Importance of Documentation and Best Practices in Case Notation

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Objectives:

1.To demonstrate how the case note is used to provide program accountability

2.To demonstrate how the case note is used to indicate client progress

3.To reinforce the importance of timely, concise, accurate, standardized case notes as a "best practice" in client care

OBJECTIVE 1:

To demonstrate how the case note is used to provide program accountability

Why Is It Important to Document?

"Case Notes are legal documents which may be viewed by judges, attorneys, clients, etc. They provide a measure of protection and substantiate compliance with auditors."

Accurate record keeping provides accountability to the
❑ Client
❑ Organization
❑ Funder

"*Social work case management is a discipline within the field of social work…*"

National Association of Social Workers Guidelines (http://socialworkers.org/)
3.04: Client Records

Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

PURPOSES OF RECORDS

Accurate record keeping supports the case manager in planning, implementing, and evaluating services for each client

- ✓ illustrates patterns of in/effective interventions
- ✓ enhances quality of service – Especially with heavy case loads or in crisis situations
- ✓ follows the agency/organization/state or other governing body protocols and these are followed in the charting.
- ✓ reflects any significant client, family or secondary service provider contact
- ✓ measures outcomes
- ✓ reminds Case Manager of services to be provided
- ✓ serves as support for insurance coverage purposes
- ✓ presents accurate history of crisis patterns

To demonstrate how the case note is used to indicate client progress

Progress Notes:

Must prove "delivery of service" with information which is
- accurate
- timely
- objective
- specific
- concise
- descriptive
- consistent
- substantive
- pertinent

Progress Notes, cont'd:

Always include:
• WHO: the name, qualifications and/or title of the qualified staff providing the service or intervention.

• WHAT: what was done, the specific interventions/skills training services provided

• WHERE: the physical site where were the services provided (office, client's home, etc.).

• WHEN: date, length of service (in units and time) and time of day.

•WHY: why the services were done. The intended goal, objective and outcome related to the interventions/skills training services.

•HOW: how the interventions were done (concrete, measurable & descriptive) along with the client's response and progress.

OBJECTIVE 3:

To reinforce the importance of timely, concise, accurate, standardized case notes as a "best practice" in client care

Ryan White Program Medical Case Management Record Review Tool Revised 6/23/2017

PROGRESS NOTES		YES	
Did MCM document a clear explanation of the following in the FA/CHA progress note:			
1	Reason for interaction with the client		
2	Client needs, if any		
3	Client's unique circumstances or changes since last assessment		
4	Client's current disease status		
5	Action taken to address the needs and or intervention performed on behalf of the client		
PROGRESS NOTES		YES	

Documentation Format Styles

❖ S-O-A-P: Subjective, Objective, Assessment, Plan

❖ G-I-R-P: Goal(s), Intervention(s), Response(s), Plan

❖ D-A-P: Data, Assessment, Plan

Consistency is the Key!

Documentation Format Styles

<u>G-I-R-P: Goal(s), Intervention(s), Response(s), Plan:</u>

<u>**G**</u>oal/objective is being worked on (from POC)

<u>**I**</u>ntervention used (reviewed, coached, prompted, assisted, encouraged, etc.)

<u>**R**</u>esponse of the client (feeling and/or action words)

<u>**P**</u>lan for next steps (next visit, client will, client plans to…)

Documentation Format Styles

<u>G-I-R-P Note Sample:</u>
(G) MCM met with client at her office for the purpose of updated her Plan of Care.
(I) MCM conducted Financial assessment and Comprehensive Health Assessment. MCM screened client for needs to be addressed.
(R) Client communicated about concerns in getting her new prescriptions filled. Client appeared slightly anxious as evidenced by her "getting up and looking out the window."
(P) MCM will generate certified referral for client to pick up prescribed medications. Client will pick up new medications within the next three days.

Documentation Format Styles

<u>D-A-P: Data, Assessment, Plan</u>

<u>D</u>ata: What did the client say during the visit? What did you observe during the visit? Include both non-verbal and intuitive senses.

<u>A</u>ssessment: What is going on? How does the client appear? What is their mental/physical state? Include both non-verbal, working hypotheses, and gut hunches about his/her situation.

<u>P</u>lan: Response or revision to his/her overall situation; next visit date, any topics to be covered next session, etc. What is your plan of action; what are you (or the client) going to do about it? What is your follow-up plan with the client?

