Documentation Training

Bureau of Long Term Services and Support
Division of Senior and Disability Services
Department of Health and Senior Services

Objectives

- Learn the principles of documentation
- Become familiar with case note guidelines
- Be aware of documentation of special circumstances
- Understand the case note requirements for the face to face reassessment

Why is documentation important?

- All provider reassessors are required to enter case notes
- Documentation is critical.
    - Other staff members will use this information to make determinations regarding the needs of a participant.

- Case Not Documentation Policy 4.30

Documentation Principles

Accuracy

- What is put into Case Notes must effectively communicate to the reader the participant's care plan

Facts

- Document who, what, when, where, why & how as it relates to the participant and their care plan
- If using professional judgment, the facts should support it
- Avoid diagnosing participants

Documentation Principles

Concise Case Notes

- Easier to read, saves time, & improves quality

Clarity

- Use plain language and avoid general terms
- Simple words and sentences are preferable to jargon, slang words, etc
- Who, what, when, where, why and how?

Case Note Foundation

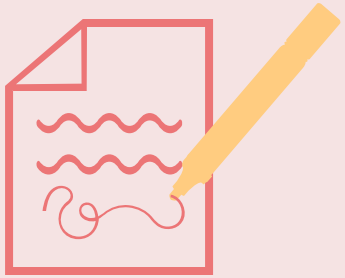
- Information gathered through screening and assessment
- The development of a person centered care plan
- Any other subsequent actions taken by DSDS staff not contained elsewhere within Web Tool
- Every contact shall be documented but avoid duplicating case notes

Case Note Structure

- Proofread all documentation before selecting "save" in Web Tool
- Write in first person, "I" point of view
- Use active voice
- Avoid vague pronoun usage to prevent confusion
- Approved abbreviations/acronyms may be used from Policy 1.05

Case Note Entry

- "Contact date" shall reflect the actual date the contact regarding the participant was made.
- Multiple contacts on the same day may be entered in the same case note. Be sure to make a clear distinction between the two contacts, such as separate paragraphs.
- If contacts are made on different days, they must be in separate notes.



Priority & Signatures

- All case notes shall be prioritied ‘Y’ or ‘N’
- First and last name
- Business affiliation
  - Example: Jane Doe, DSDS SSS

Documentation of Special Circumstances

- Protective Services:
- Mandated Reporters
- DSDS Hotline: 1-800-392-0210
    - Mandated Reporter form online
- Documented in the DSDS Case Compass Care Management System and shall not be documented in the HCBS Web Tool
    - ‘Appropriate referral was made

Documentation of Special Circumstances

Multiple participants in the same household:

- When it has been identified that multiple individuals receiving HCBS are residing in the same household, the following must be documented:
  - The identity of associated participant(s) including DCN(s) and relationship(s)
  - Information regarding coordination of services
  - Other necessary information in individual participant's record to facilitate care plan development

Documentation of Special Circumstances

Identified Safety Concerns:

- Situations may arise that pose a safety risk to individuals entering the working with a participant in their home.
  - If this is the case:
    - On the Participant Case Summary screen, select the "Verify Address" icon in the demographics section.
    - Within the address pop-up box, add a note that states "See case note dated MM-DD-YYY regarding potential safety concerns in the Directions to Residence section. Then save the entry.

Reassessment Documentation

Required
Reassessment
Face-to-Face
Documentation
Components

Reassessment Documentation

Include:

- Where the assessment was completed, who was present, and who responded to the assessment questions
- If there is a Durable Power of Attorney (DPOA) or guardianship relationship, ensure appropriate documentation has been uploaded to the HCBS Web Tool
- The participant's living arrangements
- The condition of the home
- Participant in hospital or rehab facility

Reassessment Documentation

Include:

- Formal and Informal Supports
- At reassessment:
  - Review current care plan and any requested changes
  - Requested changes to the previous care plan and supporting details of the request

Reassessment Documentation

Include:

- How the participant's health condition(s) necessitate the HCBS requested by the participant
- Document satisfaction with current provider or if a provider change has been requested
- Document any difficulties the participant has with signing the forms
- Time frame to complete case notes is seven (7) business days from reassessment

Documenting Denials/Reductions

Include:

- Document the reasons the service/task/request was denied, reduced, or closed
- Level of Care (LOC) not met-describe the participant's responses/other observations
- If services are reduced, document the reasons for the reduction

CDS Documentation Guidelines

- Document the participant's ability to communicate their needs in the care planning process
- Document any issues/observations that cause concern about the participant's ability to self-direct
- Document the use of any self-direction tools (i.e. SLUMS or self-direction questionnaire)

Questions?

BLTSS
ReassessorTraining@health.mo.gov
or
PCCP
ProviderReassessmentReview@health.mo.gov