the time of admission and are continually updated and revised throughout treatment. Treatment plan reviews provide a systematic way of evaluating and recording client progress toward goals. During this review, new goals are often developed and some goals may have changed as the client progresses. Treatment plan reviews may happen at any time however certain levels of care require reviews at set intervals (i.e., substance abuse).

Treatment Plan Best Practice Standards

- Client name
- Goal (must be realistic and measurable – should be strengths-based)
  - Example: Learn and log effective utilization of at least 3 new child disciplinary strategies each week for the next 6 months.
  - Example: Reduce oppositional and defiant behavior by following adult directions from 0x/day to 3x/day; increase prosocial behaviors with friends and family from 1x/day to 7x/day for the next 6 months.
  - Example: Increase attendance at school from 0 days to 3 days per week for the next 6 months.
  - Non-compliant goal: “Decrease psychiatric symptoms”. (The goal lacks numbers, frequency and duration related to specific symptoms and is too vague to measure)
- Objectives (what the client will do to meet the goals)
  - Example: Take medications as prescribed; attend symptom management group 1x/week.
  - Example: Attend socialization group 1x/week; participate in family therapy 1x/week.
  - Example: Client will attend weekly play therapy. Parent will bring child to all scheduled clinic appointments and attend weekly parenting group.
- Interventions (what the provider will do to assist the client)
  - Example: Clinician will provide individual therapy 1x per week and will utilize cognitive behavioral techniques to assist client in stabilizing their symptoms. The clinician will also link client to psychiatric services and community resources as needed for the next 6 months.
  - Example: Case manager will provide socialization group 1x/week; provide family therapy 1x/week for the next 6 months. Link client to community resources as needed for the next 6 months.
• Time frames for meeting goals and objectives
• Clinician signature (for electronic records, “signature on file” is sufficient)
• Clinician printed name
• Client signature (indicating that the client reviewed treatment plan, not necessarily that they agree – if client declines to sign, then clinician should write DECLINED on the client signature line)
• Date of treatment plan creation
• Date(s) of treatment plan updates and revisions

Chart Notes, Clinical Notes, or Progress Notes

A chart note (also known as a clinical note or progress note) is written documentation of any counseling session or other clinically significant events. Chart notes should include documentation of non-routine calls, missed sessions, and consultation with other professionals. Chart notes should also include documentation of client’s non-conforming behavior as well as any unauthorized discharges or elopements. Many documentation formats are acceptable for chart notes. One of the most common documentation formats is SOAP:

**Subjective:**  *Client’s* observations or thoughts; client statements
**Objective:**  *Provider’s* observations during session
**Assessment:**  Provider’s understanding of problems and test results
**Plan:**  Goals, objectives and interventions reflecting identified needs

Another common documentation format for chart notes is DAP:

**Data:**
- Subjective data about the client – what are the client’s observations, thoughts, direct quotes?
- Objective data about the client – what does the provider observe during the session (affect, mood, appearance)?
- What was the general content and process of the session?
- Was homework reviewed (if any)?

**Assessment:**
- What is the provider’s understanding about the problem?
- What are the provider’s working hypotheses?
- What are the results of any testing, screening, assessments?
- What is the client’s current response to the treatment plan?
Plan:
- Based on the client’s response to the treatment plan, what needs revision?
- What goals and objectives were addressed during this session?
- What is the provider going to do next? What is the client going to do next?
- When is the next session date? What homework was assigned (if any)?

Chart Note Best Practice Standards
- Client name
- Session type (i.e., individual, group)
- Time spent in session (i.e., 30 minutes, 60 minutes – may include session start time and end time)
- Date of service
- Name(s) of who is/are present (i.e., Family/Staffing’s)
- Clinician signature with credentials (for electronic records, “signature on file” is sufficient)
- Legible
- Documentation of what occurred since last session (i.e., progress, relapses)
- Documentation of what occurred during session (i.e., what treatment goal are you focusing on today)

Chart Note General Checklist
- Does the note connect to the client’s individualized treatment plan?
- Is the note dated, signed, and legible?
- Is the client name and identifier included on each page?
- Has referral information been documented?
- Are client strengths/limitations in achieving goals noted and considered?
- Are any abbreviations used standardized and consistent?
- Would someone unfamiliar with this case be able to read this note and understand exactly what has occurred in treatment?
- Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?
Monthly Summary SmartCare Notes

- Area of Concern: Goal as it relates to child welfare issue/presenting problem during the visit.
- Progress During Session: Summary of progress from treatment plan relating to the area of concern defined.
- Services and notes must be entered by the 5th of the month following the date of service
- Summaries need to identify issues being addressed and progress or lack thereof (as it relates to the treatment plan)
- Content of notes need to be unique to each contact, not a copy of paste
- Includes treatment plan (initial and 3 month updates)