



Health Home Care Coordinators Training

Care Coordination and Documentation



HealthPath
Washington

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Washington State
Health Care Authority



Today's Presenters

Roseann Martinez, MSW, LICSW

Quality Assurance and Contracts Specialist

Cathy McAvoy, MPA

Quality Assurance and Training Program Manager

Health Home Program

Office of Service Integration

Behavioral Health and Service Integration Admin.

Washington State Dept. of Social and Health Services



Objectives of the Training



Training Objectives

1. Care Coordination

- Care Coordination as one of the six Health Home services
- Examples of activities and services Care Coordination may entail
- Suggestions for including allied staff in care coordination activities

2. Documentation

- Tips for documenting Health Home services
- Best practices for writing a professional narrative

We were asked for general guidelines about documenting core services and activities. This webinar will provide documentation standards and their relationship to core services. This is intended to be an overview so be sure to talk to your supervisor and Lead Organization for specific policies and procedures and recordkeeping requirements.

The Six Health Home Services

- 1 Comprehensive care management
- 2 Care coordination
- 3 Health promotion
- 4 Comprehensive transitional care
- 5 Individual and family support
- 6 Referral to community and social support services

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Throughout the year we have dedicated some of our webinars to focus on one of the six core health home services.

We presented on Comprehensive Care Management at our monthly webinar in April 2015.

We presented on Comprehensive Care Transitions in May 2015.

This month we will focus on Care Coordination.

A best practice is to document in the client's narrative record which of these services were provided.

The slide features a header with two colored rectangles: a teal one on the left and a green one on the right. Below the teal rectangle, the title "Care Coordination" is written in a large, bold, teal font. To the right of the title is the logo for "HealthPath Washington", which includes a circular emblem with a map of Washington and the text "HEALTH CARE AUTHORITY" and "HealthPath Washington".

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Washington State Health Care Authority

Department of Social & Health Services

Examples taken from cases will be included. Some of the details have been modified to protect the identity of the client and Care Coordinator. Some of these examples were taken from the Quarterly Reports submitted by your Lead Organizations. Some of the examples were created to enhance this training.

1 Care Coordination

Provides cross-system care coordination to assist the client to access and navigate needed services

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This includes integrating mental health, chemical use, Long Term Services and Supports (LTSS), and primary and specialty care.

Examples of cross-system care coordination are:

- Care Coordinators scheduling and attending CARE assessments by the:
 - case resource manager from the Developmental Disability Administration;
 - social service specialist or nurse at Home and Community Services;
 - case manager or nurse from the Area Agency on Aging; or
 - social worker for Children's Administration

Other examples include establishment of an Interdisciplinary Care Teams (ICT) by the Care Coordinator or participation on pre-existing ICTs such as interdepartmental discharge planning meetings held at nursing facilities.

2 Care Coordination (cont.)

Fosters communication between the providers of care including:

- Primary care providers
- Medical specialists
- Entities authorizing behavioral health and Long Term Services and Supports (LTSS)

Examples include:

- A Care Coordinator who accompanied his client to his PCP appointments and other specialists. Following the appointments, using the Teach Back method, the Care Coordinator reviewed the medications, plan of care, and treatments to ensure that the client understood what his PCP and specialists had prescribed.
- A Care Coordinator ensured that an interpreter was scheduled for a doctor appointment which was attended by the client's paid caregiver to ensure that the client and caregiver understood the physician's orders.
- A Care Coordinator helped a client access Roads to Community Living (RCL) funds to assist the client with a housing voucher. A Community Choice Guide through the RCL Program assisted the client in submitting rental applications. Once the client was approved for an apartment by the landlord the Community Choice Guide assisted the client in purchasing household items and furniture for the subsidized apartment using RCL funds.
- The Care Coordinator enlisted the help of a peer support specialist to accompany the client to her mental health counseling to assist her in remaining in her own home as her mental health symptoms were better managed.

