# The Key to Documentation

The Basics

Phone Calls

Home Visits

# The Key to Documentation

Documentation is one of the most important parts/aspects of service coordination.

The presentation is designed to talk about basic documentation skills and how to apply those skills when documenting telephone calls and home visits.

# The Key to Documentation

- The following examples are funny, but they are examples of actual documentation.
- If you notice they are mostly two (2) ideas put together in the wrong context, which changes the meaning completely.
- The message you want to convey should be very clear, well thought out and documented!!

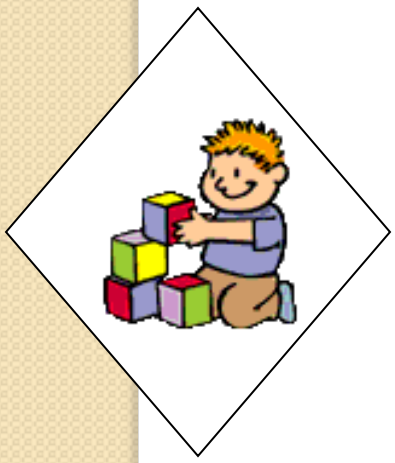
## BAD EXAMPLES

- On the second day the knee was better and on the third day it had completely disappeared.
- The patient has been depressed ever since she began seeing me in 1983.
- Discharge status: Alive but without permission.
- The patient refused an autopsy.
- The patient expired on the floor uneventfully.
- Patient has left his white blood cells at another hospital.
- The patient's past medical history has been remarkably insignificant, with only a forty-pound weight gain in the last two days.

## BAD EXAMPLES (Continued)

- She stated that she had been constipated for most of her life until 1989 when she got a divorce.
- Between you and me, we ought to be able to get this lady pregnant.
- The patient was in his usual state of good health until his airplane ran out of gas and crashed.
- The patient lives at home with his mother, father, and pet turtle, who is presently enrolled in day care three times a week.
- While in the emergency room, she was examined, X-rated and sent home.
- When she fainted, her eyes rolled around the room.
- Patient has chest pain if she lies on her left side for over a year.

# 7 Basic components of documentation:



Factual

Relevant Information Only

Objective

Full, clear description of contact

Concise

What steps have been taken

Future steps/plan

# The Key to The Basics

**Document as soon as possible after contact!** That benefits everyone (the Service Coordinator and the participant/family); as time marches on the less information may be remembered.

**Policy dictates within 10 business days and applies to all documentation** (phone calls, home visits, transition planning, receiving or making a referral, assessments, etc.)

**Document in first person singular.**

# The Key to Phone Calls

Who Called

Why they called

What information was obtained

What was the result

What is the plan

# Phone Calls

- Day-to-day information received through phone calls should be documented if it relates specifically to a participant and/or their needs.
- Probably well over 50% of participant contact is by phone; that is why it is so important to capture this information.
- This will help ensure you gathered enough information to reflect on the situation or need, and then to follow-up.
- When you have enough information through questioning, then you can document the contact in a progress note within the MOHSAIC system.
- MOHSAIC is our database for all participant records, therefore everything that happens for and with participants should be reflected in this electronic record.
- Be thoughtful when entering notes so enough information is included to adequately describe a situation and that your plans reflect outcomes.

# Phone Call Examples

Let's look at a telephone call and what information you may want to document.

Again, ask yourself the basic questions:

**Who?**
**Why?**
**What?**
**Steps Taken? and**
**Future Plan?**

Review the following slides in terms of these questions.

## Documentation of a Phone Call

Seth's mother, Beth Jones, phoned to request information for physical therapy providers in her area and wondered if this service would be covered under the program.

Beth reported that Seth saw Dr. Kimble last week and they were concerned about Seth's increased difficulty to walk. She stated that she had spoken with the doctor and received a prescription for therapy.

I reviewed program guidelines with Mrs. Jones.
(For CYSHCN-Payer of last resort, Head Injury-therapies not covered)

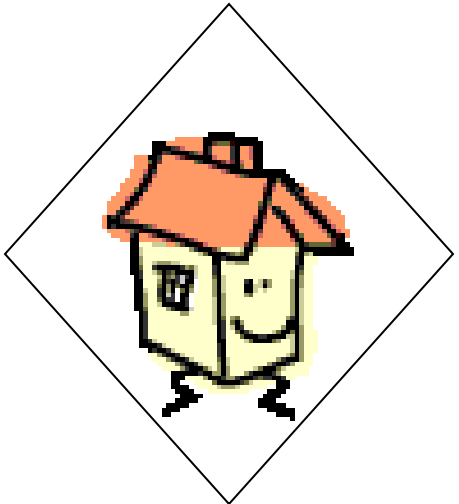
Plan: I will send Beth a list of therapy providers in her area and assist her in locating a payment source.

