# DOCUMENTATION BEST PRACTICES

This resource is intended to support the MCC team with the documentation of their efforts in order to support coordination of care within their programs and clinics. Documentation is critical for care coordination amongst the MCC team and other providers working with the patient. It is a standard of clinical and case management practice and providers should write assuming others will read and rely on your notes. Documentation is also a legal and contract management tool and is used during audits or quality monitoring.

Documentation of each MCC team member's interactions should align with the format appropriate to the staff's professional role:

- Medical Care Managers (MCMs) can use nursing note templates such as Subjective, Objective, Assessment, Plan (SOAP) or Assessment, Diagnosis, Planning, Implementation, Evaluation (ADPIE) formats.
- Patient Care Managers (PCMs) can use social work note templates such as SOAP or Data, Assessment, Plan (DAP) formats.
- Caseworkers can use narrative-style documentation or can adopt other structured template styles.

While the use of SOAP, ADPIE, and DAP formats are not a programmatic requirement, these structured documentation methods are highly recommended to promote clarity, consistency, and alignment with clinical best practices. Utilizing a standardized format ensures that critical information—such as client concerns, observations, interventions, and follow-up plans—is captured thoroughly and can be easily understood by all members of the care team.

Documentation should align with the staff member's professional scope and electronic medical record (EMR) templates and quick phrases can be deployed to make documentation efforts more efficient and standardized.

## Time Management for Documentation

Effective time management is essential for maintaining high-quality documentation within the MCC Program. Timely, accurate, and consistent documentation supports continuity of care, enables clear communication across the care team, and ensures compliance with program and legal standards. Given the responsibilities among the MCC team, adopting time-saving strategies is crucial for preventing documentation backlog and burnout.

## Same-Day Documentation is Ideal

The gold standard is to document on the same day as the client interaction. This approach ensures the most accurate recall of details, preserves clinical accuracy, and reduces the risk of missing important information. If same-day documentation is not possible, staff should aim to complete their notes within 48 hours to remain within acceptable compliance and quality

standards. Build the habit of writing notes soon after the client interaction while details are fresh.

## Prioritize Tasks

Determine which documentation tasks are most urgent or time-sensitive, such as follow-ups related to medication adherence or immediate care coordination. Tackle high-priority notes first, then move to those with fewer dependencies.

## Integrate Documentation Time into Workflows

Avoid waiting until the end of the week or day to document multiple interactions. Instead, build documentation time into your daily schedule, ideally immediately after a client contact. If this isn't feasible, designate blocks of time each day (e.g., 30 minutes in the morning and afternoon) specifically for documentation tasks. Staff are encouraged to discuss their documentation needs with their supervisor to ensure appropriate coverage and alignment with MCC operations.

- Designating "admin time" each day reinforces consistent documentation habits, minimizes the need for after-hours work, and reduces the risk of forgetting important details.

## Write with Focus and Clarity

Keeping documentation brief yet specific improves efficiency and readability. Focus on what was done, why it matters, and what the next steps will be. Structured formats like SOAP, ADPIE, and DAP help streamline this process and support clarity.

- Avoid vague or filler phrases such as "client doing okay" or "no concerns noted" unless supported by objective observations or client-reported statements.

## Use Templates and Quick Phrases When Appropriate

Use structured documentation templates—such as SOAP, ADPIE, DAP, or narrative formats—as helpful tools to guide note writing. While not mandatory, these templates streamline clinical reasoning, reduce the need to build notes from scratch, and can provide reminders of all the recommended elements to include in the progress note. Many EMRs allow for use of pre-existing or development of user-designed quick phrases that can support documentation efforts. Standardized formats support consistency and facilitate efficient communication among care team members.

## Use key elements to strengthen narrative progress notes (Six Ws)

- **Who:** Document all individuals present during the interaction. This includes the client, caseworker, any interpreters, family members, or other support persons involved.
- **What:** Summarize what occurred in the meeting in chronological order. Include concerns shared, services offered, and any resources provided.
- **When:** Include the date and specific time range of the meeting, especially when care planning or outreach occurs.
- **Where:** Document the setting where the service occurred. This may be in-person, via telehealth, or in the community, etc.
- **Why:** State the reason for the meeting or outreach. Indicate whether it was scheduled, urgent, or client-initiated.
- **What Next:** Outline the next steps in the care plan. Indicate referrals, follow-up, or other pending actions.

## Additional Guidance

- Always document no-shows and brief contacts to capture engagement patterns. Even single-sentence entries help show effort and consistency.
- Ensure that all language used in the note is free from bias, judgment, or personal opinions. Use neutral, professional tone, and avoid making assumptions about client motives or emotions. Only include observable facts or information directly stated by the client.

By incorporating these strategies and elements, MCC staff can meet documentation standards efficiently while maintaining the quality and integrity of their records. Consistent and timely documentation reinforces the MCC program's commitment to client-centered, coordinated, and accountable care.