3 Care Coordination (cont.)

Is the bridge between all the client's systems of care, including non-clinical support such as food, housing, legal services, and transportation



Some examples include:

- Connecting the client with Northwest Justice Project for legal assistance with a tenant landlord issue to get necessary repairs to the unit.
- Assisting the client to apply for subsidized transportation so she could get to her appointments.
- Assisting the client to apply for a Driver's License: in this example the client had to get glasses so she could pass her written and driving tests. The Care Coordinator worked with the client to increase her endurance so she could walk through the Licensing Department to take her tests.

4 Care Coordination (cont.)

Enlist the help of allied staff to facilitate the work of the Care Coordinator including:

- Community health workers,
- Peer support specialists,
- Wellness coaches,
- Community Connectors, and/or
- Other non-clinical staff

Examples would include:

- The Care Coordinator coordinating with the peer support specialist to accompany the client to her mental health appointments and her support group at the Depression and Bipolar Support Alliance in Bremerton.
- The Care Coordinator enlisting the help of a volunteer driver to transport the client to the Social Security Office to request a replacement Social Security card.
- The Care Coordinator referring the client to a community health worker at a local community health center to escort her to her eye appointment and local optician to get glasses.
- The Care Coordinator working with the Area Agency on Aging to access the Chronic Disease Self-Management Program. A Wellness Coach was also provided through the client's managed care plan to support the client in establishing goals for healthy eating and exercise to better control her diabetes.

5 Care Coordination (cont.)

Provides informed interventions that recognize and are tailored for the factors which impact the client's health:

- Medical
- Social
- Economic
- Behavioral
- Functional abilities
- Educational
- Cultural
- Spiritual
- Environmental
- Dietary

For example:

An immigrant may require assistance from a Care Coordinator to get free diapers from the Mission Community Outreach Center in Spokane. Without the diapers the child may not be able to attend day care and other educational and religious services to reduce the child and family's social isolation.

The Quarterly Reports submitted by your Lead Organizations contained many examples of how Care Coordinators have worked with their clients to reduce social isolation and/or improve quality of life:

- One Care Coordinator located a client's children who had been estranged during her period of substance abuse so they could be reunited after the client had maintained sobriety for a number of years.
- One Care Coordinator connected the client with the local senior center so she could take a knitting class.
- One Care Coordinator referred a client to a smoking cessation program and helped him reduce his caffeine intake to decrease his stomach pain. As a result the client was better able to re-engage in activities outside of his home.
- One Care Coordinator installed an app on the tablet of a client with a developmental disability so he could interact with other gamers. He also assisted in setting up e-mail and Facebook accounts so he could communicate with relatives and friends.

6 Care Coordination (cont.)

Care Coordinators promote:

- Optimal health outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan
- Outreach and engagement activities that support the client's participation in their care to promote continuity of care

For example:

- One Care Coordinator assisted the client in locating a new medical group so that the client's PCP and specialists practiced within the same group. This aided the client in ensuring continuity of care between the various providers. By doing this and accessing transportation the client was able to make faster progress on her goal to work toward stabilizing her blood sugar levels.
- As part of the Health Action Plan one Care Coordinator and client established a long term goal of reducing the client's blood sugars. The short term goal was to measure her blood sugar levels twice a day in order to measure her progress in reducing her blood sugar levels. The client had run out of test strips and could not locate her glucometer so the Care Coordinator contacted her managed care plan to research benefits for diabetic supplies and education. She then scheduled with an endocrinologist and worked with the pharmacy to get test strips and a glucometer so the client could measure her blood sugar levels.

7 Care Coordination (cont.)

Promotes health education and coaching to increase self-management skills to improve health outcomes for their clients

Care Coordinators may provide educational materials to clients, caregivers, and family members to aid them in understanding their chronic conditions, medications and treatments.

An example:

- One Care Coordinator worked with the Area Agency on Aging case manager to get the client referred to the Chronic Disease Self-Management Program to improve her understanding and management of her diabetes.
- Working with a Wellness Coach from the client's health plan, the Care Coordinator and Wellness Coach helped the client identify some short term goals to help her reach her long term goal of being able to increase her endurance so that she could walk the halls in her assisted living facility and join group activities.

