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CASE NOTES DOCUMENTATION

INTRODUCTION

All contacts made and actions taken regarding a participant's Home and Community Based Services (HCBS) shall be recorded in the electronic case record. The electronic case record is the participant's official case record and must contain all documentation involving the participant.

PURPOSE

Division of Senior and Disability Services (DSDS) staff, HCBS, and other providers and stakeholders have access to the case notes in the participant's electronic case record. The transparency of the electronic case record allows for information to be shared among all HCBS bureaus, HCBS providers and physicians involved in coordinating and maintaining the participant's services. Case notes are also reviewed by all parties involved in any administrative hearing.

CASE NOTE GUIDELINES

The participant's electronic case record shall only be used to document HCBS situations specific to the participant. Information unrelated to the participant, such as system issues, work order assignment, and tracking, shall not be recorded in the electronic case record.

Case notes documentation shall provide the link between information gathered through:

- Screening and assessment,
- Development of a Person Centered Care Plan (PCCP), and
- Any subsequent action taken by DSDS staff, providers, or collateral party not contained elsewhere in the participant's electronic case record.

The following documentation principles shall guide all case note entries:

- Accuracy
  - Accurate documentation of the information received effectively communicates to the reader the participant's care needs and associated service delivery.
- Clarity
  - Clarity can best be achieved using plain language. Simple words and sentences are preferable to jargon, bureaucratic language, slang words and excessive wordiness.
- Concise
  - Concise case notes are easier to read, save time, and improve the quality of the documentation.
  - Avoid vague or general terms, such as some, sometimes, often, many, several, etc. Instead, use phrases such as, "three times a week".

- Facts
  - Facts shall document who, what, when, where, why and how as it relates to the participant and any associated PCCP.
  - Avoid using judgmental phrasing.
  - Cite any professional conclusions or comments regarding the participant with a fair background and context.
  - Avoid the use of “feel” and “think”. Instead, use “observe” and “conclude”.
  - Avoid diagnosing a participant that has not been established by a medical or psychological professional. Instead, record the facts of what was observed.

CASE NOTE ENTRY

Every contact and attempt to contact made regarding a participant and their receipt of HCBS shall be documented. The contact documentation shall include:

- Note Type
- Date of the contact
  - The ‘contact date’ entered shall reflect the actual date the contact was made regarding the participant. Multiple contacts on the same day may be entered within the same case note; however, there shall be a clear distinction for each contact (e.g., separate paragraphs). Contacts with differing dates must be documented in separate case note entries.
- Identification and contact information of the contact person
- Summary of the discussion
- Identification of the type of contact (e.g. face-to-face contact, phone contact, email correspondence, etc.) for each case note entry.

At the conclusion of a case note, the electronic case record will auto-populate the following for DSDS staff:

- First name
- Last name
- Title

NOTE: HCBS provider reassessors shall include their email address at the conclusion of each case note entered.

Throughout the assessment process, DSDS staff entering the case note have the ability to edit and delete the case note until the final action is taken on the case and saved.

CASE ACTION GUIDANCE

The following guidance provides a documentation framework for the various HCBS Case Actions. HCBS is person-centered; therefore:

- Each participant and associated case documentation is unique.
- Only applicable aspects of the guidelines below shall be documented.

- Information not included in the case action guidance below that is pertinent to the participant's case record shall be included in the documentation.
- More than one set of guidelines outlined in the case action guidance may need to be used during a contact.
- PCCP maintenance applies to multiple documentation instances provided in the case action guidance. Refer to the Person Centered Care Planning subsection below on PCCP change requests and processing PCCP guidance when appropriate.

NOTE: Case notes shall be entered at the time of contact unless specific completion timeframes are stated below.

