

DIVISION OF CHILD & FAMILY SERVICES Children's Mental Health Services	
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I. POLICY

It is the policy of the Division of Child and Family Services to promote clear, focused, timely, and accurate documentation in all child/youth records in order to ensure best practice service delivery and to monitor, track and analyze child/youth outcomes and quality measures. The documentation format to be used to support this policy shall be the Data, Assessment, Plan or D.A.P. format.

Maintaining complete and accurate child/youth records is critical to the Division's ability to support and monitor quality services for children and families. The implementation of a standardized documentation format, such as DAP, is one of many ways the Division can ensure quality care and measurable outcomes for the target population we serve.

II. PURPOSE

This policy describes the "Data, Assessment, Plan" or D.A.P. documentation format model which is the DCFS prescribed charting model for all children's behavioral health services.

III. DEFINITIONS FOR MENTAL HEALTH

Avatar: The medical record and Health Insurance Portability and Accountability Act (HIPAA) electronic billing software to support mental health services delivered to children through the DCFS

Care Coordination Plan: A written individualized plan developed jointly in a Child & Family Team that specifies the goals, objectives and actions to address the medical, social, educational, and other services needed by the individual, including activities such as ensuring the active participation of the individual and working with the individual (or the authorized health care

decision maker) and others to develop the goals and identify a course of action to respond to the assessed needs.

Case Management: An activity that assists individuals in gaining access to necessary care and services appropriate to their needs. It is the individual's access to care and services that is the subject of case management, not the individual..

DCFS Staff: A mental health practitioner or psychiatric caseworker who assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral and mental health needs. (Source: MSM Chapter 100)

Child and Family Team (CFT): A family-driven, child-centered, collaborative service team, focusing on the strengths and needs of the child and family. The team consists of the child recipient (as developmentally appropriate), parents, and service professionals and may also consist of family members, care providers, and other individuals identified as being integral to the child's environment of mental health rehabilitation.

Client Record: Means the collection of all documentation regarding a child's behavioral health treatment. The record is a legal document. The client record provides the foundation for managing and tracking the provision and quality of services.

Data Assessment Plan (DAP): The documentation format which is used by the Division's behavioral health staff. The acronym is DAP, which is documented in the child/youth record as follows:

D = Data/Describe: observable, concrete; what was said by the child/youth/family.

A = Assess: the writer's assessment of the situation, analysis of the data.

P = Plan: the intervention (i.e., treatment plan) agreed upon by the counselor or treatment team and the child/youth and parent(s) or legal guardian(s).

DCFS: The Division of Child and Family Services

Goal: An expected result to be achieved through the use of the recommended treatment and services prescribed on the Treatment Plan/Care Coordination Plan. Goals are designed to direct care in order to ameliorate or stabilize mental health needs for improved functioning. (Source: MSM Chapter 400 – Medicaid Services Manual).

Health Insurance Portability and Accountability Act (HIPAA): Federal regulation addressing healthcare issues related to the standardization of electronic data, the development of unique health identifiers, and security standards protecting confidentiality and the integrity of health information.

Objective: Written statement of an expected result or condition that is related to the treatment goal. An objective is time specific and stated in measurable terms.

Progress Note: The written documentation of the treatment, services or services coordination provided which reflects the progress, or lack of progress towards the goals and objectives of the

Treatment Plan. All progress notes reflecting a billable mental health service must be sufficient to support the services provided and must document the amount, scope, duration and provider of the service.

Quality Assurance: A structured internal monitoring and evaluation process designed to improve quality of care. Quality assurance involves the identification of quality of care criteria, which establishes the indicators for program measurement and needed improvements.

IV. PROCEDURES AND PRACTICE GUIDELINES

Documentation Practice Guidelines

The following are guidelines for charting according to **DAP – Data, Assessment,**

Plan:

D

Data or Description

Describe the facts of the session:

1. Subjective data about the child/youth—what are the child/youth’s observations, thoughts, direct quotes?
2. Objective data about the child/youth—what does the case manager observe during the session (affect, mood, appearance)?
3. What was the general content and process of the session?
4. Was homework reviewed (if any)?
5. Type of service provision, family members & time seen.

A

Assessment

Evaluate child/youth’s treatment progress toward meeting their goals:

1. What is the counselor’s understanding about the problem?
2. What are the counselors’ working hypotheses?
3. What are the results of any testing, screening, assessments?
4. What is the child/youth’s current response to the treatment plan?

P

Plan

Document what is going to happen next:

1. Based on child/youth’s response to the treatment plan, what needs revision?
2. What goals, objectives were addressed this session?
3. What is the counselor going to do next?
4. When is the next session and date?
5. Each entry must contain a description of what was attempted and/or accomplished during the contact towards the attainment of a goal. On notes entered into Avatar you will identify the treatment goal on page two of your note.
6. A description of changes in medical necessity when appropriate.
7. Follow professional standards from licensing boards for recording ethical dilemmas or concerns.
8. All notes are to be entered no later than Tuesday at noon following the week services were provided.