8 Care Coordination (cont.)

Uses peer supports, support groups, and self-care programs to increase the client's knowledge about their health conditions and improve adherence to prescribed treatment

An example is:

- A client was admitted to the hospital for a routine surgery where it was discovered that he was diabetic. The Care Coordinator worked with the client's PCP to get a referral to an endocrinologist and dietician so the client could gain knowledge about this new chronic disease and how to better manage it through proper diet. The Care Coordinator also helped the client research online resources and the client joined an online support group.

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Care Coordination (cont.)

Provides transitional support when a client:

- Opts out
- Loses eligibility
- Moves to another county, state, or provider

An example is:

- A Care Coordinator had a client who moved from Bellingham to Everett. Since Health Homes are not offered in Snohomish County the Care Coordinator assisted the client in locating local services to support him as he continued to work toward his health goals. He connected with a support group for his chronic disease, referred him to Compass Health for ongoing mental health services and peer support and assisted in locating a new PCP within his current Managed Care Organization. The Care Coordinator also asked the health plan to assign a Wellness Coach to support him with his short and long term goals. When the client moved to Everett the HAP was closed and the plan for transitioning his care was documented in the electronic health record.

Additional Activities for Care Coordination

- Review and revision of the person-centered Health Action Plan to reflect changes in the client's condition/s
- Model appropriate use of healthcare resources to decrease dependence on Emergency Department care
- Ensure discharge planning to prevent avoidable hospital readmissions

Additional Activities for Care Coordination cont.

- Advocate for the client in a culturally relevant manner to access medical and social services
- Engage paid and unpaid caregivers, family members, and collaterals in the HAP
- Promote health literacy and education
- Coach on problem solving and model problem solving

To engage paid and unpaid caregivers, family members, and other collaterals in the HAP the client and Care Coordinator may wish to assign some of the action steps to these members of the client's support system.

Additional Activities for Care Coordination cont.

- Identify individual strengths and needs
- Provide supportive counseling focusing on harm reduction
- Support natural supports: support not supplant
- Model methods for navigating the healthcare system

Examples of action steps a Care Coordinator might take could include:

- Assisting the client in researching bus routes to get to an MRI appointment.
- Working with a client who is used to researching online to search for information about a chronic condition, options for medication and treatment, special diets and support groups.

Additional Activities for Care Coordination cont.

- Develop and document the Health Action Plan and provision of the six health home services
- Prepare for relapse and develop a resiliency plan
- Identify resources for crisis intervention: behavioral health support services

An example could be:

- Adult Family Homes (AFH) are required to have a relapse or resiliency plan for their clients with a mental health diagnosis. The Care Coordinator may set up a time to review the plan with the AFH caregivers and the client to ensure that they know where the plan is and what steps to take if the client becomes symptomatic.

Outcomes Resulting from Care Coordination

- Reduced Medicare and/or Medicaid expenditures by slowing the progression of chronic diseases and accessing lower cost healthcare
- Delay the onset of additional chronic conditions
- Reduce symptoms and improve the quality of life

By preventing avoidable hospitalizations and use of Emergency Departments Health Home services can reduce healthcare costs.

Tier Services

- **Tier 1:** care coordination begins with the development and implementation of the HAP
- **Tier 2:** care coordination is one of the primary services offered as the Care Coordinator and client work together on long and short term goals
- **Tier 3:** care coordination may be provided even though the client's chronic conditions have become more stable

Thank You for Your Great Work!



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Additional Care Coordination Examples:

Helping the client access recreational facilities for exercise and socialization:

- Applied for subsidized memberships to the YMCA
- Helped the client access physical therapy to increase strength and endurance in order to pursue a home exercise program
- Increased socialization and health monitoring by referring the client to an adult day health center

Assisting with getting durable equipment and supplies:

- Assisted a client needing a bariatric walker to get the walker through a local charity when Medicaid denied the request
- Researched and accessed wheelchairs and wheelchair repairs

Increasing the quality of life: decreasing isolation and improving opportunities for socialization:

- Client with an essential tremor was unable to pursue her love of beading. The CC helped the client schedule an appointment with a neurologist. Now with medications the client's tremors have lessened allowing her to pursue her hobby.
- Assisted a client with a sleep evaluation. Now that the client uses a CPAP she is more rested and can now work on increasing her strength and endurance.
- Aided the client in locating a new caregiver with more experience with diabetes
- Assisted client in getting incontinence supplies so she can now leave her home
- Assisted a young female client who had a motor vehicle accident resulting in a TBI join a head injury support group

Accessing hearing, vision, and dental care:

- Numerous clients have had help accessing new glasses to improve their quality of life and increase their safety while walking. Because they can see they can participate in hobbies and other activities such as gardening.
- Numerous clients have also had help accessing dental care and dentures. Following dental treatment a client was able to resume activities he enjoyed because he no longer suffered from headaches.
- A number of clients have been helped to get hearing aids which improve the quality of their lives as then they can increase socialization with family and others in their community. They can better enjoy telephone and talking books, again reducing their isolation.

Accessing medical care and behavioral health and other services:

- Helped to locate alternatives for treatment of substance use disorders
 - Supporting clients in their recovery
 - Developing a relapse and resiliency plan
- Accompanied a client to an intake appointment at local mental health clinic resulting in the development of a relapse plan the adult family home provider could refer to when the client had an exacerbation of symptoms
- Visited a client in the hospital who died later that day
- Ordered interpreters to reduce language barriers
 - Used a peer support to accompany client so she was able to get back on the transplant list
- Referred to a hospital based coronary exercise program with medical monitoring and supervision

Recordkeeping:

- Helped a client sort paperwork, locate and complete applications for assistance and manage her recordkeeping

Accessing safe housing:

- Filled out housing applications and ensured that they attended their housing appointments
- Knowing how to work the waiting list ensured that the client was still under consideration by updating their contact information
- Moved a client to a location closer to family. The client was the caregiver for aging parent and moving closer reduced her stress.
- Worked with Habitat for Humanity for supplies to repair the client's home
- Applied for rent assistance with the Adopt a Family Program through Catholic Community Services
- Assisted a client to open her heating vents so she could be warm again and focus on feeling better
- Helped a client reduce clutter – one client used the open space for an exercise bike

Referral to community resources:

- Helped a client complete an application for Social Security Disability benefits

- Got a new mattress for a client using a soiled mattress
- Accessed assistance with vector control to rid the home of a mouse infestation
- Wrote a letter to the Salvation Army to request cooking utensils
- Submitted a request in one of the Lead's staff newsletters which publishes as wish list for clients
- Researched alternative treatment options to support recovery

Seeking employment:

- Helped a client complete GED program. With the support of a Care Coordinator some have even pursued a college education.
- Helped a client with a referral to Department of Vocational Rehab for an assessment to either go back to work or receive training for a new career

Access to LTSS:

- Requested a COPES assessment to access in-home care, durable medical equipment, supplies, and Chronic Disease Self-Management courses
- Worked with case manager using Roads to Community Living to:
 - Apply for subsidized transportation
 - Pay for credit checks, damage deposits, and limited rental payment assistance
 - Hire a Community Choice Guide to shop for the client to furnish an apartment
 - Establish a household budget so the client could live within her means

Accessing transportation:

- Modeled how to schedule a ride using Non-Emergency Medical Transportation
- Assisted a client in getting reimbursement for gas for medical appointments
- Assisted a client to get their driver's license
 - Helped client with new glasses and increased endurance to pass the test

Working with parents and families:

- Assisted the parent and paid caregiver to access an evaluation for a learning disability
- Researched summer activities for kids to give a parent with cancer time to rest
- Located a caregiver so parents could attend parenting classes
- Helped a family to access WIC program for children with failure to thrive so they can maintain their children in their own home
- Modeled telephone skills and taught parents and the caregiver how to communicate with medical providers
- Placed weekly calls to a client and her children to support them in their grief after the recent loss of their husband/father
- Helped a client and his family interface with adult medicine care when the client with a developmental delay graduated from pediatric services to adult care. Working with caregivers she aided them in accessing an adult sized specialized medical bed and other communication equipment with a goal of improving the client's abilities to communicate with her caregivers.

