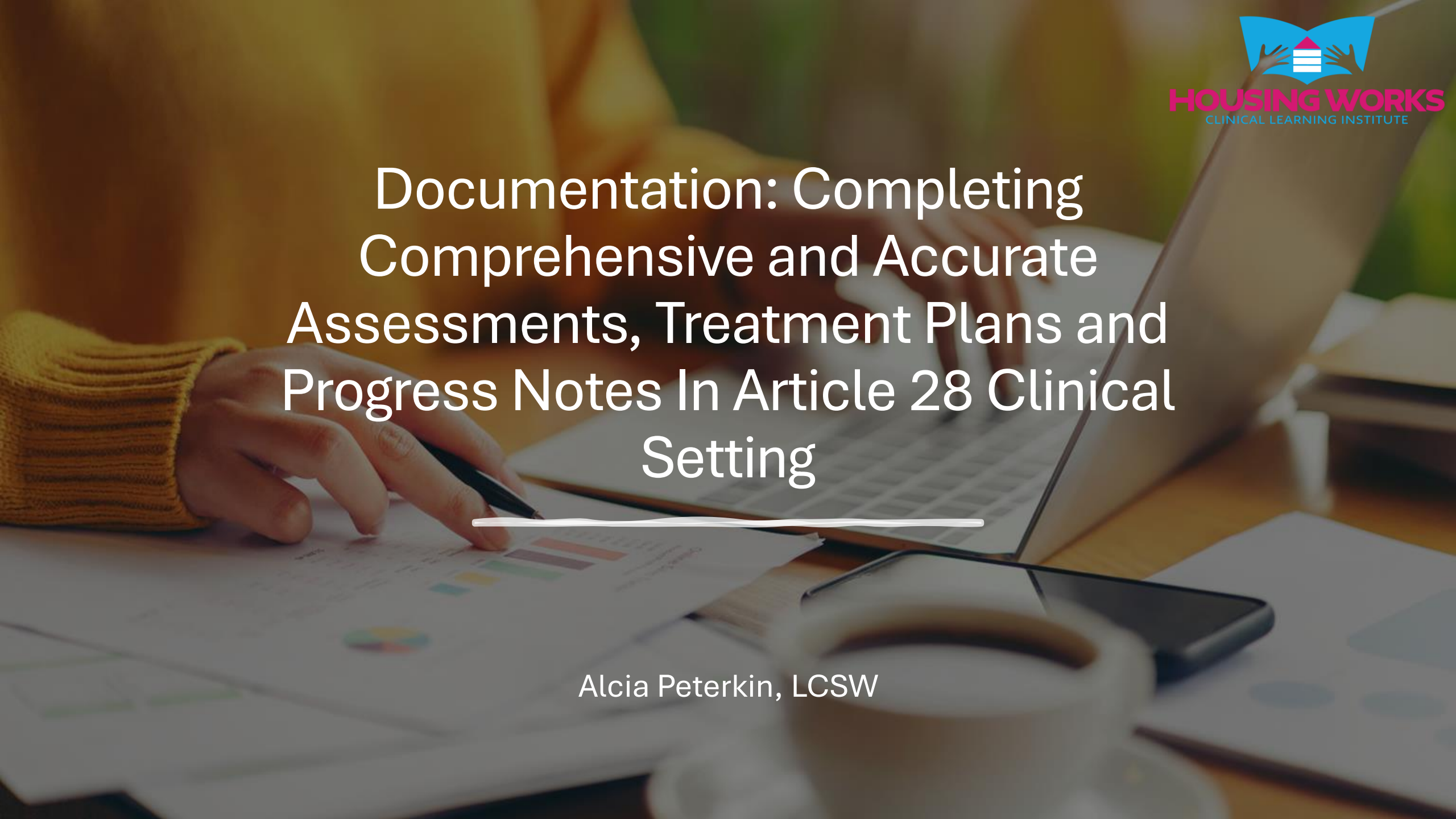

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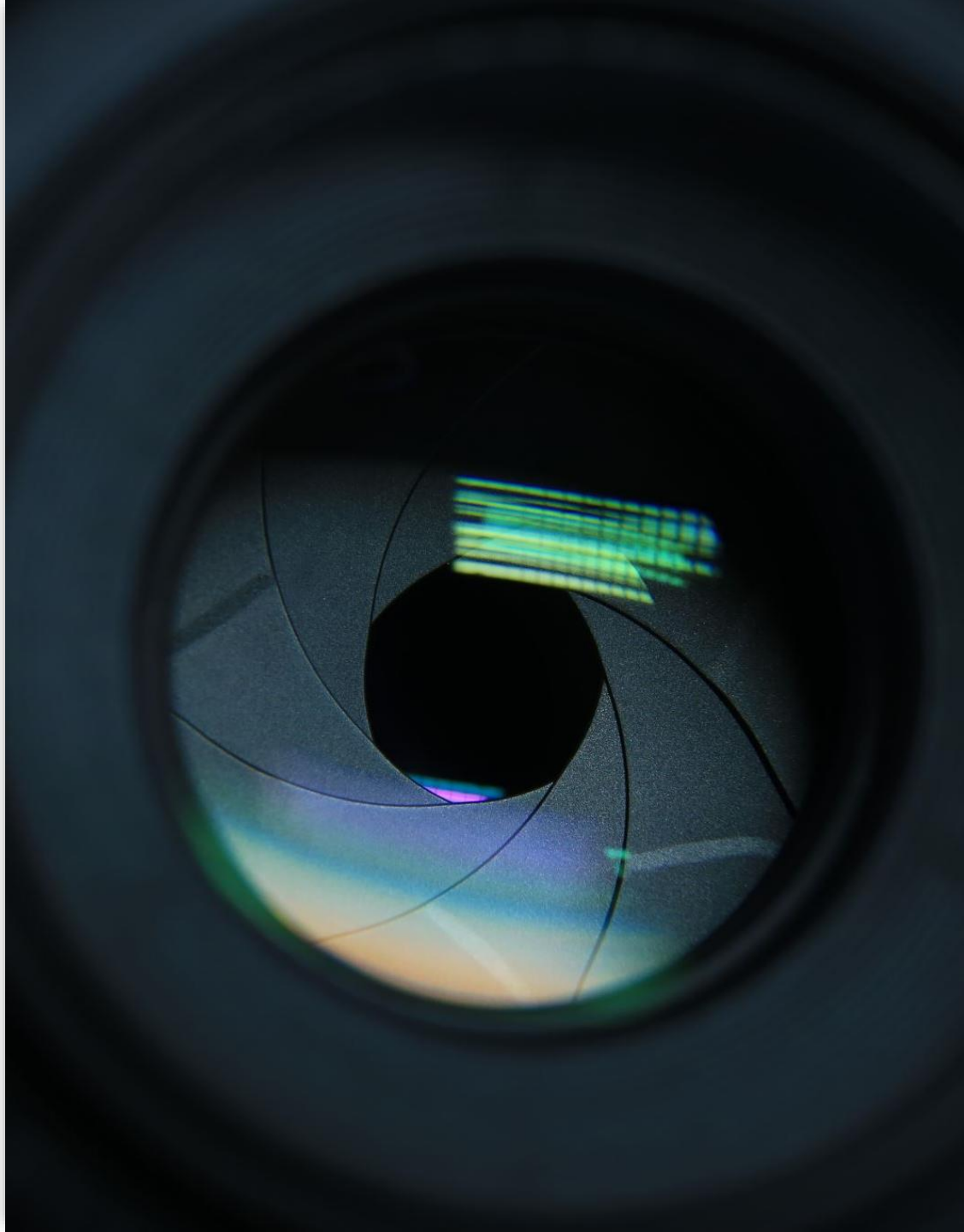
Documentation: Completing Comprehensive and Accurate Assessments, Treatment Plans and Progress Notes In Article 28 Clinical Setting

Alcia Peterkin, LCSW

Objectives

- Identify documentation best practices at Housing Works.
- Describe the purpose of documenting.
- Identify and use examples to demonstrate the electronic medical record program utilize to document client encounters.
- Discuss what is documented in client record.
- Identify important elements of a comprehensive intake process.
- Identify and use the essential elements required in a treatment plan, including client information, goals, interventions, and progress monitoring
- Describe the documentation process for effective progress notes
- Create effective discharge plans to support clients as they transition out of therapy



Documentation Best Practices

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Documentation is mandatory for all client contacts, assessments, and the delivery of services.

Documentation should be completed and locked within 48 hours after the encounter.

All documentation should be entered in the respective electronic health record (E.H.R)

Documentation should be clear, concise, and organized

Good documentation ensures accountability, service improvement, and reimbursement for services rendered.

Electronic Medical Records

E-Clinical Works (ECW) and E-ICARE used to document scheduling of services & billing

Not every program uses the same E.H.R.; OMH – e-icare; CONNECT – e-icare; OASAS – e-icare; Article 28/IOS - ECW

Documentation in the Client Record/EHR

Documentation in the Client Record/E.H.R

- Documentation should address:
  - who
  - what,
  - when,
  - where,
  - how
  - And next steps

Documentation in the Client Record/E.H.R

- **Who:** client; the social worker; any additional individuals present

- **What/Why:** issue/concern, reason for visit, task to be addressed, purpose

Documentation in the Client Record/E.H.R

- **Where:** location of service, client, clinician/provider, esp. *telehealth
- **When:** date of service, time of visit, length/duration

Documentation in the Client Record/E.H.R

- **How:** intervention, modality and frequency
- **Next Steps:** plan of action next visit

Telephone Encounters (TE) in eCW

Telephone Encounters in the E.H.R

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Telephone encounters: document communication with patient concerning treatment. Can range for a variety of reasons (follow-up, outreach, scheduling, information gathering).

Components of a Telephone encounter

Reason: IOS care coordination

Assigned: person for follow-up

Provider line: Change the provider to the behavioral health provider (e.g. remove Dr. Vaty and then Put Jeremy Douglas)