Documentation Format Styles

D-A-P Note Sample

(D) Clinic-visit with client to complete and update care plan. Client spent most of the visit talking about her medications. She mentioned that she gets sick often and suffers from nausea from time to time for no apparent reason. She said she has tried to follow the directions given by the doctor, but is concerned about the recent weight loss she has had and wonders if it is due to the medications.

(A) Client fidgeted, talked fast, and seemed stressed over her medical condition. During the visit she spoke little about her family life, she seemed to be more preoccupied with having her meds changed and getting past the nausea. Not much improvement from her last visit.

(P) Will follow up with client to ensure she relates info to her doctor during her next visit and refer for adherence counseling until client feels better. Continue to work with client on adherence.

Documentation Format Styles

S-O-A-P Note Sample

(S) Client reported difficulties in keeping appointments with providers including this case manager, ADAP, and the doctor. Client expressed concern with memory issues and transportation challenges.

(O) Client was polite and joking throughout meeting. He was neatly dressed, well spoken but had to stop to think about what he was saying as he had trouble staying focused.

(A) Client is at risk of being non-adherent to medications and other appointments. Client needs reminders to assist with keeping appointments, a pillbox to help with medication adherence and help with transportation.

(P) Provide client with a pillbox and have nurse in clinic assist in setting it up. Provide client bus tokens to assist in getting to appointments. Call client 24 hours prior to visit with case managers as a reminder.

Documentation Format Styles

S-O-A-P: Subjective, Objective, Assessment, Plan

Subjective Data: information from the client, such as the client's description of pain or the acknowledgment of fear. Including subjective input from the client in his participation in the plan of care. Appendix 3 O –

Objective Data: data that can be measured. Laboratory data, observations of appearance or home environment, and making appointments with providers are sources of objective information.

Assessment: an interpretation of the client's condition or level of progress. The assessment determines whether the problem has been resolved or if further care is required.

Plan(s): may include specific orders designed to manage the client's problem, collection of additional data about the problem, individual or family education, and goals of care.

General Professional Guidelines

Things to include:

- ✓ Highlighting the client's strengths, supports and coping mechanisms
- ✓ Specification of where the information came from (ie client reports/states, as per medical report)
- ✓ Client's identification on each page
- ✓ Documentation of the link of successes and failures to the service plan
- ✓ Tracking of client activities (job pursuits, assessments, etc.)
- ✓ Tracking of program/agency monitoring activities (contacts, lab results, etc.)

General Professional Guidelines

Things to avoid:

- casual abbreviations
- taking shortcuts at the cost of clarity (re-read out loud)
- generalizations or over-interpretations
- grammatical errors
- negative, biased, and prejudicial language.
- details of the client's intimate life unless it is relevant to care plan.
- use of medical diagnoses that have not been verified by a medical provider (ie rather than "the client is depressed", say, "client states that he is having feelings of sadness or depressed mood" or "client describes seeing hallucinations or feeling sad on a daily basis"

General Professional Guidelines

Tips and Suggestions:

- Stay organized
- ➢ Carry notepad

- Maintain encounter log

- Account for "case noting" time
- ➢ Save time to document
- ➢ Secure time to document

- Utilize staff resources to improve

Case Note Documentation Practical Application

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Which best meets criteria for a well-written note?

❏ John Doe came to her appointment. He is doing fine. –JS 5/25/18

❏ mcm spoke with John Doe on 05/25/2018 to follow up on Optometrist's Appointment. He is far sighted so they will give him his tomorrow.

❏ MCM spoke with client, John Doe, by telephone on 05/25/2018 from 8:45am to 9am to follow up on his scheduled Optometrist Appointment at Bascom Palmer. Client informed this MCM that his exam indicates that he is far sighted so he will be fitted for new glasses tomorrow, 05/26/2018, from Bascom Palmer. Client stated, "I still have the bus pass you gave me so I won't need transportation to take me tomorrow." This completes Goal #2 on his Plan of Care. MCM directed client to call back after his appointment tomorrow to confirm that his step was accomplished. Client reported that he continues to maintain adherence with all other aspects of his HIV treatment. Note submitted by Jane Smith (Medical Case Manager) 05/25/2018

Self Check:

Did your note prove "delivery of service" with information which is accurate, timely, objective, specific, concise, descriptive, consistent, substantive, pertinent?

❑ Give a reason for your interaction with the client?

❑ Indicate any client needs?

❑ Indicate any changes in client status since last assessment / encounter?

❑ Address client's current disease status?

❑ State action taken on the client's behalf?