Suggestions for working with new clients:

- Show an interest in the person not the diagnosis

- Provide a resource when you first meet the client – is there anything I can help you with now?
- Make regular and consistent contacts: keep your promises and follow through
- We want to supplement not supplant their services and natural supports
- Focus on the client's strengths not weaknesses and instill a sense of hope that health changes are possible



Documentation



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Revisit SW and RN Ethics

- Nursing Standards (WAC)
- National Association of Social Workers (NASW) Code of Ethics

The [standards of nursing care](#) include the principle that any of your coworkers should be able to pick up a chart and understand the status of that patient's condition and care. This is important since quality care is a team effort. The team must be able to work together and ensure that each patient's individual needs are clearly communicated to each other.

Both professional practices call for taking reasonable steps to ensure that documentation is accurate and reflects the services provided. The NASW Code of Ethics Standard 3.04 specifically states, "(a) social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided, (b) 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."

The Role of Documentation

- Coordinates and evaluates service needs
- Accountability
- Liability and risk management tool
- Supervision

Documentation plays a role in coordinating and evaluating service needs. It is necessary in order that other partners working with the client can pick up the record and know the plan. Also should the Care Coordinator get sick or need to leave suddenly the next Care Coordinator or other team member would know the plan and how to resume working with the client.

Documentation provides a record of the services actually provided and documents claims related to reimbursements. Documentation provides accountability for utilization reviews, legal reviews, Health Home Leads' audits and becomes a record of actions taken and by whom.

Documentation is a liability and risk management tool. Both the nursing and social work professions make use the adage, "if it is not documented, it didn't happen." You want to be able to prove your actions in court, in supervision and in treatment and your record should be precise about your actions and conversations with the client and other collateral contacts.

Documentation provides the basis for supervision and helps supervisors identify areas of strengths and perhaps areas to increase training.

Tips

- Be accurate and thorough
- Be objective
- Be timely
- Be legible
- Be free of acronyms
- Be professional

I will now discuss each of these tips in greater detail.

Accurate and Thorough

- Have the right chart
- Focus on client
- Type of contact
- Time and date
- Summary

If you see lots of clients, you may want to ask their name and confirm any other identifying information. One time I went to the doctor and was greeted with “Hi Ms. Martinez how is your lupus?” The doctor clearly had been given the incorrect health record.

Focus on client, not your interpretation of the facts.

Document the type of contact, if it was face to face, and where the visit was held. Note who was present and their relationship to the client. Make a notation of the date and time. Summarize the contact highlighting the discussion and any agreements made. Write down what the next steps will be to aid you when you follow-up with the client at a later date.

Objective

- Exact words
- Observations
- First person language
- Non-judgmental

Exact words can be recorded in the narrative. When recording statements by the client or collaterals, if they are the exact words, put them in quotations.

State facts that support your observations by giving a balanced description of the client, focus on the positive strengths as well as the unfavorable behaviors.

Identify the person first not the disability or chronic condition....if it is necessary to the note. Example: a person who is deaf versus a deaf person...a person who uses a wheelchair instead of a wheelchair-bound person.

Use words that do not imply judgement, describe the behavior not your interpretation. The record belongs to the client and they have the right to see anything you have written. Your record is a representation of your ethical and professional behavior.

Timely

- Chart in the moment

Chart in the moment. If you remember an important point after you've completed your documentation, chart the information with a notation that it is a "late entry" and include the date and time of the late entry.

Legible

- Errors

If you identify an error add a note referring to the date and contact and enter the correction and date of the entry. Do not erase notes. If possible draw a line across the notes that are in error and initial or use the “strikethrough” feature on your computer if available.

Free of Acronyms

- HCS - Home and Community Services
- DSHS – Department of Social and Health Services
- CP- Cerebral palsy
- COPD – Chronic Obstructive Pulmonary Disease
- CHF - Congestive Health Failure
- PVD – Peripheral Vascular Disease

This is helpful to allied staff and those from disciplines different than your own.