Summary of conversation

Next step

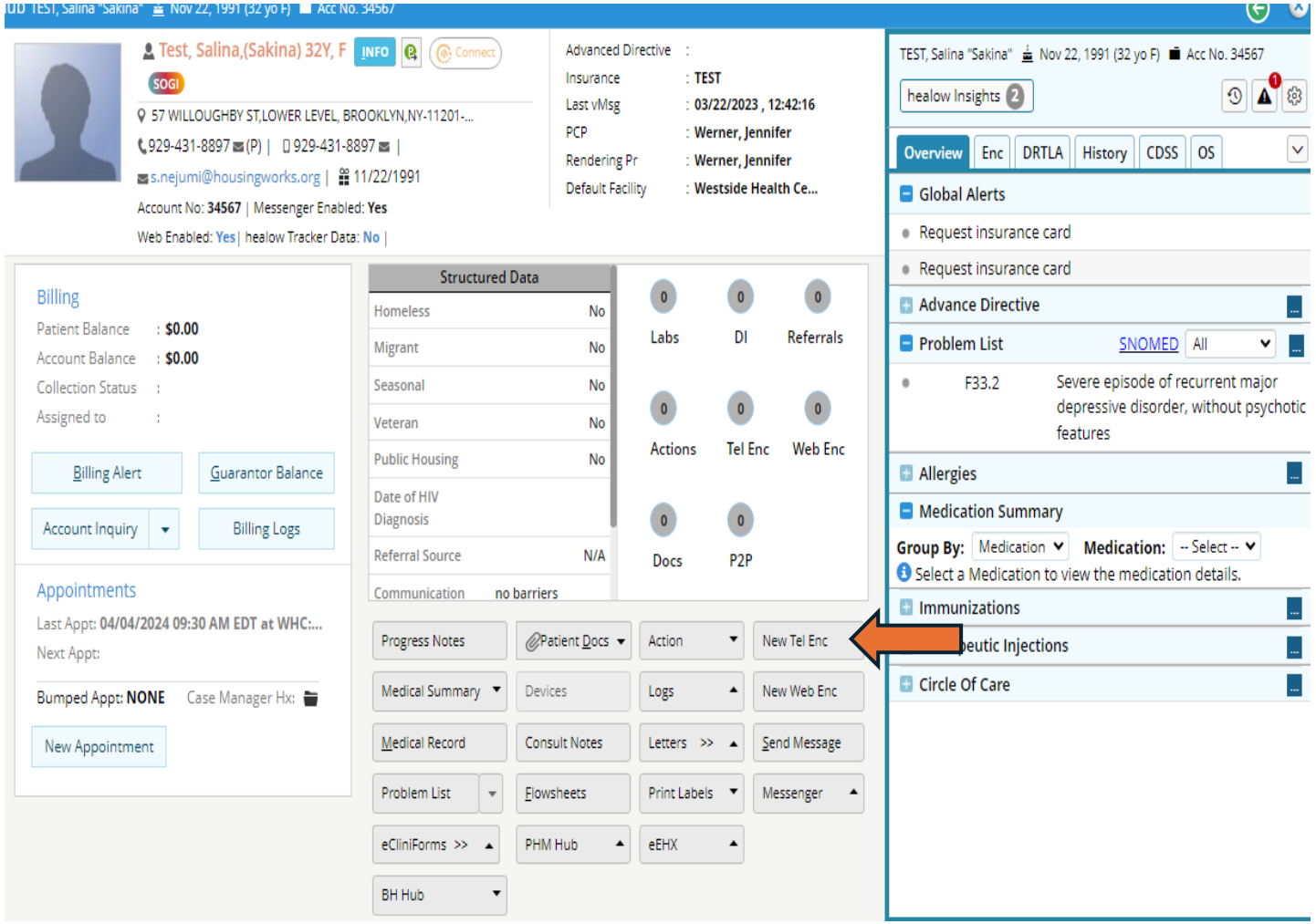
Time stamp

Components of a TE

- Reason: This should be a succinct statement of the purpose/content of the TE e.g. "IOS care coordination"
- High priority: you can select this box, located under reason, if this is an urgent communication
- Assigned: This is selecting the person who will be following-up on the identified issue or to whom you are wanting to communicate with
- Provider line: Change the provider to the behavioral health supervisor (e.g. remove the current provider and then add BH "supervisor's name)
- Facility: Best practice is to change this to the facility you are operating in but is not required for most TEs
- Messages: In this area is where you will have the meat of your message. Should include summary of conversation/the issue you are addressing
- Action taken: In the initial message, you are simply going to select *Time stamp* to indicate when you are sending this message. Further conversation between providers would continue within this action taken section, with a time stamp for each time that you make an entry

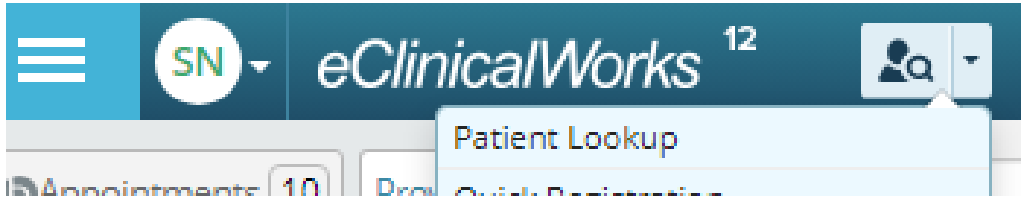
Documenting a Telephone Encounter

- Select New Tel Enc

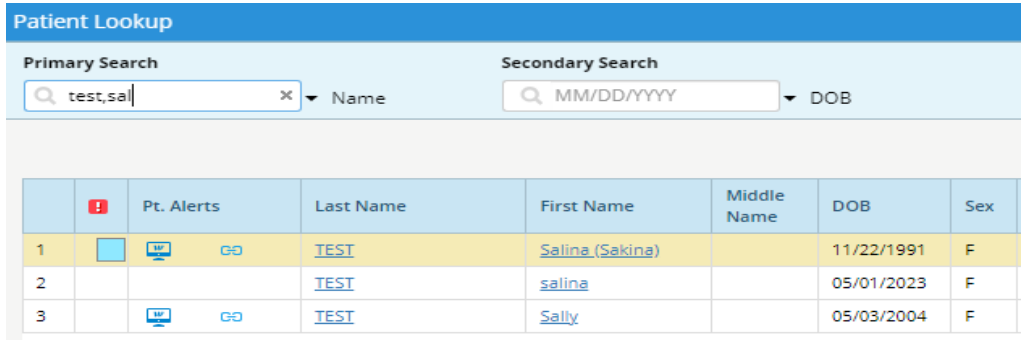


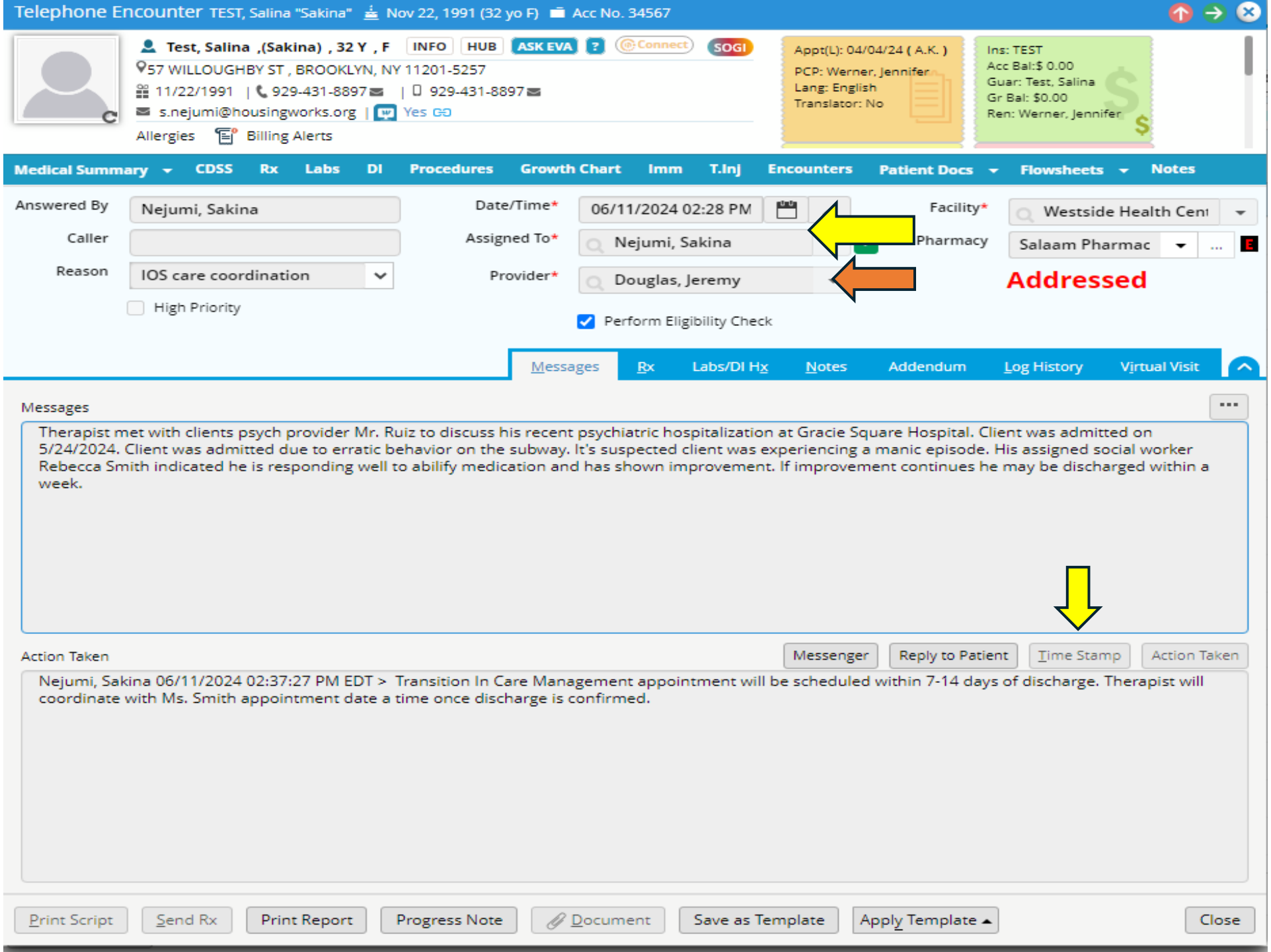
Documenting a Telephone Encounter

- Select patient look up



- Primary search by last name, first name or Secondary search by Date of Birth
  - If you know Medical Record Number (MRN), you can also use that to search directly





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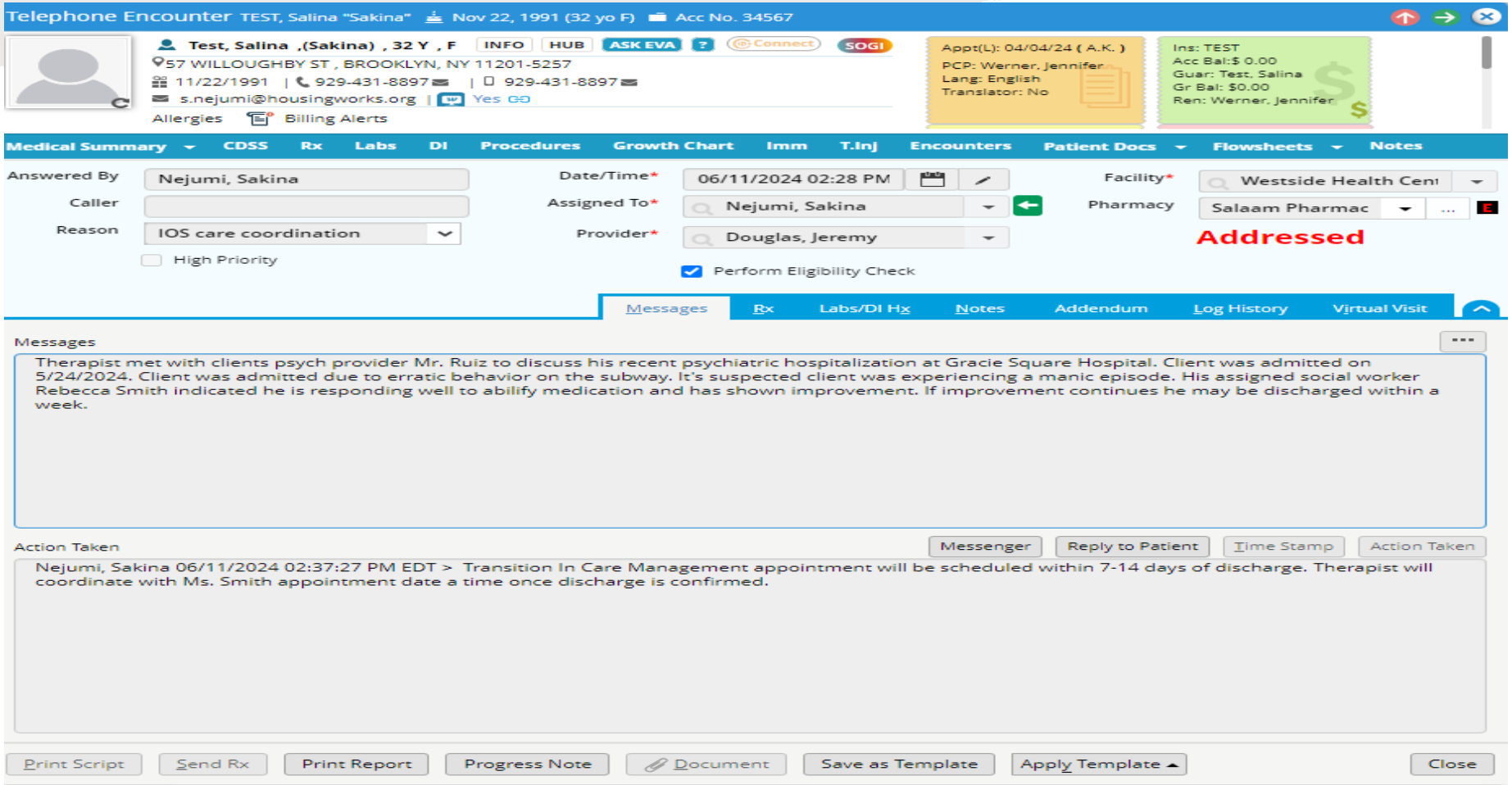
If TE will be shared with provider, change assigned to and replace provider name

Ensure Provider is a BH supervis or

Document next step and remember to time stamp

Documenting a Telephone Encounter



- Completed Telephone Encounter

Documenting The Intake Process

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The Intake Process

- Initiates the treatment process
- Connects to your treatment plan
- Connects to progress notes

The Intake Process: Setting the Stage

Through the intake and engagement process, the social worker strives to develop a rapport with the client that will help to facilitate the client's commitment to work together on their identified goals

When first meeting the client...