CASE ACTIONS

REFERRAL INTAKE

Referrals may be received via phone, email, or online. All referrals are entered into the Online HCBS Referral Form to document the details of the referral request. Additional documentation outside of the information included in the referral form includes:

- Date received
- Notation that the referral form was uploaded to the documents section of the case record
- Online submission number (if submitted online)

Documentation for an inappropriate referral includes:

- Date received
- Reason it was inappropriate
- Online submission number (if applicable)

NOTE: Inappropriate referral documentation is only entered if the participant has a historical case record. A new case record shall not be opened only to enter an inappropriate referral.

PERSON CENTERED CARE PLAN CHANGE REQUEST INTAKE

PCCP Change Requests may be received via phone, email, or online. All requests are entered into the Online PCCP Request Form to document the details of the PCCP change request. Additional documentation outside of the information included in the request form includes:

- Date received
- Key details of change(s) being requested
  - Provider changes should include the details of the new requested provider
- Notation that the request form was uploaded to the documents section of the case record
- Online submission number (if submitted online)

Documentation for an inappropriate/no longer needed request includes:

- Date received
- Reason it was inappropriate or no longer needed

- Online submission number (if applicable)

ASSESSMENT

Documentation for an initial assessment and reassessment includes, but is not limited to, the following:

- Where the assessment was completed
- Who was present and who responded to the assessment questions
  - If there is a guardianship relationship, ensure appropriate documentation has been uploaded to the participant's electronic case record
- Condition of the home and any needed referrals to address identified issues
- Participant's living arrangements
  - If other persons in the home are authorized for HCBS, document how services are to be coordinated to avoid duplication of tasks.
  - If other adults are living in the household, identify shared spaces and the other adults' abilities/responsibilities.
  - If the participant is currently in a hospital, skilled nursing facility, or rehabilitation facility, include name of facility, the reason for stay and date of discharge.
- Formal (e.g. Home Health/Hospice) and/or informal supports providing assistance and how the requested HCBS will be integrated with the supports
- How the participant's health condition(s) necessitates the need for the HCBS requested by the participant
- Elaboration on the coding of vague assessment questions (e.g. Physician ordered diet type)
- Denials, reductions, and closings information (e.g., LOC, unmet need, or Medicaid ineligibility). See section below.
- Any difficulties the participant has with signing the required forms and the associated accommodations made
- Any paperwork sent to the participant (if applicable)
  - At initial assessment, document the forwarding of the Physician Notification.
- PCCP documentation (see section below)

Case note documentation related to an assessment may require multiple contacts and entries. Each action during the assessment process shall be entered as soon as possible, but no later than five (5) business days following the assessment.

PERSON CENTERED CARE PLANNING

The following outlines general PCCP documentation guidelines that may be applied during a PCCP change request or an (re)assessment:

- Document any discrepancies between the coding of the assessment and the tasks on the PCCP (e.g. if a participant is coded as needing bathing assistance due to safety risks but refuses assistance due to modesty concerns).

- Provide explanation when task frequency exceeds or deviates significantly from the suggested times and frequencies.
- Provide specifics related to denials, reductions, closings information. See section below.
- Provide the reason for underutilization when the PCCP remains the same or are increased despite recent underutilization.
- Provide explanation of vague PCCP tasks (e.g. treatments, clean/maintain equipment, other nursing task, transfer device assistance.)
- Document referrals or information provided to the participant to assist with risks or needs that could not be addressed in the PCCP.
- Document the participant's provider choice and/or satisfaction.
  - At initial assessment, document the participant's preferred provider.
  - At reassessment/PCCP change request document the participant's satisfaction of the current provider(s) or document the preferred provider when a change is requested.
- Contact with the provider(s) regarding the PCCP (re)authorization. Include PCCP specifics reviewed, effective date of the change(s), provider staff name and phone contact number/email address.
- Any paperwork sent to the participant (if applicable)

PCCP change specific documentation includes, but is not limited to the following:

- Identity of PCCP change requestor
  - If not the participant, document name, relationship to the participant and phone contact number.
  - If there is a guardianship relationship, ensure appropriate documentation has been uploaded to the participant's electronic case record.
- Change(s) being requested, e.g. increase or decrease of service, new service type, or provider change.
- The contributing factors to the change(s) being requested.
  - New health condition or change in status of an existing health condition.
  - Change in living arrangement.
- Reason for requesting a new provider when related to future PCCP needs
- Any formal (e.g. Home Health, Hospice, etc.) and/or informal supports providing assistance and how the requested HCBS change will be integrated with the supports
- Provider change request information including provider name and contact information (if applicable)
- Any paperwork sent to the participant (if applicable)

NOTE: HCBS provider complaint information shall not be documented within case notes, but staff shall indicate an appropriate referral was made.

<u>CDS ABILITY TO SELF-DIRECT</u>

CDS ability to self-direct documentation includes, but is not limited to the following:

- Participant's ability to participate in the assessment and communicate their needs during the PCCP process

- Concerns with the ability to self-direct which may include:
  - Participant deferring to others present during assessment for answers.
  - Participant displays confusion regarding PCCP needs and completion.
  - Participant not understanding how to use the Electronic Visit Verification (EVV) system or concerned with learning the process if they are new to CDS.
  - Any other observations that led to cognitive or memory coding on the assessment.
  - Documents obtained and/or contacts made that validate a participant's inability to self-direct.
  - Summarization of the results of the St. Louis University Mental Status (SLUMS) Exam and Self-Direction Assessment Questionnaire.
    - If applicable, identify if another individual responds to the Self-Direction Assessment Questionnaire on behalf of the participant
- Information given regarding the availability of other services when the participant is determined unable to self-direct

PROVIDER REASSESSMENTS REVIEW

Provider reassessment review documentation includes, but is not limited to:

- Confirmation the provider reassessment was reviewed
- Denials, Reductions, Closings information (e.g. LOC, unmet need, or Medicaid ineligibility)
- Follow-up contact(s) with the provider and/or participant
- Necessary when information is incomplete
- Approved PCCP
  - Notification provided to the provider (including provider staff name and phone contact information) and participant.
- Paperwork sent to the participant (if requested)

SHOW-ME HOME

Show-Me Home (SMH) Money Follows the Person (MFP) documentation shall include, but not limited to:

- When the initial referral was received and from whom
- Document the current situation
  - Name of facility
  - Reason for stay
  - Date of admission
  - Date of discharge (if known)
  - Name and phone contact information for facility discharge planner (if applicable)
- SMH eligibility
  - Document whether the participant meets all criteria for participation in the SMH, and if applicable, documentation that the Show-Me Home Approval Notice has been uploaded to the participant's

electronic case record and a copy of the Show-Me Home Approval Notice has been sent to the contractor of the region where the participant will reside.

- The participant's proposed living arrangements if able to transition to the community, including other household members and shared spaces.
- If there is a guardianship relationship, ensure appropriate documentation has been uploaded to the participant's electronic case record.
- Completion of the Show-Me Home Referral Assessment for participants that do not need HCBS.

Case note documentation shall be entered as soon as possible, but no later than ten (10) business days after the contact was made or information received.

DENIALS/REDUCTIONS/CLOSINGS

Documentation shall include, but not limited to the following:

- Reasons the service/task/request was denied, reduced, or closed
  - Such action must be supported by the citation contained on the Adverse Action Notice.
- Level of Care (LOC)
  - Describe InterRAI HC responses and other observations in relation to each of the categories in LOC.
- Ability to Self-Direct
  - Describe the inability to self-direct, referencing information gathered during the completion of the InterRAI HC, SLUMS, Self-Direction Assessment Questions and related contacts.
- Service Reduction
  - Document the reasons why the service/task is being reduced.
- Contact and discussion regarding adverse action
  - Document contact and discussion with the participant and/or authorized representative, including whether the participant agreed with the action.
- Notice of Closure
  - Document the participant's understanding that an Adverse Action Notice or Notice of Closure will be mailed and their right to appeal, if applicable.
  - Date the Adverse Action Notice or Notice of Closure is mailed.
- Changes to PCCP
  - Document any changes made to the PCCP including contacts to the participant and the appropriate provider.