Professional

- Don't alter a record

Altering medical records can have very damaging impact. At the minimum it is unethical and at the most could be a federal offense and result in the loss of your license.

Documented Evidence for Health Home Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion and Coaching
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services

I want to give you some tips about documentation related to Health Home Services. Please visit the DSHS Health Home Website for a copy of the Documentation Guide developed for Care Coordinators and allied staff. Some activities may actually fall under more than one of the six core services so your narrative may include multiple types of Health Home core services.

Health Home Care Coordinator Documentation Guide

Health Home Program Health Home Care Coordination Documentation Guide		
Health Home Services	Activities	Documented Evidence
<p>1. Comprehensive Care Management</p>	<ul style="list-style-type: none"> • Initiates contact with client and/or collaterals • Completes initial and follow up visits with the client and/or collaterals • Completes telephone contacts and follow up • Reviews PRISM data prior to first client contact or face-to-face visit • Completes the required and optional screenings • Assesses the client's self-management skills and readiness • Completes the initial Health Action Plan (HAP) • Provides monthly contacts to provide: <ul style="list-style-type: none"> ◦ Continuity of care between providers ◦ Support to enable the client to achieve their self-directed health goals ◦ Assistance as needed to improve functional or health status or prevent or slow declines in functioning • Provides cross-system care coordination to assist the client in navigating and accessing needed services • Reviews PRISM for updated claims and utilization activity • Reviews and edits the HAP at every contact to: <ul style="list-style-type: none"> ◦ Check on completion of action 	<ul style="list-style-type: none"> • Client case notes should indicate: <ul style="list-style-type: none"> ◦ Outreach attempts to locate and contact the client ◦ Date outreach was completed, who completed the outreach, and names of collaterals if client was not contacted ◦ Verbal approval by the client or client's representative to contact collaterals and/or share client information ◦ Date and time of the initial and other visits ◦ Other persons present during visits ◦ Summation of the purpose of the contact and highlights from the discussion ◦ Notable comments and exchanges ◦ Objective observations • Scores, levels, and dates of required and optional screenings. Include the name and relationship of the person if others complete the screening <ul style="list-style-type: none"> ◦ When the client or representative declines to complete a required screening note the date, reason, and the name and relationship of the person

Contact your supervisor and/or Lead Organization for additional documentation requirements

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This is an image of the guide which is available on the DSHS Health Home website. Use the quick links to access it from the Classroom Training Manual. It provides guidance on the types of activities you may wish to document as they relate to the six core services.

Comprehensive Care Management

- Health Action Plan (HAP)
- Date and time
- Scores
- PAM – engaging conversation
- Discussion of goals
- Who will do what

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Note completion of the Health Action Plan. If you are going to use an acronym type out the entire term the first time you use the acronym.

The printable HAP must be given to the client or authorized representative. Note the format, how the HAP was provided, the date, and who the HAP was given to. For example if the HAP was attached to an e-mail message to the parent note this in the narrative section of the client's record.

The client record notes should indicate the day and time of the visit, summation of the conversation and notable comments and exchanges.

Scores and dates of the required and optional screenings should be noted. If a client, parent, or caregiver refuse to complete a required screening note the date and reason the screening was not completed. Note additional attempts to complete the screenings and the reason the client or collateral did not complete the screening.

The Patient Activation Measure is an indicator of the client's self-assessment of their activation and motivation. Conversations with the client about their engagement and progress should be noted.

Document conversations and activities with client such as reviewing and updating the HAP including their goals, their reported progress on the goals and action steps.

Care Coordinators should note the activities they accomplished in supporting the client. Allied staff should document any of their contacts and activities working with the client, other providers, and other client collaterals and representatives.

Care Coordination

- Releases, contact information, referrals
- Names and organizations providing social supports
- Contact provider
- Notes about the actual contact
- Client's participation level
- Transitions

The Information Sharing and Consent form should provide contact information for all providing care.

Identify the names and organizations being used to provide social and other supports.

Clearly note in the documentation who will make the contact with the provider.

When contact is made describe the interactions, conversation, and the plan of action.

In the case notes or narrative describe the client's participation in social/support groups that have increased their knowledge about health care and self-management of their chronic diseases.