- Provide a short description of your role and function within the organization setting
- Share information about confidentiality, the helping process, the type of treatment services offered and expectations for entering services and the program

The Intake Process: Setting the Stage cont’d

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The information obtained during the intake process will help to formulate the assessment

The process is a collaborative relationship to engage and build rapport with the client

It's important to be respectful, thoughtful, genuine and non-judgmental

Help the client understand the next step in the overall treatment process and /or help with identified referral

The Intake Process: Setting the Stage cont'd

As part of initiating treatment, you will also want to

- Review Consents and document in the progress note that consents were "reviewed and understood" by the client

Obtain and review Release of Information (ROI) to collaborate with collaterals

See Disclosures training for more info on ROIs

Remind client that engagement in services is voluntary

The Intake Process: Consent Forms

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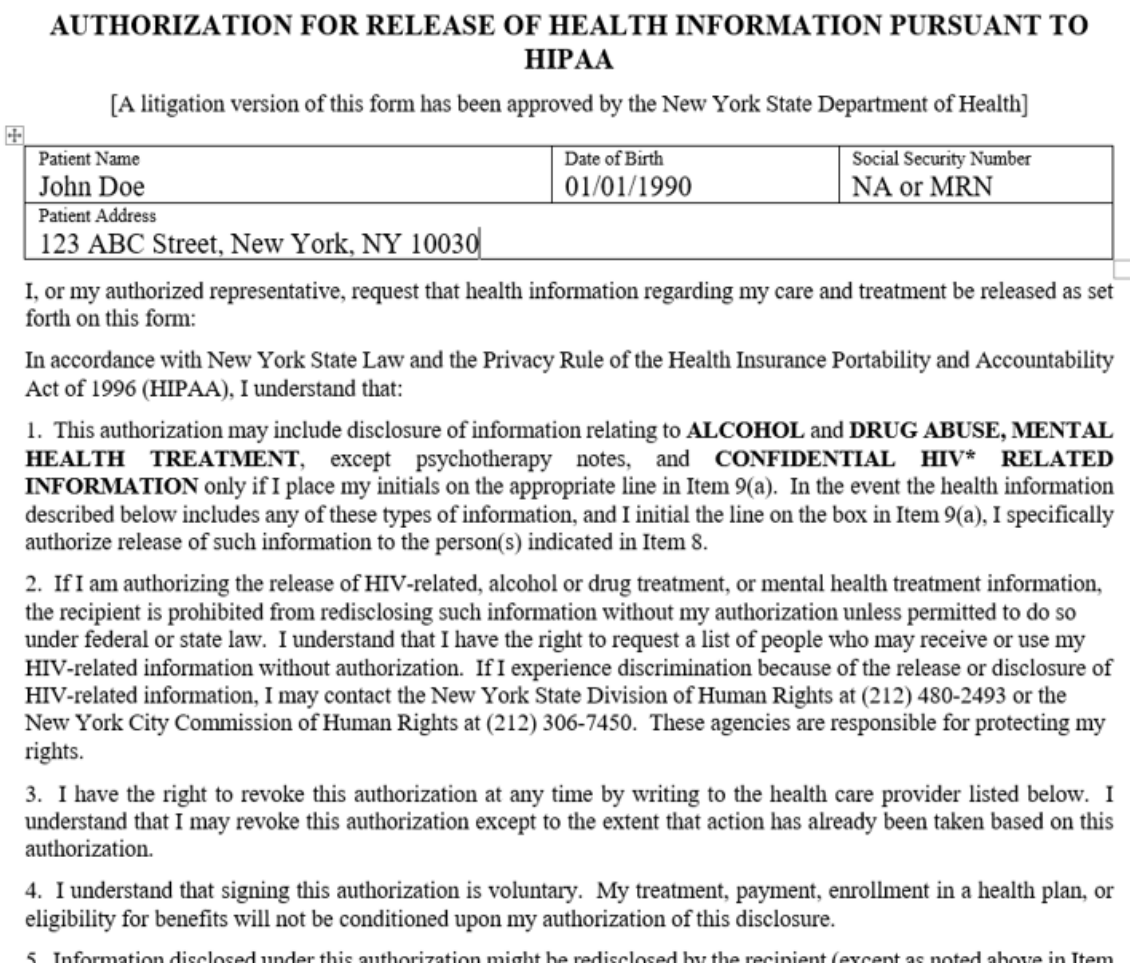
- Since A28 therapy is part of the medical clinic, there are not any additional consents to be completed when someone is enrolling therapy
- At the completion of referral from A.28 Primary Care or Psychiatric Provider, with prescribed sessions noted, if the patient is appropriate for service, they will be scheduled for an initial appointment
- For consents to be valid, the following must be present:
  - Client has signed & dated, where indicated
  - Staff/witness signature & dated, where indicated
  - At least 2 forms of identifying info (combo of name, DOB, or MRN/eCW #)
- Intake packet/consents should be absent of any blank/unsigned consent forms
  - **If not signed writer "void" across the consent**
- The only additional consent form you may be adding is a ROI

Third Party Authorization to Disclose PHI form

Also known as:

- Release of Information (ROI)
- Or HIPAA form



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[A litigation version of this form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
John Doe	01/01/1990	NA or MRN
Patient Address		
123 ABC Street, New York, NY 10030		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

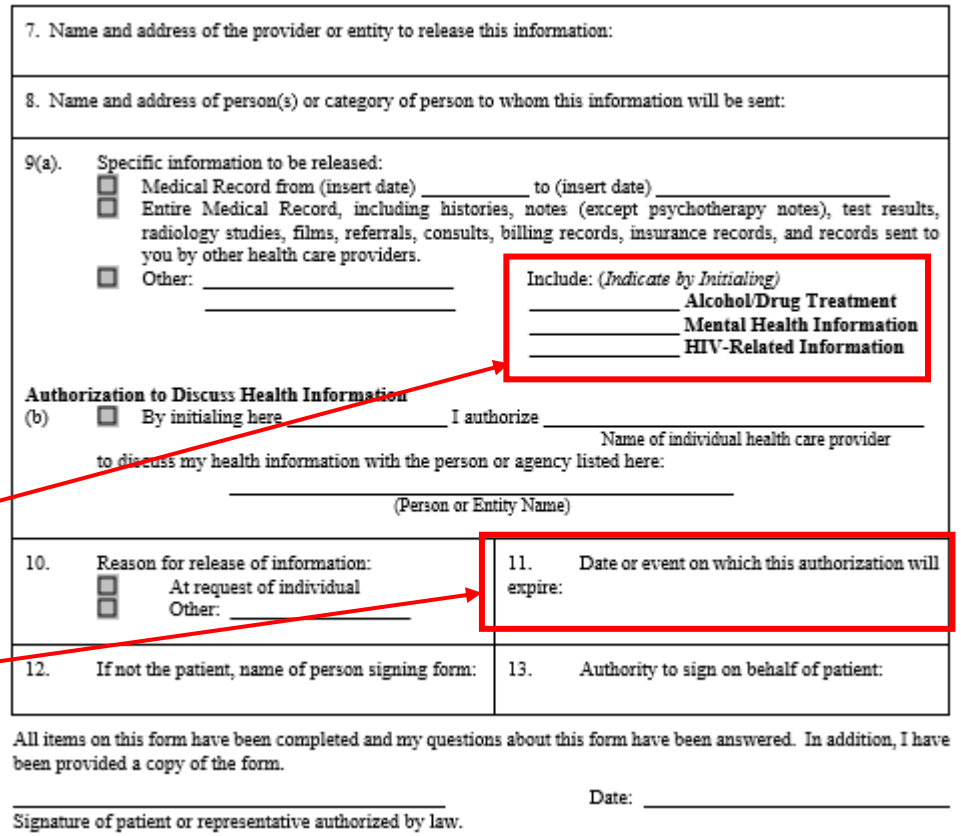
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item

Third Party Authorization to Disclose PHI form

PHI Release of Information (ROI) requests must be responded to **within 5 and no more than 10 calendar days**.

- Patient must complete the Authorization for ROI Form
- **If authorizing disclosure, EACH section must be completed**. The patient must:
  - **indicate** exactly which records are being requested.
  - **initial** the ALCOHOL/DRUG section, as applicable.
  - **initial** the MENTAL HEALTH, as applicable
  - **initial** the HIV-RELATED section, as applicable

  Redact any Alcohol/Drug, Mental Health, or HIV-Related information if these boxes are NOT initialed
- Expiration (item #11) must be indicated, or the form is **INVALID**
- Patient information should only be released by the Patient Care Coordinator, Med Record Coord, or Health Center Director by hard copy, PDF file transmittal, or electronic fax, adhering to the records request workflow.



7. Name and address of the provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:
☐ Medical Record from (insert date) _____ to (insert date) _____
☐ Entire Medical Record, including histories, notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: _____

Include: (*Indicate by Initialing*)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information
(b) ☐ By initialing here _____ I authorize _____
Name of individual health care provider
to discuss my health information with the person or agency listed here:
_____
(Person or Entity Name)

10. Reason for release of information:
☐ At request of individual
☐ Other: _____

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

The Intake Process: Content

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- Demographics
- Reason for Treatment:
- History of the Problem:
- History of Mental Health Treatment/Hospitalizations
- History/Current Substance Use:
- Current & History of Medical Issues
- Family & Social History:

The Intake Process: Content

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- Educational and Occupational History:
- Current Living Situation:
- Legal/Forensic Hx:
- Interests/Hobbies/Strengths:
- Mental Status Exam and Risk Assessment:
- Screeners:
- DSM 5 Diagnosis
- Case Summary

The Intake Process – Best Practices for Clinicians

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- Intakes must be **written up and submitted for review** to a supervisor within a prescribed number days of a client's initial appointment /interview*
  - 2 business days after the intake interview
- All intakes must be fully completed (signed/cosigned, and reviewed by supervisor) within
  - 5 days of interview
- Intake must include a DSM5 –TR diagnosis or ICD 10 code along with recommendations/initial plan for treatment
- Ensure any authorization forms have been completed & added to the chart.

