California Department of AGING

CBAS Documentation Challenges: How to Avoid Plans of Correction

Presented by:
Leigh Witzke, CBAS Nursing Operations Bureau Chief
Julia Smith, CBAS Field Operations Manager
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Agenda

- CBAS documentation responsibilities Understanding the fundamental role of documentation
- Interconnectedness of documentation flow in the health record
- Most frequently cited documentation challenges in the Health Record
- Best practices through documentation systems
- Q & A throughout

Documentation: The Key to Success

- Documentation is imperative for any organization or project, regardless of size or industry. It helps teams stay organized and on track by providing a clear understanding of process requirements, progress, and any potential problems.
- Proper documentation can help ensure that centers meet regulatory requirements and avoid the process of responding to plans of correction and improve participant outcomes

The benefits of meaningful documentation:

- Improves quality process and control
- Eliminates duplicate work
- Streamlines hiring and onboarding processes
- Keeps teams on the same page
- Improves training resources
- Meets compliance regulations
- Saves teams time and energy
- Improves job satisfaction and performance

Documentation: The Key to Success

- **Good documentation is critical for operational success**

Documenting processes and procedures enables teams to work together more efficiently, eliminating the need for backtracking and ensuring everyone is aligned.

Without proper documentation, vagueness and omissions can occur, leading to miscommunication, duplicated work, lost purpose and poor outcomes- something that no center, no matter how successful, can afford to experience.

Most relatable, is that lack of proper documentation is the leading contributor to centers having to respond to plans of correction.

Importance of Documentation

Documentation helps us:

1. Remember what we did. As our processes evolve, it's easy to forget the details of *how the participant has progressed over time*. By documenting these things, we have a written record of data to which we can refer

2. Communicate with others. Documenting our work forces us to articulate our thoughts in a way that others can easily understand. This is important when we need to share our work with others, whether team members, reviewers, or anyone taking our place

3. Improve our work. By documenting our work, we can step back and take a bird's eye view of what has transpired. This can help us identify areas needing revision and make changes accordingly.

Despite these good reasons for documentation, it remains one of the most frequent reasons a plan of correction is required

Documentation Culture

California Department of AGING

The Administrator and Program Director are responsible to:

Make documentation a priority, by making it a part of center culture. Treating it like any other deliverable: planned, budgeted for, and reviewed as part of your team's quality assurance efforts.

Ensure the MDT providing services has time outside of service hours to document observations and responses to intervention provided in the participant health record, including liaison responsibilities, in addition to completing meaningful evaluations for reassessments scheduled for the month.

Ensure the MDT providing services understands they are the owners and stewards of telling the participants story and the reasons why meaningful documentation is important.

CBAS Scope of Required Documentation

- **Centers are required to document:**

Personnel records, staff training records, staff time schedule, consultant logs, financial and accounting records, plan of operation, disaster plan, fire drills, Incident Reports, Participant Characteristic Reports, MSSRs, Staffing services arrangement form, admission process and discharge reports, policies and procedures, transportation records, attendance and billing records, solid waste storage and disposal records, medication storage and disposal records, pharmacy consultation records, person centered service plan, grievance log, demographic report, plan for meeting nutritional requirements, food safety/temperature logs, menu plans, food purchases, activities schedule, quarterly utilization review, therapy and consultant hours, and more!

Health Record Documentation Requirements

- **Documentation must include:**
  - ✓ All required core services provided each day of attendance
  - ✓ Services provided as scheduled on IPC
  - ✓ Documentation of services completed, signed and dated on day service provided
  - ✓ Documentation sufficient to demonstrate service was provided, including the specific service provided and the result (i.e., participant response, status, outcome)
  - ✓ Documentation must be legible, and amendments must comply with requirements

Daily documentation format can be flow sheets, progress notes, or both!