If the client wishes to end their participation in Health Homes note the date and reason for opting out of the program. As appropriate note any plans to continue with their goals and who will support them. Note any referrals or information shared with the client about other resources. Document your efforts to transition the client on to other services or another Care Coordination Organization or Lead Organization when appropriate.

Health Promotion

- Activation scores
- Allied staff, appointments
- Note any materials given to client

Your notes should describe the activation scores and what they mean for the individual, document the client's response.

Allied staff can accompany clients to appointments and notations of these activities should be recorded.

Descriptions of written or visual materials given to client should be noted in the client record. Referrals to other providers such as a nutritionist for education about a special diet should be noted along with the name and phone number of who was contacted and/or accepted the referral.

Comprehensive Transitional Care

- Discussion with inpatient facility staff is recorded in client record
- Sign releases of information
- Plan for follow up

Discussions with inpatient facility staff is recorded in the client record. Describe who will take which actions on behalf of the client.

Secure written approval on the Information Sharing and Consent form. If written approval is not available note verbal approval to share protected information and include the date and name of the person who provided approval if the client has a legal representative working on their behalf.

Document any plans for follow up such as contacting the client to ensure that durable medical equipment was delivered and that the client and/or caregiver understand how to safely use the equipment or supplies.

Individual and Family Support

- Family members and caregivers, releases
- Engage informal supports by helping client have conversations with their peers
- Direct client to participation in peer group sessions
- Help facilitate conversations with caregivers about chronic conditions
- Client record should note cultural considerations and resources available

Case notes should describe the names and relationship of family members and caregivers. The Information Sharing and Consent form should be signed to allow communication with each of these individuals.

Engage peers by helping the client with conversations with their peers. Provide directions so that clients may participate in peer support group sessions. Note in the record the client's participation in those groups.

Help facilitate conversations with caregivers about chronic conditions and note attempts to offer resources about these conditions.

Client records should note cultural considerations and resources available, for instance, the client's special needs or preferences related to their spiritual beliefs, language and cultural or ethnic values.

Referral to Community Supports

- Resource and referral information
- Contacts with other services
- Allied staff work

Resource and referral information should be kept in client file. Contacts with other services and referrals dates should be noted in the client record. Care Coordinators or allied staff may provide one-on-one support in completing applications for other services so include phone numbers and the names of anyone that was contacted.

Best Practices

- Document when client provides verbal approval to contact someone or a provider before they can sign the Information Sharing Consent form
- Document review of the HAP and when a copy was provided and how
- Identify the relationship of any collateral contacts

Best Practices cont.

- Give a balanced description of the client
 - Focus on the positive strengths as well as the negative behaviors
 - Document past attempts to change behavior, what worked, for how long, what happened (according to the client or collateral) which may have caused a relapse or a change to the HAP
- Note any progress on the HAP and/or challenges or obstacles

For example: the client quit her daily walking routine. Instead note that the client's paid caregiver was ill so the client was not able to complete her daily walking routine.

Best Practices cont.

- Document monitoring of the HAP
 - Provides an opportunity to address issues with implementation and/or the need to revise the HAP
 - Narrate a summary of changes to the HAP
 - Completion or revision of short term goals and action steps
- Document collaboration or care coordination activities with other providers and collaterals

In Summary

- Care Coordination is one of the primary Health Home Services
 - It can be provided at all Tier levels of service
- If it is not written down it didn't happen
- Clear, precise free of judgement
- No regrets
- Consult your supervisor if you don't know (and make a note of it)

Cathy talked about Care Coordination and provided some examples. Care coordination includes a nearly endless list of activities that may be done on behalf of your client or with their caregiver, parent, or representative.

Your Lead Organizations may have specific expectations on documentation so check with them about their policies, procedures and requirements for documenting your work with your clients and/or their collaterals.

Post Webinar Discussion

- Please share some examples of your most unique care coordination activities.
- How have you worked with allied staff such as peer support specialists and community health workers to complete some of these care coordination activities?
- Give some examples of how good documentation has supported your work or others on the team?