Article 28 Intake Process

Article 28 Intake Process

Client meets criteria for services by:

Receiving Primary Care or Psychiatric Services at Housing Works FQHC

Presenting with some Mental Health Issue as reported by Primary Care/Psychiatric Provider

Client is referred to treatment often by medical/psychiatric provider

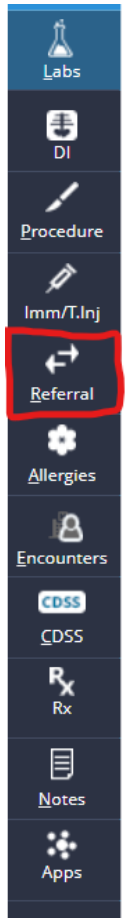
Warm Handoff from referring provider – including prescribed psychotherapy visit in care plan

Front Desk Scheduling – per directive of provider

Warm Handoffs from care managers – provided the above criteria for admission is met

ECW Referral

Article 28 Intake Process Cont'd



Patient: [redacted]

Incoming | Outgoing

New | Delete

	Date	Reason	Referral From	Referral To	Speciality	Start Date	End Date	Allow	Used Visits	Status	Sub Status	Consult Note Rec.
☐	11/20/2024	presents with new onset Chest pain , please evaluate for stress test	Poitevien, Vaty, M		Cardiology	11/20/2024	11/20/2025	10	0	Pending		
☐	10/28/2024	Referred for continued Article 28 therapy for anxiety	Bhikham, Melissa		Psychotherapy	10/28/2024	10/28/2025	24	0	🔒		

Article 28 Intake Process Cont'd

Referrals are scheduled for intakes within 2 weeks – 30 days of initial contact/referral from provider

If client is deemed High risk intakes are scheduled within 5 business days of screening date*

Intakes can be scheduled as either 1 *60-minute initial visit* or 2 sessions of *30-minute initials*.

If referrals cannot be scheduled within 30 days, clients will be provided with alternate scheduling options – at another site - or be placed on a waitlist

Article 28 Comprehensive Intake Focus Areas

- Screening for dependence on alcohol or other substances
- Assessment for Risk
- Presenting Problem
- Current Family and Social Situation
- Mental Status Evaluation
- Medical History

Article 28 Comprehensive Intake Focus Areas

- Screening for dependence on alcohol or other substances
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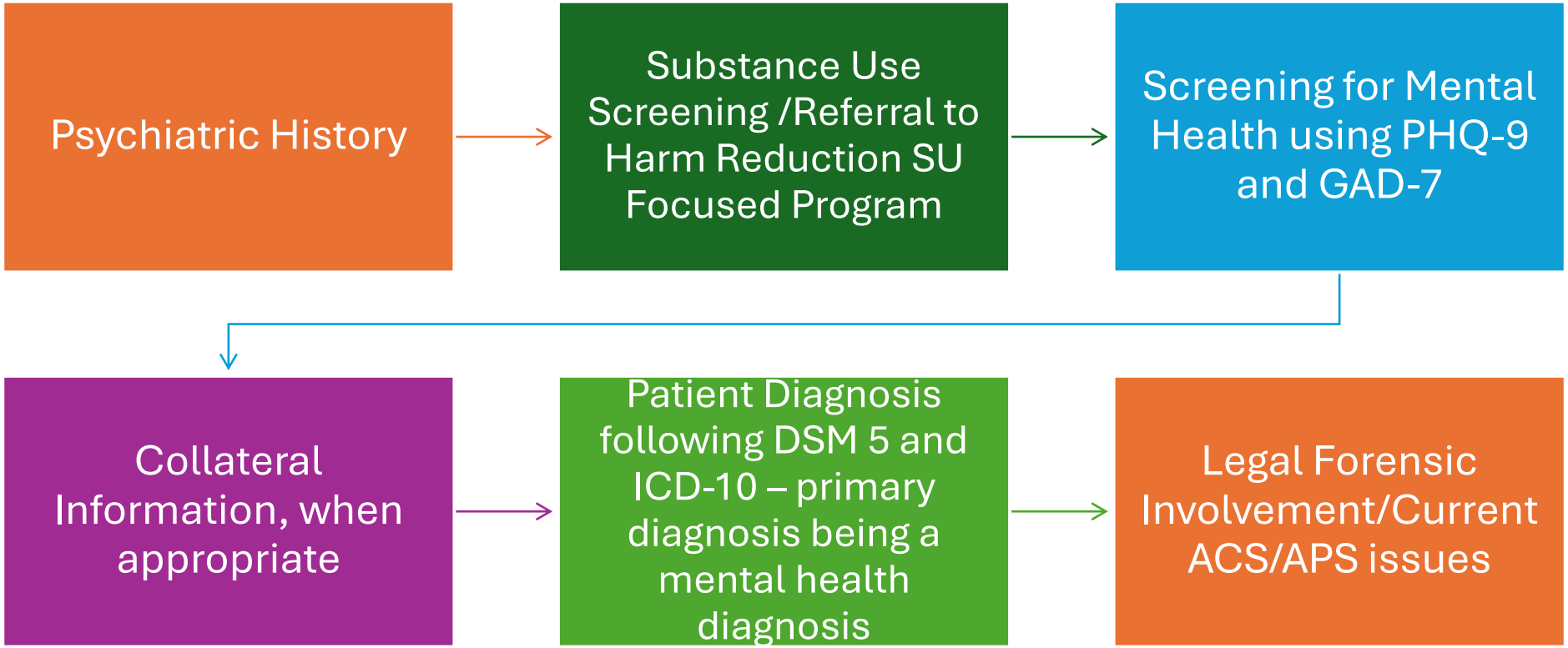
- Current Family and Social Situation
- Mental Status Evaluation
- Medical History

Article 28 Comprehensive Intake Focus Areas, Cont'd



Article 28 Intake Process, Cont'd

Identify Support and Ancillary Providers for coordinating collateral service

Obtain consent for collateral communications (this includes mandated providers along with ancillary providers)

Ensure all forms are completed and signed by client– consent, privacy policies etc.

Offer client a copy of the intake package and document if they accept or decline

All intakes are submitted for review to the Director/Supervisor within two business days of completion

Diagnoses

- Diagnoses should be consistent across all documentation
- At intake, you may still be fully assessing the DSM diagnosis and may find it helpful to pull in previous diagnoses from current/previous psychiatric provider or previous therapist. If you pull in a diagnosis from another provider, indicate that you have pulled in previous dx and from whom next to the diagnosis
- Whenever there is a diagnosis change during a tx episode, the content of the progress note must include symptomology that supports the change and/or addition of the diagnosis

Documenting Intake in the E.H.R

Reason for Appointment

1. Part 3
2. "I'm feeling more confident"

History of Present Illness

Depression Screening:

- PHQ-9
  Little interest or pleasure in doing things *Several days-1*
  Feeling down, depressed, or hopeless *Not at all*
  Trouble falling or staying asleep, or sleeping too much *Not at all*
  Feeling tired or having little energy *Not at all*
  Poor appetite or overeating *Not at all*
  Feeling bad about yourself-or that you are a failure or have let yourself or your family down *Several days*
  Trouble concentrating on things, such as reading the newspaper or watching television *Nearly every day*
  Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual *Nearly every day*
  Thoughts that you would be better off dead, or of hurting yourself in some way? *Not at all*
  Total Score *8*
  Interpretation *Mild Depression*
- Intervention
  Depression Screening Result: *Positive*
  Interventions *Initiate treatment (medication and/or psychotherapy)*

COMPLETED ON 5/2/2024.

General HPI:

- General HPI Client is a 45-year-old Puerto Rican, cisgender woman (she/her pronouns), attending an Initial Assessment Part 2 in person. Michael Goins referred client to address her anxiety and depressive symptoms. .

Anxiety Screening:

- GAD-7 (2018 Edition)
  Feeling nervous, anxious, or on edge *More than half the days*
  Not being able to stop or control worrying *Nearly every day*
  Worrying too much about different things *More than hafl the days*
  Trouble relaxing *Several days*
  Being so restless that it is hard to sit still *Several days*
  Becoming easily annoyed or irritable *More than half the days*
  Feeling afraid as if something awful might happen *Not at all*
  Total GAD-7 Score *11*
  If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people? *Somewhat difficult*
  Interpretation of Total *(10 to 14) Moderate*

  COMPLETED ON 5/2/2024.

IMPACT:

- DAST-10
  Have you used drugs other than those required for medical reasons? *Yes = 1 THC every day no ETOH or cigarettes.*
  Do you abuse more than one drug at a time? *{...}*
  Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes") *{...}*
  Have you had "blackouts" or "flasbacks" as a result of drug use? *{...}*
  Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No". *{...}*
  Does your spouse (or parents) ever coplain about your involvement with drugs? *{...}*
  Have you neglected your family because of your use of drugs? *{...}*
  Have you engaged in illegal activities in order to obtain drugs? *{...}*
  Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? *{...}*
  Have you had medical problems as a result of your drug use? *{...}*
  Score: *00*
  Interpretation: *{...}*

  COMPLETED ON 6/27/2024.

Tobacco Questionnaires:

  COMPLETED ON 6/27/2024 non smoker.

Medical History:

- Medical History
  Medical conditions (any pertinent details and length of time): *{...} Rectal bleeding and hemorrhoids.*
  Prescribed medical medications: *{...} See below*
  Are you engaged in primary care (within last 12 months)? *Yes*
  Provider at Housing Works clinic location? *Yes*

Provider Name: *Michael Goins*
HIPAA consent for provider obtained? *No Client's PCP is at Housing Works.*
Date of last HIV test: *12-2023 Non-reactive.*
Date of last HEP C test: *12-2023 Non-reactive.*

COMPLETED ON 5/2/2024.

ocial and Family Hx:

- Social and Family Hx

How does the client describe their family growing up? How do they describe the familial dynamics? *{...} Client stated her upbringing was "very bad and dysfunctional." Client stated her mother not a good mother. Client came to the US from to Puerto Rico when client was 5. Client's mother had depression and other issues; - client was a parentified child. Mother was abusive towards client when she broke up when her broke up with her boyfriends. Client noted she became like her mother and hit her children in the past. The father was not in the house and client has abandonment issues. Client's mother was always on the defensive and tried to keep her boyfriends away from client.*
Any known family medical/mental health/substance use diagnosis? *Mother has undiagnosed mental health issues. Client's grandmother lives with Schizophrenia. Client denied medical or substance use issues. Client stated her mother drank and got drunk sometimes. Client would also drink to see what it was like. Client stated drinking made client feel forget and also made her feel better alcohol. Client reported she used to drink until she passed out. Client does not drink anymore and has not had a drink in years.*
Describe your current familial relational dynamics (children, partners, etc): *{...} Client stated she had an "okay relationship" with her mother, but it was sometimes toxic. Client has 7 children three of which live with client. Client is finding she has better boundaries with her children.*
Any family/relational dynamics issues of concern for therapy? (Ie ACS/IPV/Ruptures) *No*
Educational background and highest level of learning/certification: *{...} GED and did some trade school for construction and cooking.*
Any known learning challenges/disability? ----- *Denied*
Does the patient report any challenges with reading and/or writing? ----- *Denied*
What is the client's cultural/ethnicity identity? What role does this play in their life? *{...} Client identifies as Native American mostly (also Puerto Rican). Client feels the Native American side of her is mild and believes this has been a hindrance in her life.*
What is the client's spiritual/religious identity? What role does this play in their life? *{...} Client believes there is a God and Goddess and feels she has both guiding her. Client is also connected to Mother Nature.*
Summary of work experience: *{...} Client attended culinarily school but was not passionate about it. Client also worked in construction: Non-Traditional Employment for Women (NEW).*
Current voc/educational activities or needs: *{...}*
Where is the client currently living? *{...} Brownsville*
Who is the client currently living with? *{...} Client lives with her three children and her fourth child visits in the summer.*
Current income source(s): *{...} Benefits*
Client reported strengths and abilities: *{...} Strengths: resilient, compassionate, smart, has a desire to always learn, is loving open and approachable. Challenges: client believes she is too kind and too passive.*
Community resources and needs assessment (Hierarchical needs: food stability, housing stability, bills/arrears, safety): *{...} N/A*