- Documentation Requirements (54425, 54313, 54315, 54323, 54329, 54339, WIC 14530)

Correcting Documentation in the Health Record Errors or Omissions

- The most critical advice in documentation is that there should never be an attempt to change an existing record. Should a particular record entry need changing for accuracy purposes, to align with the facts, or to correct an accidental notation in the wrong chart or record, the key principle to remember is the principle of transparency.
- Transparency refers to the quality of documentation whereby the original and the correction or addition are both clearly marked so that viewers know when the original was written and when corrections or additions were made. No attempt is made to mislead the reader or to "fudge" the record content.
- **Do** use a single line to draw through the incorrect information. The person making the correction, should sign, date and time the correction.
- **Do** avoid use of correction fluid or obliterating the original entry.
- **Do** use late entry documentation to correct omissions. Write "late entry and date" followed by documentation of missing information and signature.
- **Do** include Health Record Documentation in your annual training requirements

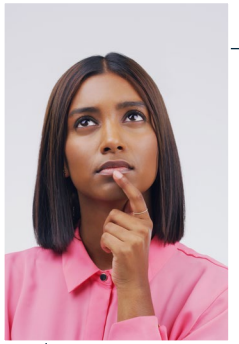
Questions?

The Participant Health Record

- The Participant's story is a tapestry. It begins upon admission to the program and is woven through the **sustained assessment process.** The daily documentation of services and outcomes, using progress notes and flow sheets are the threads that inform the assessment and care planning process. The professional observations and assessments used to identify the person-centered needs of the individual are stitched together to tell their unique story.

Health Record Documentation Requires:

Systems: **creating documentation practices that are consistent, efficient, proven, successful, repeatable and meet regulatory requirements**