Correct these notes to better meet criteria

Placed a phone call to follow up on a job interview John Doe had on 5/10/2018 – JS 5/15/2018

I learned that Jane Doe has no money for a bus pass so I submitted the paperwork for supportive services – 5/25/2018

Jane Doe and I are working together to identify a Math Class or Workshop that can assist with the skills she needs as an accounting assistant. – JS

Self Check:

Did your note prove "delivery of service" with information which is accurate, timely, objective, specific, concise, descriptive, consistent, substantive, pertinent?

- ❑ Give a reason for your interaction with the client?
- ❑ Indicate any client needs?
- ❑ Indicate any changes in client status since last assessment / encounter?
- ❑ Address client's current disease status?
- ❑ State action taken on the client's behalf?

Q & A

Resources

Guidelines for Social Work Case Management Documentation. National Association of Social Workers. Retrieved May 25, 2018 from www.socialworkers.org.

Care Plans. ACT. Retrieved May 25, 2018 from www.ctaidscoalition.org/pdf/cmti/care_plans.pdf. Florida HIV/AIDS Case Management Operating Guidelines. Florida Department of Health. Retrieved June 19, 2018 from http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/_documents/eligibility-information/Appendix.pdf.

Wohltmann, T. (2015, April 24). Intro to Case Notes for new social workers. OER Commons. Retrieved June 19, 2018, from https://www.oercommons.org/authoring/8157-intro-to-case-notes-for-new-social-workers.

Case Management and Writing Effective Case Notes. Experience Works. Retrieved June 19, 2018 from http://www.experienceworks.org /site/ DocServer/ Case_Management_Writing_Effective_Case_Notes.pdf?docID=23124.

The AIDS Education and Training Center (AETC) Program is the training arm of the Ryan White HIV/AIDS Program. The AETC Program is a national network of leading HIV experts who provide locally based, tailored education, clinical consultation and technical assistance to healthcare professionals and healthcare organizations to integrate high quality, comprehensive care for those living with or affected by HIV.

The U.S. Department of Health and Human Services (DHHS) has released updated versions of its antiretroviral treatment guidelines for adults and adolescents, and for children with HIV. The new adult guidelines include revised recommendations for first-line antiretroviral therapy (ART) as well as management of treatment-experienced patients. The revised pediatric guidelines include a discussion of very early treatment for HIV-infected infants.

References
HHS Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*. Updated April 8, 2015.
DHHS Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection*. Updated March 5, 2015.

TRAINING OPPORTUNITIES

Preceptorships
An intensive clinical training program offered to healthcare providers in Florida who have an interest in learning more about the diagnosis and management of HIV/AIDS, opportunistic infections, and co-morbid conditions. Each preceptorship is structured to meet the unique needs of the individual participant based on his or her previous experience, geographic location, and time available. Experience 4 to 240 hours of clinical training at adult, pediatric, obstetric, and/or family practice clinics where care is provided to HIV-infected patients. All training provided is consistent with current guidelines from the Department of Health and Human Services or other nationally recognized guidelines when available.

Clinical Consultation
Individual and group clinical consultations are offered. Individual clinical case consultation is provided on the diagnosis, prevention, and treatment of HIV/AIDS and related conditions. These consultations take place by telephone, email or face-to-face meetings. Group clinical consultation with case-based discussions include information on pharmacology, clinical antiretroviral therapy updates, drug-drug interactions, and antiretroviral resistance.

FOR MORE INFORMATION, PLEASE VISIT:

http://hivaidsinstitute.med.miami.edu/partners/se-aetc

National HIV/AIDS Clinicians' Consultation Center
UCSF – San Francisco General Hospital

Warmline
National HIV/AIDS Telephone Consultation Service
Consultation on all aspects of HIV testing and clinical care
Monday - Friday
9 am – 8 pm EST
Voicemail 24 hours a day, 7 days a week

PEPline
National Clinicians' Post-Exposure Prophylaxis Hotline
Recommendations on managing occupational exposures to HIV and hepatitis B & C
9 am - 2 am EST, 7 days a week

Perinatal HIV Hotline
National Perinatal HIV Consultation & Referral Service
Advice on testing and care of HIV-infected pregnant women and their infants
Referral to HIV specialists and regional resources
24 hours a day, 7 days a week

HRSA AIDS ETC Program & Community Based Programs, HIV/AIDS Bureau
& Centers for Disease Control and Prevention (CDC)
www.nccc.ucsf.edu

Need Additional Information?

Contact the South FL SE AIDS Education and Training Center

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Thank you!