COMPLETED ON 7/26/2024.

ehavioral Health Treatment:

- Behavioral Health Treatment

Client identification and diagnosis (self reported, provider dx): *{...} Anxiety, generalized - F41.1 (Primary) Major depressive disorder, recurrent - F33.9*

Symptoms as described by client: *{...} Client reports her anxiety over court cases causes her to blank out. Client will be assessed for dissociation during f/up sessions.*
History of symptoms (onset/length of time/frequency/intensity): *{...} Client reports the onset of her symptoms were from she was a pre-teen. Client stated, "My mother was always depressed and, in her bed, and this affected me as a child." Client noted abandonment issues related to her father, which led client to "mute" her feelings and depression with alcohol.*
Identify any experience of perceptual disturbances, psychosis, mania (past or current experience, onset, length of time): *{...} Client reports she sometimes saw shadows from mid-teens and has experienced paranormal experiences (TV turning on and up in volume by itself. Client stated she is seeing more recently and sometimes thinks she sees someone. Client denied AH and paranoia.*
History of substance use (substances used, route of administration/MAT/MOUD current/history): *{...} Client used psychedelics in the past. Client has not used ETOH for 4 years. Client smokes THC daily.*
Currently in any treatment program(s)? *No*
Referral offered/needed? *No*
Prescribed psychotropics: *{...} No - client reports she is open to psychotropics and has an upcoming psych COMP*
Past BH Treatment: Psychiatrist/psychologist/social worker/LMFT/Substance Abuse Counselor/ other(specify)/ Reason for leaving(specify): *{...} Client had therapy at Housing Works with Michell Lubeth until therapist moved to a different program within Housing Works.*
Did patient consent to release of information for coordination with previous/current providers? *No Declined due to having therapy at Housing Works.*
History of psychiatric hospitalization: *{...} Yes - at 21 due to client being intoxicated and under the influence. Client was admitted to Kings County.*
Any historical experiences of suicidal ideation/attempts (dates/frequency/method)? ----- *Client reported she had SI in her early teens. Client stated she used to cut herself and drank medicine and bottles of alcohol and took her mother's antidepressants. Client was never hospitalized. Client reported this was a gesture with no real intent. Client stated, "I was dipping my toe to see what would happen." Client denied any other experiences of suicidal ideation/attempts.*
Any historical experiences of homicidal ideation/attempts or assaultive behavior(dates/frequency/method)? ----- *Denied*

COMPLETED ON 6/27/2024.

Trauma History:

- History of Physical Abuse/Relational Violence Yes.
- History of Sexual Abuse Yes.

COMPLETED 7/26/2024.

Legal Involvement:

- Legal Involvement History
  Legal History (any arrests, charges, periods of incarceration): *Yes Client was arrested for being drunk in public disorderly conduct - no jail time served.*
  Pending Charges: *No*
  Current Parole/Probation: *No*
  Current Orders of Protection: *No*
  Current Attorney/Public Defender: *No*

COMPLETED ON 7/26/2024.

COMPLETED ON 5/2/2024.

Mental Status:

- Appearance Groomed.
- Attitude Positive ego syntonic.
- Affect Broad.
- Motor Activity WNL.
- Eye Contact Maintained good eye contact.
- Mood Euthymic.
- Speech Spontaneous, clear, with appropriately placed inflections and good articulation.
- Thought Process Goal oriented, linear and logical, no flight of ideas; no thought-blocking..
- Thought Content Denied SI/HI; AH or paranoia, no delusional beliefs expressed. Endorses VH..
- Disturbances of Perception None observed.
- Memory Intact.
- Cognitive Function Oriented x 4.
- Judgment Good.
- Insight Good.
- Reliability Good.

Client is a 45-year-old Puerto Rican, straight, cisgender woman (she/her pronouns), attending an Initial Assessment Part 3 in person. Therapist used empathy, reflective and active listening, and supportive therapy to continue to assess, engage, and build rapport and a therapeutic alliance with client.

Client demonstrated good insight and motivation into behavioral health goals, stating she believed she was becoming more confident and assertive, especially in her communication with others. Client noted some hostility and wariness in the ADHC department from other females, but noted she was only there to attend her groups and grow. Client stated she had stopped vaping.

Two-week f/up session scheduled to complete ICP. Therapist used empathy, reflective and active listening, and supportive therapy to address current stressors, and build a rapport and a therapeutic alliance with client.

Suicidal/Homicidal Assessment:

- History of Suicidality See above.
- Current Suicidality: Denies .
- History of Homicidality No History .
- Current Homicidality: Denies .
- History of Assaultive Behavior No .
- Gun Ownership No .

COMPLETED ON 7/26/2024.

Current Medications

Not-Taking

- GNP Omeprazole 40 mg Tablet Delayed Release 1 tablet Orally Once a day

Social History

Drug/Alcohol:

- AUDIT-C (Standard)
  Did you have a drink containing alcohol in the past year? *No*
  Points *0*
  Interpretation *Negative*
- DAST-10 (2021 Edition)
  1. Have you used drugs other than those required for medical reasons? *Yes*
  2. Do you abuse more than one drug at a time? *No*
  3. Are you always able to stop using drugs when you want to? *Yes*
  4. Have you had \"blackouts\" or \"flashbacks\" as a result of drug use? *No*
  5. Do you ever feel bad or guilty about your drug use? *No*
  6. Does your spouse (or parents) ever complain about your involvement with drugs? *No*
  7. Have you neglected your family because of your use of drugs? *No*
  8. Have you engaged in illegal activities in order to obtain drugs? *No*
  9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? *No*
  10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding etc.)? *No*
  Results: *1*
  Interpretation of Score: *Low level*

  COMPLETED ON 6/27/2024.

Vital Signs

Assessments

1. Anxiety, generalized - F41.1 (Primary)
2. Major depressive disorder, recurrent - F33.9

Diagnosed by attending therapist based on PHQ-9: Client meets Criteria A (depressed mood and loss of interest or pleasure. Feeling bad about herself like she is a failure, psychomotor agitation/retardation, feeling worthless and excessive guilt, diminished ability to focus and concentrate. Criteria B (the symptoms are causing client distress, especially when client is at home). GAD-7 Client meets Criteria A (excessive anxiety and worry occurring more days than not for at least 6 months), B (client finds it hard to control her worry). C (client's anxiety and worry are associated with restlessness and feeling on edge, difficulty concentrating and client's mind going blank, and irritability. Client's worry is causing significant distress and impairment in important areas of functioning (ADLs).

Treatment

1. Anxiety, generalized

Notes: Provided 30 minutes of psychotherapy provided from 11:30 am to 12pm..

Clinical Notes: Therapist used empathy, reflective and active listening, supportive therapy.

Goal: Address anxiety, depression and feeling overwhelmed.

During today's session, client did not make any gestures or statements indicating that client was an obvious danger to self or others.

Procedure Codes

- 90832 Psychotherapy, Individual 30 (16-37) min.

Follow Up

2 Weeks (Reason: ICP)

Risk Assessment

Risk Factors: Suicide

- **Distal Risk Factors – Chronic and longstanding risk factors**
  - Demographic factors- death by suicide, previous suicide attempts (past year, past 3 months), psychiatric hospitalizations
  - Family hx of suicide or violence
  - Adverse childhood experiences
  - HX of Psychiatric Illness & symptoms – Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Substance Use Disorders, Eating Disorders, Posttraumatic Stress Disorder, Borderline Personality Disorder) (Suicide Prevention Resource Center, 2018)
  - Chronic Pain

Proximal Risk Factors- acute or current factors that identify more imminent risk

- Current and active psychiatric sxs
- Current substance use
- Stressful life conditions
  - COVID -19 Pandemic
- Direct access to lethal means
- Exposure to suicide in community, social circles or the media

- Other Risk factors
  - Some cultural or religious beliefs

MH risk factors

See the Behavioral Health Orientation training for more info on Suicide risk & safety planning

Routine Follow-Up to continually assess MH Risk Factors

Identify any discrepancies in assessments , for e.g. PHQ 9- rendorse SI but denies in general intake

Risk Areas should include NSSI, SI, HI, IPV/DV

Safety Plan Creation and Reassessment

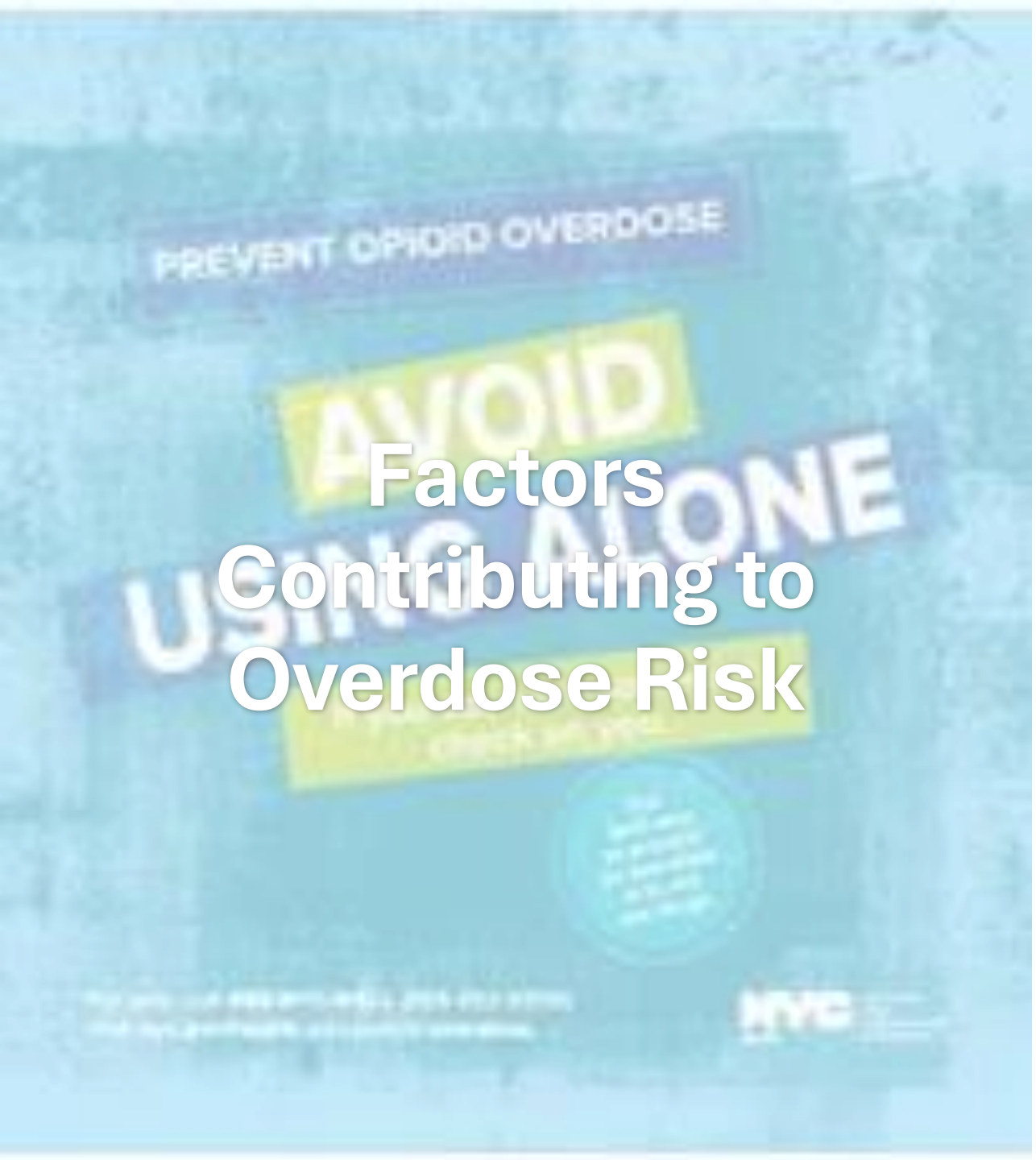
Documentation in E.H.R and also shared with patient (i.e. also note in documentation if patient declined copy)