ADVERSE ACTIONS/HEARING REQUESTS/HEARING PROCEEDINGS

Documentation shall include, but not limited to:

- Hearing Request
  - Document how the hearing request was received from the participant (through mail, telephone, or in person).

- Additional information
  - Document follow-up with participant for any additional pertinent information that would affect the adverse action.
- Review Time Frames
  - Document if the request was received within the appropriate time frame.
- Participant Contact
  - Document the discussion with the participant regarding the appeal process, including whether the participant wants to maintain level of services, if applicable.
- Hearing Application
  - Document the date the Application for a State Hearing is forwarded to the DSDS Supervisor and supervisory review of the Application for a State Hearing.
- Hearing Documents
  - Document the description of the information and documents, and the date sent to the Division of Legal Services (DLS) and the participant.
- Date of receipt of Notice of Administrative Hearing
- Date of receipt of the Final Decision and Order

Case note documentation shall be entered as soon as possible but no later than ten (10) business days after the contact was made or information received.

DOCUMENTATION OF CONCERNS AND SPECIAL CIRCUMSTANCES

PROTECTIVE SERVICES

Protective service investigations and interventions are documented in the DSDS Adult Protective Services (APS) case management system and shall not be documented in the participant's electronic case record.

When a contact indicates a potential protective service situation, DSDS staff or designee shall make the mandated hotline report and enter a note in the participant's electronic case record stating an 'Appropriate referral was made'.

SAFETY CONCERNS

Pertinent information regarding the participant and/or household to ensure continuity of care and alert DSDS staff and HCBS providers of special circumstances shall be documented in the 'Safety Concerns' field on the participant's main screen in the electronic case record.

- 'Safety Concern' includes situations that pose a safety risk (e.g., drug use, weapons, etc.) to individuals entering and working with a participant in their home.
- Include the date of the case note(s) referencing the concerns.
- Further details surrounding the potential safety risk may be documented in case notes if needed.

ADDRESS NOTES

If needed, enter the directions to the participant's residence in the 'Address Notes' field on the participant's main screen in the electronic case record.

INTERPRETER SERVICES

If a participant requires an interpreter, they should be encouraged to use DSDS provided interpreter services. The offering of interpreter services shall always be documented along with the participant's decision to use or refuse them. If the participant refuses DSDS provided interpreter services and chooses an adult family member or friend as the interpreter, this preference must also be recorded. Documentation shall be entered in the 'Accommodations' field on the participant's main screen in the electronic case record.

OTHER SPECIAL CIRCUMSTANCES

The electronic case record provides additional fields to select that are specific to the special circumstances below. These fields are located on the participant's main screen in the electronic case record and limited DSDS staff can only make the selection. Additional documentation may be included in case notes as applicable.

- Notification the participant is Consumer Directed Services (CDS) Restricted
- Notification of SMH participation
- Notification of a (Department of Mental Health) DMH waiver
- Notification of dual waivers
    - This will only occur in very rare situations as Medicaid participants are not permitted to be in more than one (1) waiver at a time.

Other necessary information in each individual participant's record to facilitate the PCCP development.

- Shared households shall be documented

Bureau of Federal Programs (BFP) notification of approval to exceed cost maximum

- Provides notice the participant has been approved to exceed the cost maximum through an Aged and Disabled Waiver (ADW) service.

NOTE: All requests to exceed the cost maximum shall be sent to BFP for approval. If a PCCP is over the cost maximum and no documentation is provided, BFP shall be contacted to determine if approval was granted. The 'Cost Cap Pre Approved' in the participant's electronic case record shall be selected when approval is granted.