# The Key to Home Visits

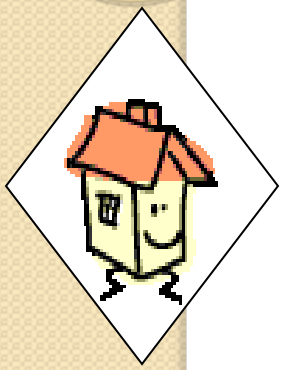
Use the home visit template

OR

Document the same info in a progress note



# The Key to Home Visits or Face to Face



- The purpose is to complete required assessments and/or develop a service plan to meet participants needs.
- Home visits are generally the best way to get to know your participant and their family. There is really nothing that can take the place of an opportunity to sit down with someone and talk to learn more. You find out more about their life, medical needs, abilities, limitations and goals.
- Information gathered from a participant, along with our expertise as service coordinators will construct an assessment and build a plan to meet the participant needs.
- Doing the actual assessment is one activity and documenting it is another.
- How do we document a home visit? I'm sure everyone has their own style to document and that's great, but here are some tips on how to be successful when documenting to reflect all of your work.
- Do not forget to use the home visit template; it will help you obtain answers to the important questions.

# Home Visits or Face to Face Examples

Back to gathering information -- Let's look at those questions again that we asked ourselves

Who?

Why?

What?

Steps Taken and

Future Plan?

Here are examples of a progress note in which a template is more of an outlined format.

Let's review the outline:

- Persons Attending the Visit
- Person Providing the Information
- Significant History- enough information to describe past events or circumstances, without going overboard – What is relevant?

## Home Visit Template

Persons attending visit: Sandy Jones-Service Coordinator, Kevin Johnson, Robin Johnson (Kevin's mother)

Person providing information: Kevin and Robin Johnson

Significant History: Kevin sustained a traumatic brain injury in 2002 as a result of a motor vehicle accident. Kevin received extensive in-patient and out-patient rehabilitation during his recovery. Kevin ambulates independently and can take care of his own personal needs. Kevin has seizures as a result of the accident. His mother reports difficulty concentrating, irregular sleep patterns and severe headaches 1x per week, lasting 1-2 hours at a time. He exhibits short-term memory loss and symptoms of post-traumatic stress disorder relating to the severity of the accident.

## Home Visit Template (continued)

Purpose of Visit: Evaluate needs of the participant and services authorized.

Provider Referrals/Community Referrals Needed: Kevin is receiving 12 hours of Transitional Home and Community Support per month through ABC Provider.

Plan: Continue services as in place. I will continue to monitor progress of goals by reviewing monthly progress reports and talking with participant, family and provider. Recommend that Kevin see his primary care physician for headaches. Mom will look into legal issues regarding guardianship.

Next Visit: December, 2008

# What did the AHI Service Coordinator Learn?

- Purpose – is the Why?
- Provider Referrals/ Community Referrals Needed – is the What or can be the Steps Taken?
- Plan – is the Steps Taken or the Future Plan?
- Next Visit – helps everyone stay on track and let's the participant know what to expect

## Home Visit Template

Persons attending visit: Susie and her father, Sam Sunshine.

Person providing information: Susie Sunshine and Sam Sunshine

Significant History: Susie was born six weeks premature. She had an intraventricular hemorrhage (brain bleed) and was on a ventilator for three weeks. A hearing loss was discovered through the newborn hearing screening process. Susie is becoming more spastic and Dr. Medulla is now recommending Botox injections.

## Home Visit Template (continued)

Purpose of Visit: The Service Coordinator Assessment (SCA) was completed at this visit. We discussed planning for a disaster using the Red Cross Disaster Preparedness guide. I would like to request updated medical records from Dr. Medulla, therefore reviewed Notice of Privacy Practice Policy (HIPAA) and had Mr. Sunshine sign the Privacy Policies Acknowledgment and Authorization for Disclosure of Consumer Medical/Health Information forms.

Provider Referrals/Community Referrals Needed: No referrals needed at this time.

Plan: To continue with medical care from Dr. Medulla and Dr. Pinna, begin Botox injections from Dr. Medulla, continue with physical therapy, and adjust/repair the wheelchair as needed.

Next Visit: I plan to visit in six months.

# Key Items to Remember

Keep it clear

Keep it simple

No opinions, only facts

Be ready to defend your documentation

Don't embarrass yourself!

# Remember

- Documentation is a big part of the job:
- Case files (electronic and hard copy) are a legal document.
  - ✓ Don't embarrass yourself – make it as professional as possible.
  - ✓ They are reviewed often & monitored periodically for quality.
  - ✓ They should provide everyone with information to support our participants & families.
  - ✓ Someone might need to step in and do your job.
  - ✓ It is important that what you write, you would feel good about!
- Four (4) reasons why documentation is so important:
  1. If the event is not documented, it did not occur.
  2. Helps you know where you are with a case.
  3. Helps your supervisor evaluate your work.
  4. If called to court, the documentation is the focus of your testimony.

- Questions?
- Comments?

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