Warning Signs & Protective Factors

- *Warning Signs – changes in behavior and new behavior that highlight imminent risk*
  - Threatening to hurt or kill self or talking of/wanting to kill oneself
  - Recent increase in suicidal thinking/planning
  - Making preparations
  - Feeling burdensome
  - Hopelessness, no reason to live, feeling trapped or being in unbearable pain
  - Increase in social isolation/social withdrawal
  - Increase in substance use or differing behaviors as it relates to substance(s) and types of use
  - Insomnia/sleep disturbance
  - Rage/revenge seeking behavior
  - Verbalizing “not being around”
  - Recent and intensive changes in mood

Protective Factors

- Coping strategies
- Problem Solving skills
- Help-seeking behavior
- Family (close, supportive, sense of responsibility)
- Spirituality
- Fear of consequences
- Fear of death
- Minimize access to Lethal Means
- Social Support/Sense of Belonging
- Strong therapeutic relationship with a trusted provider



Factors Contributing to Overdose Risk

- Recent Use of Opioids/Other substances high potential for overdose (Within past 12 month period)
- Past Hx of overdose
- Health and Life Stressors:
- Any personal factors : explore and solicit from the individual
- Process of Substance use: (the what, how and when)

See the Behvioral Health Orientation trainig for more info on Harm reduction & overdose prevention

Documenting Treatment Plans

Treatment Planning: The Process

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- A collaborative process between therapist and the client and includes client feedback
- Addresses the client's presenting problems via goals and actionable objectives.
- The treatment plan includes a statement of the clinical problem, the interventions and room to measure client's progress.
- Considers the client's strengths and barriers along with their circumstances

Treatment Planning: The Process

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- Includes the interventions by clinician, modality of treatment, frequency and duration
- Is ongoing/ not static.; allows for adjusting the interventions/objectives etc.
- The initial treatment plan must be completed within 30 days of admission session
- Treatment plan reviews are expected to continue to track progress and changes***
- Plans are updated: every 90 days, change in diagnosis, increase in frequency, change in goals/life events

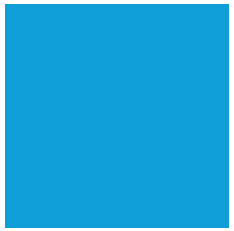
Writing Effective Treatment plans

- Treatment plan connects to the Intake .
- Use client quotes of what they want to work on for their goals.
- Be detailed about the interventions you will use.
- Add a timeframe to the goals stated.
- Have measurable objectives to determine the client's progress.
- Periodically review client's progress and update treatment plan as needed.
- Adjust objectives if no progress in treatment
- Use SMART goals to identify the plan to address the presenting problem or need.

Identifying the Problem/Problem statement

Identify the problem based on information from the assessment

Identify the most acute/ troubling problem that affects the client's level of functioning



Identify what is most important for the client, what they want to address

The problem statement should be related to the client's diagnosis or their presenting concern

Creating a Goal

- Clinical statement of the condition you expect to change
- The goal is tied to the assessment and problem statement
- The goals are reasonable and achievable
- Goals and objectives are often confused in treatment plans so keep in mind there is a difference.
- If you can see the client do something (i.e.- complete a journal entry, attend AA, etc.) then it is an objective.
- If you can't see a client do something (i.e.- reduce anxiety, accept powerlessness) it is a goal.

Goals

For A28, must include at least one goal around behavioral health

Must also include a medical goal and social service needs goal

If client is not interested in addressing either of these in tx right now, these can be changed to deferred goals until client is ready to address

A SU goal may be added if client would like to be a part of their tx; however, SU cannot be the main focus of tx

If SU is a main focus of tx, client would benefit from referral to one of the other treating programs

Goals should be regularly updated/reviewed when reviewing objectives at the 90 day intervals

SMART GOALS

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Make objectives	
Specific	Goals and objectives are more easily accomplished when they are clearly stated. Answering the 5 “W” questions (who, what, when, where, and why) is helpful in setting specific goals
Measurable	Establishing concrete criteria for measuring progress can help motivate continued effort to achieving the goal. How will we know when the goal is accomplished?
Attainable	Goals should be reasonable and achievable. Trying to do too much in too little time is not the best way to succeed.
Realistic	A goals is probably realistic if the person believes that it can be accomplished. To be realistic, a goal must represent something a person is willing and able to do.
Timely	Goals are more grounded when there is a time frame attached to them. Identifying short-term steps within a longer term goal can help to create hope and momentum.

Creating Objectives

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- Objectives are what the client will do to meet the goals
- Must be stated in behaviorally measurable language
- Objective must be clearly stated
- Objectives are the skills developed by the clients and when accomplished will result in achievement of goal(s)
- Each objective should include a target end date for completion

Interventions, Modalities, Frequency

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"Interventions are actions of the clinician designed to help the patient complete the objectives." Perkinson, R.P., & Jongsma, A.E., (1998)

• What you do, as the clinician, to help the client complete/meet the objective.

Includes the frequency of intervention as well

• Should also be written in a measurable way

• Services can be considered a form of an intervention (IOP, case management, outpatient, peer services, etc.).

Risk Assessment in Treatment Plan

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- No risk: have a general risk statement
  - Client does not currently present with significant risk
  - No major risk factors observed or reported by client
- Risk: Identify level of risk and for what and possible factors present
  - Client presents with _____ (low/moderate/high) for _____ (suicide/homicide/violence/relapse or other –and then name this) as evidenced by _____ (ideation (passive/active), plan, intent, means etc.)
- If risk is present create a safety plan
  - Identify that client received a copy or that they declined etc.

Understanding the Client

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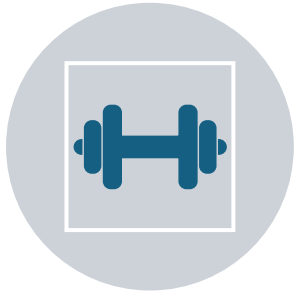

Consider the client's strengths, emotional and physical circumstances, and what they're trying to achieve.

Select services: Use the client's strengths when choosing services.

Create measurable goals: Set goals that can be measured as the client progresses.

Choose interventions: Interventions are techniques, tools, and exercises that help the client meet their goals. Some examples include counseling, crisis intervention, advocacy, safety plans, behavior plans, and crisis plans.

Review The Treatment Plan

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- Is your goal related to your assessment?
- Do you have at least one clinical/ medical/social service treatment goal?
- Are your objectives SMART and do they relate to the goal?
- Are your time frames reasonable?
- Have you described your interventions in a way that accounts for the good work you are doing?
- Do you have more than one goal that accounts for the needs of the client (treatment, case management, etc.).
- Is the treatment plan signed?

Sample treatment plan

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PROBLEM	Drug/Substance use has caused problems in the client's life, most notably negatively impacting his relationship with his children.	"Using drugs has caused too many problems in my life and is affecting my relationship with my kids"
GOAL	To reduce or stop drug use and decrease experiences of relapse "	"I want to stop using drugs and figure out how to not relapse anymore"
OBJECTIVE #1	Client will write/outline a detailed substance use history	**Date established: 3/9/24** **Targeted Completion: 6/9/24**
OBJECTIVE #2	Client will identify 3 triggers that will lead to relapse	**Date established: 3/9/24** **Targeted Completion: 6/9/24**
INTERVENTION	Clinician will support client in creating a detailed outline of his substance use hx Clinician will provide psychoeducation on triggers and high-risk situations	**Modality: individual sessions (/ group/ couple etc.)** **Frequency: Weekly (biweekly, monthly etc.)** **Duration: 6mths /12mths**
MEDICAL NECESSITY & REASONS FOR DISCHARGE	Treatment is medically necessary to decrease the impact of substance use and improve daily functioning	Client will be discharged when treatment goals are attained or client chooses to withdraw from treatment…

Article 28/IOS ICP

Assessments

1. Major depressive disorder, single episode, severe without psychotic features - F32.2
2. GAD (generalized anxiety disorder) - F41.1

Treatment

1. Major depressive disorder, single episode, severe without psychotic features
Notes: 30-minute psychotherapy: 11am-11:30am.
Clinical Notes: Therapist utilized MI/OARS and supportive therapy. See HPI section for intervention details.

Procedure Codes

90832 Psychotherapy, Individual 30 (16-37) min., Modifiers: 95

Follow Up

1 Week (Reason: f/u therapy)

CarePlanProblems

Problem:Behavioral Health*
Goal:"I want to wake up and feel like I have a purpose: I want to feel like I'm needed; to wake up without fear; not let fear conquer my life; when I wake up in the morning that's the one thing that overwhelms me." Objective:will get to a 7 from a 3 in terms of scale of fear (10 being no fear within normal limits) by identifying 3-5 contributing factors to quotidian sense of fear - objective to be completed by 12/28/2023
Notes:, Care Plan Notes: Care Plan Notes Client states Wow I have made strides. Client states that he still has some fear but is at a 7. Goal completed.

Problem:Behavioral Health*
Goal:"I have to get more more attached with people--binding together with people" Objective:Client will identify at least 3-5 barriers to attaching and binding with others - objective to be completed by 1/24/2025
Notes:

Problem:Medical*
Goal:To improve current overall health Objective:Client will attend PCP appointments at least 1x/6 months
Notes:

Problem:Medical*
Goal:"To be able to go without psychotropic medications" Objective:identify at least 3-7 barriers to getting off said medications - objective to be completed by 12/28/2023
Notes:, Care Plan Notes: Care Plan Notes Client states that he believes this is a farsighted goal. Client states that a primary barrier to getting off of psychotropics is his tendency to dwell.

Treatment Plan Update: Documenting Change/Progress

- Important to document progress in treatment plan updates
- Progress must be clearly connected to objectives
- Document progress in behavioral terms
- Article 28 Plans (ICP's) are updated every 90 days

Assessments

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Follow Up

1 Week (Reason: f/u therapy)

CarePlanProblems

Behavioral Health*"I have to get more more attached with people--binding together with people"Client will identify at least 3-5 barriers to attaching and binding with others - objective to be completed by 1/24/2025, Care Plan Notes: Care Plan Notes Client states that he has been making friends, but would like to get involved with people that have the same values that I have, which he has been struggling to find. Goal to be continued.Medical*To improve current overall healthClient will attend PCP appointments at least 1x/6 months - objective 1/24/2025, Care Plan Notes: Care Plan Notes Client states that he wants to lose weight, but has been consistent with medical appointments. Client states that he is concerned that his weight is impacting his mobility and causing pain. Goal to be continued.Social Services Needs*"I want to get more involved at Fountain House"Client will go to Fountain House every Thursday - objective to be completed by 1/24/2025, Care Plan Notes: Care Plan Notes Client states that he has been attending activities at Fountain House at least one time per week. Goal to be continued.

