



All contacts made and actions taken by Division of Senior and Disability Services (DSDS) staff regarding a participant's Home and Community Based Services (HCBS) shall be electronically recorded in the HCBS Web Tool within CyberAccess. The HCBS Web Tool is the participant's official case record and must contain all documentation involving the participant. Case Notes summarize the participant's circumstances, justify the actions taken and provide a record of the interaction between the participant, collateral contacts and HCBS providers. Stakeholders, including HCBS providers, have access to the Case Notes within the HCBS Web Tool. The transparency of the HCBS Web Tool allows HCBS providers, physicians, and other designated state agency staff to follow-up on participant records and requests without the need to contact DSDS for updates. Case Notes are also reviewed by all parties involved in any administrative hearing.

The following documentation principles shall guide all Case Note entries:

- **Accurate** documentation of the information received effectively communicates to the reader the participant's care needs and associated service delivery. An accurate Case Note serves as an accountability measure of DSDS staff's response to the participant's request/ongoing need for HCBS. Care should be taken to avoid the use of psychological or medical diagnosis describing participant conditions or behaviors that require qualifications other than those of DSDS staff.
- **Clarity** can best be achieved by the use of plain language. Simple words and sentences are preferable to jargon, bureaucratic language, slang words and excessive wordiness.
- **Concise** Case Notes are easier to read, save time, and improve the quality of the documentation. Avoid vague or general terms, such as: some, sometimes, often, many, several, etc.
- **Facts** shall document who, what, when, where, why and how as it relates to the participant and any associated care plan. In forming and recording professional judgment about the participant's needs, the facts should support the judgment, not vice versa. Cite any professional conclusions or comments regarding the participant with fair background and context. Avoid the use of "feel" and "think," rather use "believe" and "conclude."

#### **HCBS Web Tool Case Note guidelines**

Every contact made regarding a participant and their receipt of HCBS shall be documented. The contact shall include the date of contact, the identification and contact information of the contact person (if needed), a summary of the discussion, and the name and provider (if applicable) of the person entering the Case Note. Attempts to make contact shall be documented as well. For HCBS Web Tool guidance regarding adding, searching, and modifying a Case Note see HCBS Technical Guide, Chapter 6 – Case Activity.

### Case Note Foundation

- Case Notes documentation shall provide the link between information gathered through screening and assessment, the development of a person centered care plan and any subsequent action taken by DSDS staff not contained elsewhere in the HCBS Web Tool. Duplicative Case Notes shall be avoided. Information gathered throughout the HCBS Web Tool application does not need repeating within a Case Note.
- The HCBS Web Tool shall only be used to document participant specific HCBS situations. Nonparticipant related information shall not be recorded in the HCBS Web Tool, e.g. system issues, work order assignment and tracking.

### Case Note Structure

- Thoroughly proofread all documentation before selecting 'save' to ensure proper spelling, sentence structure, punctuation, and grammar are used.
- Write in first person; from the 'I' point of view.
- Utilize active voice when writing a Case Note. For example: 'Sheila Jones, the neighbor will clean the house every Saturday' as opposed to, 'The house will be cleaned by Sheila Jones, the neighbor every Saturday.'
- Use action verbs and descriptive phrases which are specific instead of general.
- Avoid vague pronoun usage to prevent confusing statements. For example: 'The participant said the aide gave her medicine to her nurse.' Whose medicine was given to whose nurse?
- Abbreviations/acronyms from Policy 1.05 may be used. Abbreviations/acronyms not found in Policy 1.05 may be used following initial explanation of their meaning, such as Mrs. Jones (Mrs. J), etc. Specific identification of the parties' involved and consistent use of designated abbreviations will promote a clearer understanding of the documentation.

### Case Note Entry

- The 'contact date' entered shall reflect the actual date the contact regarding the participant was made. Multiple contacts on the same day may be entered within the same Case Note; however, there shall be a clear distinction, for each contact (e.g., separate paragraphs). Contacts with differing dates must be documented in separate Case Note entries.
- Identify the type of contact (e.g., face-to-face contact, phone contact, email correspondence, etc.) for each Case Note entry. Refer to Policy 1.05 for approved abbreviations/acronyms.
- At the conclusion of a Case Note entry, DSDS staff shall enter their first and last name and business affiliation, (e.g. DSDS Reg. x, MEAAA).
- A note entered in error can be deleted by a DSDS administrative user in the associated region.
- A previously entered Case Note requiring updates or changes may be modified once. (See HCBS Technical Guide, Chapter 6 – Case Activity)

## Documentation of Special Circumstances




### Protective Services

- Protective service investigations and interventions are documented in the DSDS Case Compass Care Management System and shall not be documented in the HCBS Web Tool. When a contact indicates a potential protective service situation, DSDS staff shall make the mandated hotline report and enter a note in the HCBS Web Tool that states 'Appropriate referral was made'.

