

LEARNING THE BASICS

DOCUMENTATION

Overview:

Documentation is “the act of furnishing or authenticating with documents”. It includes the progress notes reviewed from providers, case notes, summaries, letters etc. Service coordinators are, in effect, giving information in writing of what actually exists or has happened.

Documentation is needed for assessment and evaluation so we can know how to improve the quality of life for people we support, and how to maintain their health, safety and welfare.

Documentation:

- Is a means of communication for planning and implementing the activities that are important to the person’s life.
- May also be considered legal testimony if the Division is called into court for any reason.
- Provides justification for billing for services/supports provided by Regional Office staff.

Documentation should reflect the course of services/supports provided and skills that are learned during the time those services are being provided. It is used to communicate between agencies contributing to the person’s support, and health care providers. It contributes to the continuity of services to the person between providing agencies.

Some important things to remember about writing case notes are:

- The individual’s name and DMH ID number should appear on every page.
- Each entry should be dated.
- The writer should sign each entry, and include his/her title.
- Entries should be made with black ink or typed. Never use pencil.
- Be specific, objective, prompt, and complete. Language must be factual, detailed, accurate, and objective. Remember, language reflects professionalism.
- Write legibly and abbreviate correctly.
- Make entries continuous. Strike through empty lines or “X” through large empty spaces.
- Never write and sign an entry with another person’s name.
- Make alterations or corrections by drawing a single thin pen line through the error, making sure it is still legible. Date and initial the change. Note why the entry was changed. Do not obliterate the error by erasing, scratching through, using correction fluid, or in any way making the original entry impossible to read.

Progress Notes and Monthly Reviews from Providers

What to Look For:

Service providers are expected to keep adequate documentation regarding which services they rendered for which they received reimbursement. This assures that the service can be discerned and verified. Information should include:

- The person's name
- Middle initial or birth date
- The service given
- Date and time of service (include clock time, if required)
- What did or did not occur during the time period reviewed
- Progress toward the goals of the Individual Service Plan (ISP)
- Any concerns noted and how those concerns will be addressed
- The provider's signature and the signature of a QDDP if different from the author

Service Coordinator Documentation

What To Include

Different programs may require different documentation. Refer to program specific topics in this manual if you are unsure of what is required.

For TCM documentation requirements please refer to the TCM manual for specific guidelines. Documentation written today may be reviewed for audits or other purposes long after the author is gone. It must be written clearly enough so that any reader may determine what occurred. Remembering to answer the basic questions of "who, what, when, where, why and how" is a good guideline to thorough documentation.

Quarterly reviews: That the quarterly review of the plan took place (when and where) may also be recorded in a case note, but typically a more formal summary will be written, drawing conclusions from both the individual contacts and the provider record review. This is referred to as a "quarterly report" and should be kept with the individual's record, either with the plan of care or under its own heading. The quarterly report need not be long, and it does not need to duplicate information from case notes or from the provider records.

Documentation

Much of the time a service coordinator spends in documenting can be included with the previously mentioned activities; e.g., the time spent writing an ISP can be logged under "planning". The service code for documentation may be used when the time spent writing, cannot conveniently be included with another activity. Documentation time which can be billed to Medicaid under the TCM program includes maintaining appropriate records in accordance with federal/state programs, policies, and procedures. This would include obtaining necessary releases and otherwise ensuring the confidentiality of all written and verbal discourse. See Section XI, Logging and Documentation, in the Targeted Case Management Technical Assistance Manual for more information.

Examples: Writing letters, memoranda, case notes, transfer summaries, and discharge summaries.

Service Coordinator Roles and Responsibilities

1. Maintain accurate documentation of time spent for the purpose of ensuring continuity and progress, as well as TCM billing
2. Complete quarterly review of the ISP to ensure progress towards outcomes and continued need
3. Review provider documentation to ensure continuity of care and services provided