Article 28 Treatment Plan in ECW- The Integrated Care Plan (ICP)

ECW Billing

Billing

Billing is captured in a separate EHR than the clinical documentation: eCW

What's included:

All assessed diagnoses

Telehealth questionnaire for telehealth visits

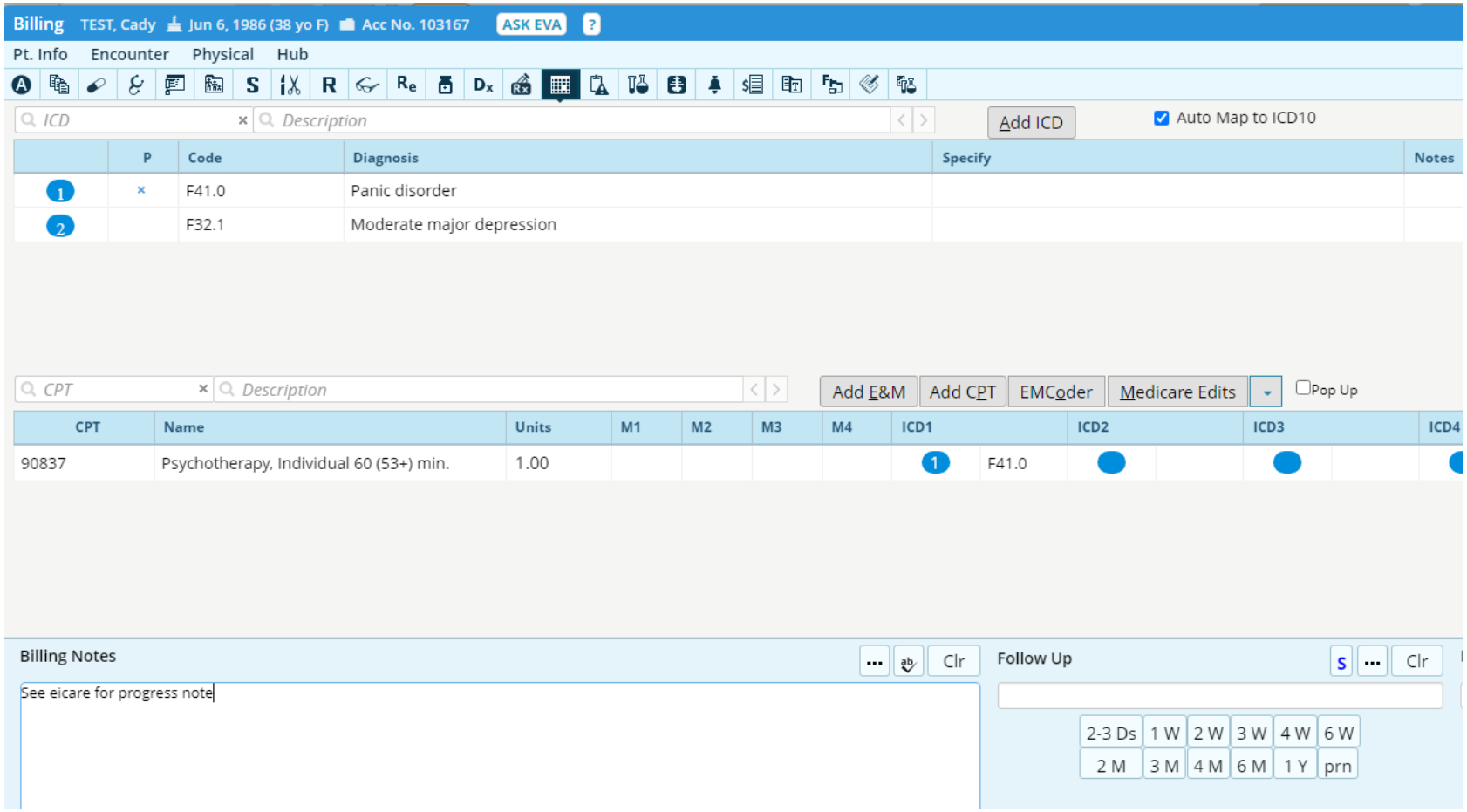
CPT/billing code

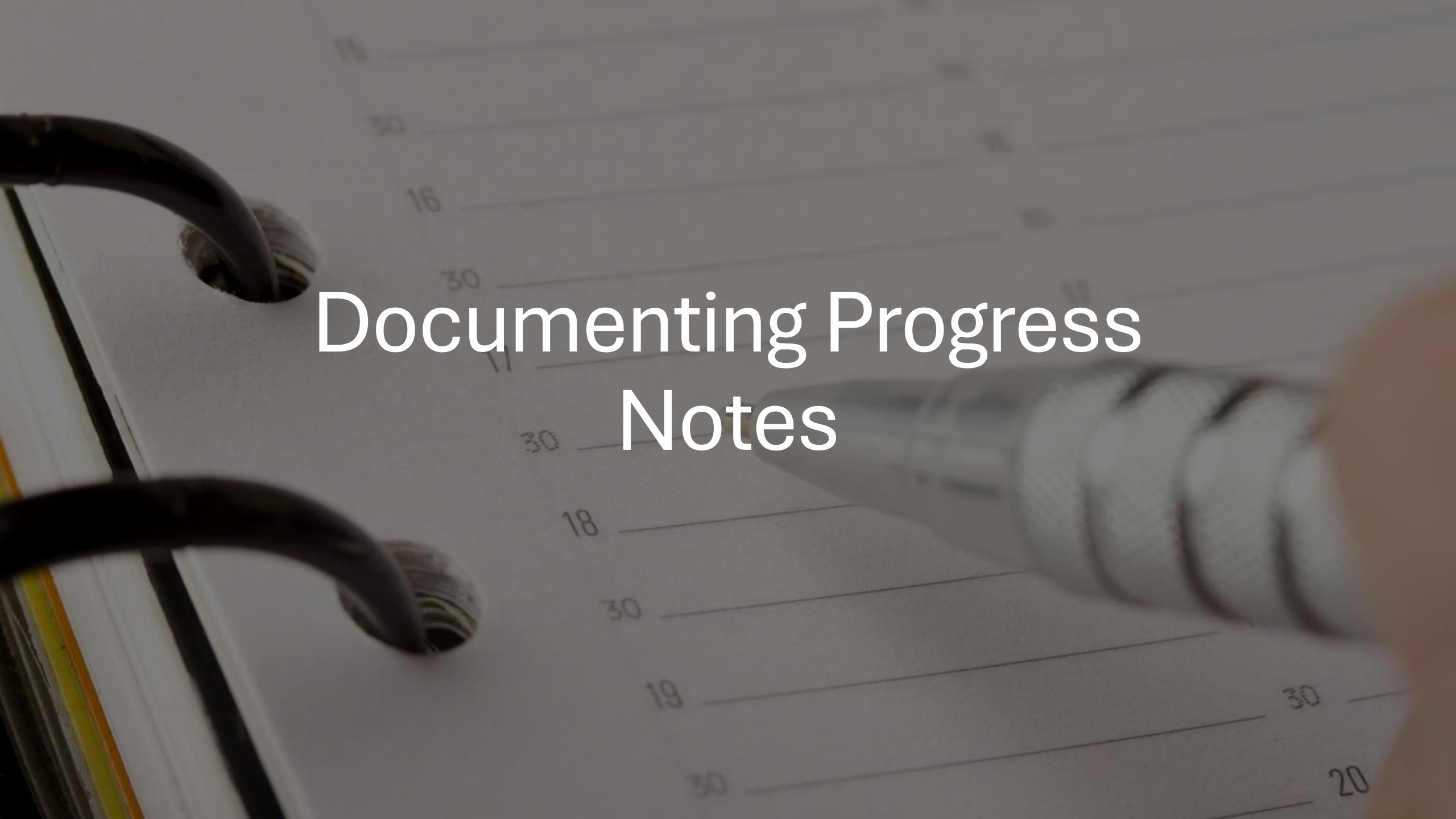
Billing note to "See eiCare for progress note"

Signature of clinician providing services

Example of billing

Review further with your supervisor





Documenting Progress Notes

Progress Notes

- Progress notes are a key element to recovery. Each individual's record must contain progress notes that are reflective of the individual's progress and provide an overview of what is covered in each session.

- Continues the connection from intake and treatment plan

Progress Notes Cont'd

- Progress notes must address:
  - advancement toward goals, identified barriers to progress
  - symptom reduction
  - functional improvement
  - Identify the services provided (consistent with the Individualized Treatment Plan
  - Create the informational framework for the program and the individual to review and update the assessments and especially the Individualized Treatment Plan
  - Provide documentation to demonstrate that services are delivered as defined in the treatment plan, so that Medicaid billing is supported.
  - Include duration/time of services rendered
  - Dated and signed by a clinical member of the clinical program staff
  - Dually signed by supervisor

Progress Note Cont'd

A. Progress notes must include, at a minimum:

A summary of services received after the last progress note;

A description of the progress made toward the goals identified in the individualized treatment plan subsequent to the last progress note; and

Identification of any necessary changes to the treatment plan and services related to such changes.

B. Progress notes must be completed, at a minimum, after engagement with the client

C. A progress note must also be completed for any significant event and/or unexpected incident. ***

Suicide Risk, Increased frequency of session,

Types of Progress Notes

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SOAP

- Subjective
- Objective
- Assessment
- Plan

DAP

- Data
- Assessment
- Plan

BIRP

- Behavior
- Intervention
- Response
- Plan

Types of Progress Notes - Other Styles

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- Reflection Based
- Results Based/Goal - Oriented
- Motivation Based
- Positivity-Based
- Skills based
- Relationship-Based

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Group Progress Notes

- Group Summary: Group name + purpose/goal; facilitator(s); # of clients; themes/topics discussed; outline of session; interventions(skills etc.); time started and ended

- Individual summary: individual note template + focus on client's group interaction, client's role as a part of the group dynamic, client's participation in connection to goals and objectives

- Signature and Date

Other Notes: Collateral Contacts/Case Conferences

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- Best Practice: can be beneficial for treatment especially for complex cases
- Provides a more holistic treatment process
- Can occur with any other treatment/service provider: PCP, Psych Provider, Case Manager, Housing Specialist etc.
- Some programs require collaborations with specific providers, e.g. OMH – if client is on psychiatric medications, then collab with Psych provider must take place etc.

Other Notes: Collateral Contacts/Case Conferences

- Recorded in E.H.R. – may have specific coding/billing depending on program– case management, complex care management etc.
- Attendees: Include all attendees and role in client's care; date and time and location
- Content: Focus of the Contact/case conference; symptoms or problem areas
- Goals/Objectives of Collateral/Case Conference
  - Identify how this connects to client's care/treatment plan
- Plan: Action Items- note if there is follow-up by each participant?

Article 28 Progress Note

- Any contact with client including outreach will be documented in the client's E.H.R.
- All Article 28 case/progress notes will be completed and signed within 2 days of the client contact/session.
- Each progress note should address the patient's treatment goals and objectives and document clinician intervention.

Example of Article 28/IOS Progress Note

Reason for Appointment

1. F/u therapy
2. Doxy
3. "Much better this week"

History of Present Illness

Mental Status:

Appearance Casual, well-groomed. Attitude Cooperative, bright. Affect Full range, bright. Motor Activity WNL. Eye Contact Appropriate. Mood See chief complaint. Speech WNL. Thought Process Logical, linear. Thought Content No SI/HI/AVH. Judgment Fair. Insight Fair.

Client presents for f/u therapy. Client reports feeling a great deal of relief secondary to news he received from his building management that he may be able to move an apartment on a lower floor to accommodate progressive, though mild, ambulatory challenges. Therapist and client discuss sessions in which client's anxious transference. Therapist reflected that throughout the treatment, it appears that while his depression has receded anxiety has seemed to take precedence. Therapist adjusted primary diagnosis to GAD and adjusted MDD to being in remission. Client was amenable to this suggestion. However, client went on to discuss relationship with mother, both in the past and the introjected version of her. Client states, "I think my mother was gay," while providing various points of evidence. Therapist self-disclosed an inquiry that popped into their head, about what gender the voice in his head is. Client states that "it is female." Therapist and client explored his relationship with gender throughout his life. When prompted, client expressed that he may have transitioned if he grew up in another time. Client expressed that he believes he is not receiving optimal effects from current psychotropic. Therapist suggested that client discuss other options with psyc, such as Prozac, given its reputability as a treatment for anxiety disorders at higher doses. Client was amenable. Therapist utilized MI/OARS, STPP, and supportive therapy to continue building rapport, provide holding environment for eliciting client information, explore intrapsychic experiences, and aid in affect regulation. F/u telehealth therapy scheduled in 1 week.