### Multiple HCBS Participants within the Same Household

- When DSDS staff have identified that multiple individuals receiving HCBS are residing in the same household (regardless of the authorized HCBS provider), the following information shall be documented in Case Notes:
  - The identity of the associated participant(s) including the DCN(s) and relationships;
  - Information regarding coordination of services; and
  - Other necessary information in each individual participant's record to facilitate care plan development.

### Identified Safety Concerns

- Situations may arise that pose a safety risk (e.g., drug use, weapons etc.) to individuals entering and working with a participant in their home. Upon identification of the safety concern, details surrounding the potential risk shall be documented in the HCBS Web Tool.
- The following steps shall be followed to thoroughly document a safety concern:
  - 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 xx-xx-xxxx regarding potential safety concerns' in the Directions to Residence section.
    - Select the save icon  at the bottom of the Address pop up box.
    - Select the save icon  at the bottom of the Demographics Section.

Address

FSD Address

Address

8591ADD2  
8591ADD2  
8591CITY, MO 63026

Primary Phone: 859-000-0000  
County/FIPS: JEFFERSON 099

Is this the participant's Current Address?  Yes  No

Directions to Residence

See Case Notes dated 1/15/2016 regarding potential safety concerns.

Data is saved.

- Navigate to the Case Activity screen.
- Add a Case Note documenting the potential safety risk.

### **Guidance for various HCBS contacts**

All case actions and communications regarding a participant and their receipt of HCBS require documentation. The following guidance provides a framework for the appropriate documentation of various HCBS case actions. HCBS services are person-centered; therefore, each participant and associated case documentation is unique. While every applicable aspect of the guidelines below shall be documented, it is understandable that all guidelines may not apply to every participant. Additionally, there may be information not included below which is pertinent to the participant's case record and shall be included in the documentation.

Finally, the guidance below for each type of case action also includes timeframes for Case Note entry. In circumstances where completion of the authorization occurs during the face-to-face (re)assessment, the timeframe expectations below do not apply. Pertinent service delivery information shall be communicated to all respective parties at the time of authorization and documentation shall be entered within seven (7) business days.

**PreScreen documentation includes, but is not limited to, the following:**

- The form of the initial contact (phone call, fax, email).
- The identity of the contact. If not the participant, document name, relationship to the participant and phone number.
- If the participant is currently in a hospital, skilled nursing facility, or rehabilitation facility, include name of facility, reason for stay, date of admission, date of discharge (if known), and name and phone contact information for facility discharge planner (if applicable).
- The HCBS requested by the participant/caller.
- The participant's health conditions which necessitate the need for HCBS.
- Any informal supports currently providing assistance.
- Any identified safety concerns e.g., hazardous home conditions, dangerous animal or person, weapons, illegal drug activity, pest infestation, or a contagious or infectious disease.
- Any other pertinent information that would assist the assessor.
- Any paperwork sent to the participant (if applicable).
- Regional notification of the pending referral (if applicable).
- If ineligible for HCBS, document the Level of Care (LOC) not met and refer to Denials/Reductions/Closings guidance section of this Policy.

***Time Frame for Completion:*** Case Note documentation shall be entered upon completion of the PreScreen.

**Face-to-face assessment documentation includes, but is not limited to, the following:**

- 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.
  - If the participant is currently in a hospital, skilled nursing facility, or rehabilitation facility, include name of facility, reason for stay, date of admission, date of discharge (if known), and name and phone contact information for facility discharge planner (if applicable).
- The condition of the home.
- The participant's living arrangements. If other adults are living in the household, identify shared spaces and the other adults' abilities/responsibilities.
- Any formal (e.g., home health/hospice) and/or informal supports providing assistance and how the requested HCBS will be integrated with the supports.
- How the participant's health condition(s) necessitate the need for the HCBS requested by the participant.
  - At reassessment:
    - Review of the current care plan; and
    - Requested changes to the previous care plan and supporting details of the request.
- Explanation when task frequency deviates significantly from the suggested times and frequencies.
- If ineligible, document the HCBS requirement(s), e.g. LOC, unmet need, or Medicaid eligibility, not met. Refer to the Denials/Reductions/Closings guidance section.

- At initial assessment, participant's preferred provider and an alternate provider if their first choice is not able to staff their services. If the participant does not have a preferred provider, verify the list of provider choices was given or mailed at a later date to the participant.
  - At reassessment;
    - Document the participant's satisfaction of the current provider(s), or
    - Document the preferred provider when a change is requested.
- The contact with the provider regarding the (re)authorization, to include the specific provider staff name and phone contact number.
  - At reassessment, when a care plan change(s) is required, document the provider contact(s) to inform of the specifics change(s) and the effective date of the change(s).
- Any difficulties the participant has with signing the required forms and the associated accommodations made to facilitate the participant's understanding of the information.
- The participant's receipt of their care plan.
  - At initial assessment, document the forwarding of the Physician Notification.