TeleHealth:

TeleHealth Questionnaire , Client consent obtained for telehealth visit? Yes, Visit occurred via telemedicine interface? Yes, Mode: Doxy Video, At least 50% of encounter spent counseling/coordinating care? Yes, Provider at Housing Works clinic location? Yes, Patient at Housing Works clinic location? No, Client's current permanent location? NY State.

Example of Article 28/IOS Progress Note

Thought Process Logical .
Thought Content No reported SI/HI .
Disturbances of Perception Reported AH, paranoia, delusions. Denied VH. No reported flashbacks.
Cognitive Function AOx3.
Judgment Good.
Insight Poor to fair .

Client (CT) 65 yo transwoman presented in person for f/u therapy with writer, and writer used open-ended questions to inquire about CT welfare. CT reported continued AH of "neighbors" who are "saying" they are going to "kill me." Client reported rx adherence to 1mg resperidone but had no change in sx and was sleeping very little due to AH. Brooklyn respite housing did not have availability when case manager worked with client on application. Writer used socratic questioning throughout to improve insight, and CT was open to suggestions and help. Writer was informed prior to visit that CT was given new rx of 2mg resperidone at night which CT could pick up after visit which CT agreed to do. Writer assessed client's feelings of safety, and CT said she did not want to go back to her apartment. Writer looked up CPEP in CT's zipcode and discussed voluntary hospitalization and explored CT's hx with hospitalization to avoid retraumitization, and CT said she would rather go to hospital than return home. Writer invited case manager (HIPPA consent on file) into office to work collaboratively on other respite housing options. Writer provided new list, and CT and case manager submitted new application following visit to SUS Respite Housing at 1719 Montrose Ave in Brooklyn. Writer reviewed and signed off on application (uploaded to pt documents) and was informed client could be accepted the following day. CT stated goal to pick up medication and either go to respite housing or CPEP if feeling unsafe. Client stated she would try increased dose of resperidone and asked for clarity which writer provided by looking up rx in CT chart. Client verbalized strategy to "drown out voices" by using music if she returns to her house to pick up clothing prior to going to respite housing. Writer provided print out of upcoming Housing Works appts to present to anyone as confirmation of receiving MH and PC services.

Client was cooperative and open to tx and has re-engaged in psych care and resuming rx. CT reported no change since last visit and plan to provide temporary safe environment for client and to try increase dose in resperidone. More frequent f/u appts scheduled during this period for continued monitoring and support. F/u scheduled 1 week.

Assessments

1. Paranoid schizophrenia - F20.0 (Primary)
2. PTSD (post-traumatic stress disorder) - F43.10
3. Gender dysphoria in adult - F64.0

dx per previous treating psych provider Aviva Epstein, PA, endorsed by new psych provider Syesha Anderson, NP, and endorsed by counselor. Counselor changed primary MH dx to schizophrenia based on presentation.

Treatment

1. PTSD (post-traumatic stress disorder)

Notes: Provided 45 min psychotherapy. Start time: 1:20PM. End time: 2:05PM.
Clinical Notes: Writer used socratic questioning and provided care coordination and warm hand off. Client stated goal to pick up medication after exploring other respite house options and to go to respite housing as possible or CPEP if feeling unsafe to return to apartment.

2. Others

Documenting Discharge

Discharge Note/Plan/Summary

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A discharge note is provided at the end of a client's treatment process

- Confirms the termination of this specific treatment process
- Important standard of care

Provides a summary of the client's treatment process

Is given on the conditions outlined at intake among other reasons for discharge

- Mutual ending of treatment
- Client termination of treatment
- Client non-return to treatment
- Lack of response to outreach etc.

Helps with the continuity of care (for client, for other providers etc.)

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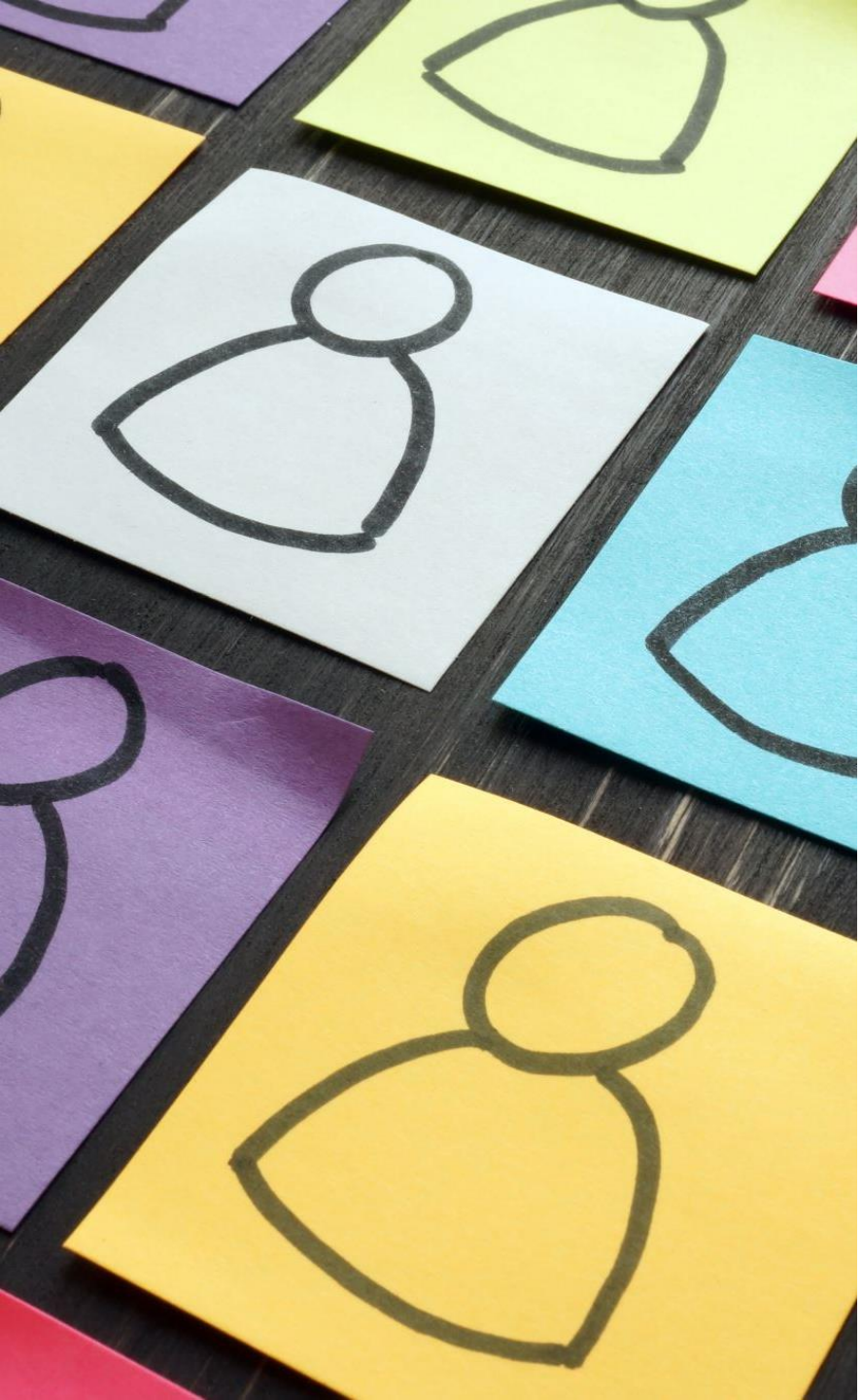
Discharge Note/Plan/Summary

- Client Demographic Information
- Date Treatment Began
- Date of last contact:
- Date of Discharge
- Reason for Discharge:
- Overview of treatment: Reference treatment plan goals and objectives
- Client status at discharge: Include risk status as well
- Follow-Up Recommendations:
- Notification of discharge:



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Discharge Note/Plan/ Summary Best Practices

- Reflects individual strengths and level of social support
- Addresses psychiatric, substance use disorder, chronic medical, and social needs - as well as consider all available services in the particular community.
- The plan should also address relevant concerning information obtained from collateral sources of information.
- As a best practice, all clients should have a confirmed, scheduled appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge.
- Offer information about treatment resources significantly increases rates of successful care transitions, even among clients who decline referral

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Discharge Note/Plan/ Summary Best Practices

- Each plan should include the names and phone numbers of people that the member can call for help, including local crisis services and toll-free hotlines.

Article 28 Discharge Summary/Note in ECW

FOR ARTICLE 28/IOS : ENTER A TELEPHONE ENCOUNTER IN E.H.R. DOCUMENTING DISCHARGE

REASON – DISCHARGE

Example of Content for a Discharge Note

- Client is psychiatrically stable, engaged in psych care, and is low risk for psychiatric hospitalization, self-harm, or problematic substance use. Client was referred to OMH at West 48th St Clinic and scheduled for intake with Isabel Lodge on 10/7/24.
-
- Discharge Summary:
-
- Behavioral Health:
  Improve house cleaning and reduce clutter; reduce anhedonia
  Objectives: Increase frequency and time of cleaning from 0 to 2 hours to 2x a week; play bass guitar at least 4x per week; increase physical activity with physical health goals; identify at least 3 triggers and coping strategies.
  Partially met: Client did well with taking walks as coping strategy but limited insight into other triggers or coping strategies. Client did not meet objective with cleaning/decluttering but spent one or two times doing so in course of tx. CT went through periods where he had depression and sleep disturbances and some periods where he was doing better. Client also was often successful with bass playing but also went through periods where he was depressed and did not play at all. Client is now playing bass again.
-
- Medical
  Gain 20 pounds
  Increase meal intakes from 1-2 to 2-3; 2-3 walks per week for 1 mile.
  Goal partially met with weight: Client gained some weight, approximately 6 pounds but continued to eat 1-2 meals a day.
  Goal met with walking.
-
- Maintain stability for housing and food security; explore schooling option
  Objective to recertify HRA benefits and SNAP as needed; explore in sessions at least 1x every 3 months decisional balancing around schooling
  Goal partially met. Client navigated difficulties with care manager with HRA benefits, especially rent, and showed good self-efficacy and remained housing and food secure with recertifications as needed. Partially met with exploring schooling; writer and client explored this on occasion but not every 3 months due to change in ICP review frequency.
- has context menu

Summary

Summary

- Documentation is an ongoing aspect of the client's treatment process
- All aspects of documentation should show a connection between each section, intake, treatment plan, progress notes, discharge – i.e. golden thread
- Documentation (accurate and comprehensive) supports the patient's treatment goals
- Is necessary for billing
- Crucial aspect of ethical practice and rick management

Summary Cont'd/

- It is mandatory to document all client contacts, assessments, and the delivery of services.
- Clear, concise, and organized documentation reflects the hallmark of quality social work services and often serves as the mode of communication between a social worker, other professionals and clients
- Documentation must reflect an accurate account of services. All encounters with clients must be documented in electronic health record ECW/Eicare.
- A comprehensive intake process set's the foundation for the continued documentation process. as The information obtained during the intake process will help to formulate the assessment
- The goals and objectives identified in the client's treatment/ service plan are connected to the assessment and problem statement
- Progress notes are a key element to recovery. Each individual's record must contain progress notes that are reflective of the individual's progress towards their goals and objectives.
- Provide an ongoing record of the client's progress toward his or her goals; and
- Progress notes must be completed, at most, within 48 hours of engagement with the client

Summary Con't

- Before completing a discharge from the program, ensure that there is documented outreach in client's chart. At least 3 outreach notes are recommended.
- A discharge summary is also required within 3 days of discharge from the program.
- The discharge plan should reflect individual strengths and level of social support psychosocial
- Discharge summaries/plan should include information about treatment resources even for clients who decline a need for it.

References

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