***Time Frame for Completion for Initial Assessment:*** Case Note documentation shall be entered as soon as possible, but no later than ten (10) business days following the assessment or upon completion of the service authorization, whichever is sooner.

***Time Frame for Completion for Reassessment:*** Case Note documentation shall be entered as soon as possible, but no later than thirty (30) business days following the assessment or upon completion of the service authorization, whichever is sooner.

**Consumer Directed Services (CDS) Ability to Self-Direct documentation includes, but is not limited to, the following:**

- The participant's ability to communicate their needs and participate in the care planning process.
- Any issues/observations that cause concern about the participant's ability to self-direct, i.e. confusion regarding what tasks are to be completed, deferring to others present for answers, verifying the wages to be paid to the attendant, understanding Medicaid recertification paperwork, difficulty understanding how to read and complete a timesheet, etc.
- The appointment of a guardian or invoked DPOA.
- Documents obtained and / or contacts made that validate a participant's inability to self-direct, including summarization of the results of the St. Louis University Mental Status (SLUMS) exam (Policy 4.00, Appendix 8) and self-direction assessment questionnaire (Policy 4.00, Appendix 10).
  - If applicable, identify if another individual responds to the self-direction assessment questionnaire on behalf of the participant.
- Contacts with the participant's physician or other collateral contacts regarding their ability to self-direct, if applicable.
- Information given regarding the availability of other services when the participant is determined unable to self-direct.

***Time Frame for Completion:*** Case Note documentation shall be entered as soon as possible, but no later than ten (10) business days following the assessment or upon completion of the service authorization, whichever is sooner.

**10 Day Follow-up documentation includes, but is not limited to, the following:**

- Identity of the individual contacted. If not the participant, document the name, relationship to participant and phone number of the individual.
- Review of the care plan to ensure it is adequately meeting the participant's needs.
  - Requested changes to the care plan and the associated reasons.
- Receipt of authorized services.
  - If the participant is not receiving services, document all contacts with the provider to determine the reasons HCBS has not been initiated and the steps taken to ensure service delivery.

***Time Frame for Completion:*** Case Note documentation shall be entered upon completion of the contact.

**Care Plan Maintenance documentation includes, but is not limited to, the following:**

Typically, documentation for care plan maintenance requires a Case Note entry for the requests for change and another entry for the actual processing of the change. In some cases, both actions are completed at the same time and would require only one entry for documentation.

**Care Plan Change Request:**

- The form of the contact (phone call, fax, email,).
- The identity of the contact. If not the participant, document name, relationship to the participant, and phone number.
  - If there is a DPOA or guardianship relationship, ensure appropriate documentation has been uploaded to the HCBS Web Tool.
- The change(s) being requested, e.g. increase or decrease of service, new service type, or provider.
- The contributing factors to the change(s) being requested.
  - New health condition or change in status of an existing health condition.
  - Change in living arrangement.
  - Reason for requesting a new provider when related to future care planning need. HCBS provider complaint information shall not be documented within Case Notes, but rather, an appropriate referral made.
- If the participant is currently in a hospital, skilled nursing facility, or rehabilitation facility, include name of facility, reason for stay, date of admission, date of discharge (if known), and name and phone contact information for facility discharge planner (if applicable).
- Any formal (e.g., home health, hospice, etc.) and/or informal supports providing assistance and how the requested HCBS change will be integrated with the supports.
- If a specific provider is being requested, the provider name and phone contact information and any specific staff names, if available.

***Time Frame for Completion:*** Case Note documentation shall be entered within three (3) business days of the contact.

**Processing the Care Plan Change**

- The identity of the contact. If not the participant, document name, relationship to the participant and phone contact number.

- If there is a DPOA or guardianship relationship, ensure appropriate documentation has been uploaded to the HCBS Web Tool.
- Validate the information previously received in the care plan maintenance request:
  - Changes(s) being requested, e.g. increase/decrease of service, new service, or provider.
  - Contributing factors to the change(s) being requested.
    - Change in health condition, or status of condition.
    - Change in living arrangement.
  - Reason for requesting a new provider when related to future care planning need. HCBS provider complaint information shall not be documented within Case Notes, but staff shall indicate an appropriate referral was made.
  - Location of the participant.
  - Any formal (e.g., home health/hospice) and/or informal supports providing assistance and how the requested HCBS change will be integrated with the supports.
  - If a specific service provider is being requested, the provider name and phone contact information and any specific staff names, if the information is available.
- If a care plan change was made and the effective date.
- If the request was denied, refer to the Denials/Reductions/Closings guidance section.
- Explanation when task frequency deviates significantly from the suggested times and frequencies.
- Contact with provider(s) to include individual spoken with, review of the participant's needs and the care plan, and the start date of new care plan.
  - Contacts with each provider to coordinate services when there is a provider change.
- Any paperwork sent to the participant (if applicable).

**NOTE: Case Note documentation shall be entered within three (3) business days of the contact, or upon completion of the new authorization, whichever is sooner.**

**Provider Reassessment Reviews documentation includes, but is not limited to, the following:**

- The review of the InterRAI HC, HCBS-3, and Case Notes.
- Review of information to determine it appropriately supports the requested care plan.
- If ineligible, document the HCBS requirement(s), e.g. LOC, unmet need, or Medicaid eligibility, not met. Refer to the Denials/Reductions/Closings guidance section.
- Follow-up contact(s) with the provider and/or participant when information is incomplete.
- Notification of the approved care plan with the provider (including provider staff name and phone contact information) and participant.
- Paperwork sent to the participant (e.g., the new care plan and HCBS-3)
- Direction to the provider to provide a copy of any paperwork to the participant.

***Time Frame for Completion:* Case Note documentation shall be entered as soon as possible, but no later than the start date of the new Prior Authorization.**

**Provider Contacts documentation includes but is not limited to the following:**

- The name of provider, specific provider staff, and phone contact information.
- The issue discussed.



- The outcome of the contact.
- The need for follow up. If so, who will be following up and timeframe for completion.

***Time Frame for Completion:*** Case Note documentation shall be entered upon completion of the contact.

**Money Follows the Person Demonstration (MFP) documentation includes, but is not limited to, the following:**

- When the initial referral was received and from whom.
- If the participant is currently in a hospital, skilled nursing facility, or rehabilitation facility, include name of facility, reason for stay, date of admission, date of discharge (if known), and name and phone contact information for facility discharge planner (if applicable).
- Whether the participant meets all criteria for participation in the MFP Demonstration, and if applicable, documentation that the MFP Approval Notice (Policy 7.00, Appendix 6) has been uploaded to the HCBS Web Tool.
- Which MFP Contractor the participant chose as their Transition Coordinator (TC).
- The participant's proposed living arrangements if able to transition to the community, including other household members and shared spaces.
- If there is a DPOA or guardianship relationship, ensure appropriate documentation has been uploaded to the HCBS Web Tool.
- Completion of the MFP Referral Assessment (Policy 7.00, Appendix 3) for participants that do not need HCBS.

***Time Frame for Completion:*** Case Note documentation will require multiple entries. Each action within the process shall be entered as soon as possible, but no later than ten (10) business days after the contact was made or information received.

**Denials/Reductions/Closings documentation includes, but is not limited to, the following:**

- The reasons the service/task/request was denied, reduced, or closed. The reason should be supported by the citation contained on the HCBS-12.
  - LOC: Describe InterRAI HC responses and other observations in relation to each of the nine categories in the LOC policy.
  - Ability to Self-Direct: Describe the inability to self-direct, referencing information gathered during the completion of the InterRAI HC, SLUMS, self-direction assessment questions and related contacts.
  - Service reduction: The reasons why the service/task is being reduced.
- Contact and discussion with the participant and/or authorized representative, including whether or not the participant is in agreement with the action.
- The participant's understanding that a HCBS-12 or HCBS-12m will be mailed and their right to appeal, if applicable. Date the HCBS-12 or HCBS-12m is mailed.
- Any changes made to the care plan including contacts to the participant and the appropriate provider.

***Time Frame for Completion:*** Case Note documentation shall be entered upon completion of each action.

**Adverse Actions/Hearing Requests/Hearing Proceedings documentation includes but is not limited to the following:**

- How the hearing request was received from the participant (through mail, telephone, or in person).
- Follow-up with participant for any additional pertinent information that would affect the adverse action.
- If the request was received within the appropriate time frame.
- Discussion with the participant regarding the appeal process, including whether or not the participant wants to maintain level of services, if applicable.
- Date the HCBS-12a is forwarded to the Adult Protective and Community Supervisor (APCS), and supervisory review of the HCBS-12a
- Description of the information and documents, and date sent to the Division of Legal Services (DLS) and the participant.
- Date of receipt of Notice of Administrative Hearing.
- Date of receipt of the Final Decision and Order.

***Time Frame for Completion:*** Case Note documentation will require multiple entries. Each action within the process shall be entered as soon as possible, but no later than ten (10) business days after the contact was made or information received.