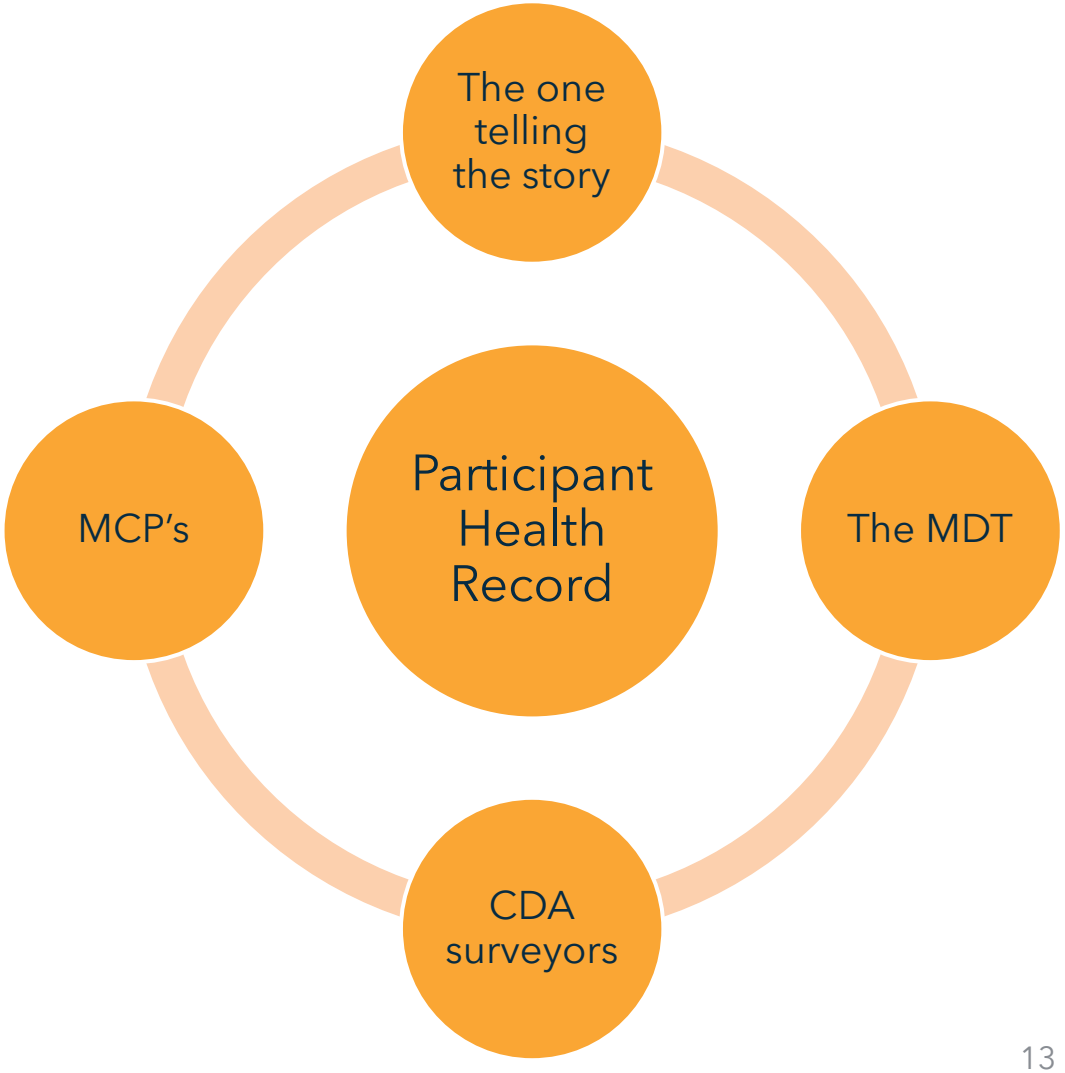


Understanding the why: **understanding the concepts of CBAS health record documentation flow**

Time: **Documentation requirements in the CBAS program takes a major chunk of staff time and energy and is an area of frustration often reported**

Participant Health Record

- The Participant Health Record tells the story
- To the one documenting the story
- To the Multidisciplinary Team
- To the Managed Care Plan Partners
- To the CDA Survey Team



Daily Documentation: The Sustained Assessment

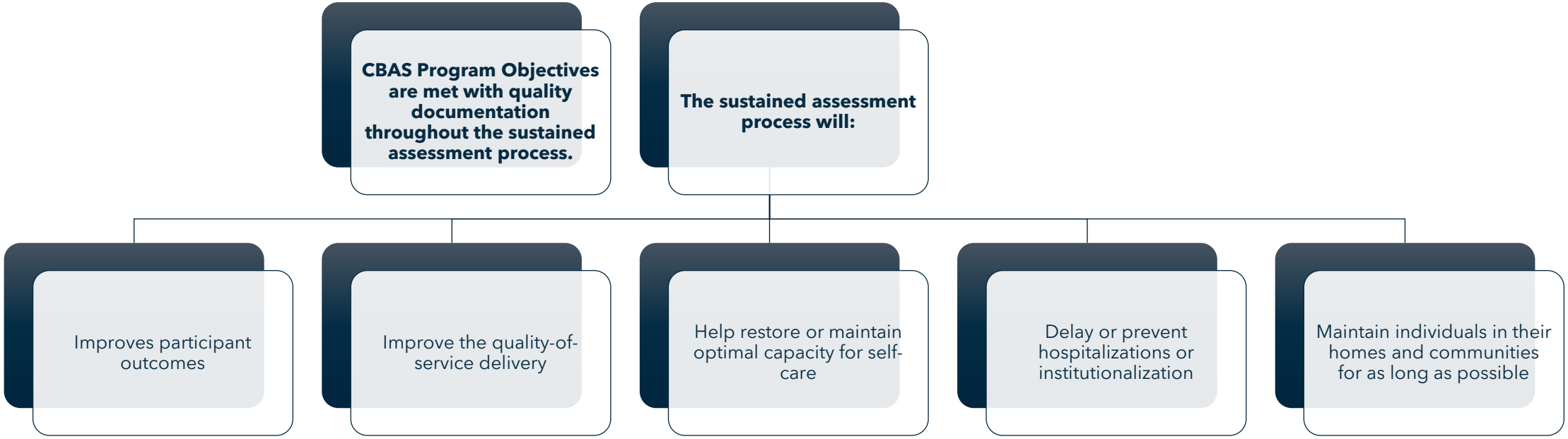
- Identifies the presenting problem, the incidentals along the way, and the interventions received
- Helps to plan and evaluate a participant's interventions
- Creates a permanent record for the participant's future care

THE PURPOSE OF DOCUMENTATION AND MONITORING IS TO TRACK THE PARTICIPANTS PROGRESS OVER TIME AND PLAN THEIR CARE ACCORDINGLY

THE HEALTH RECORD PROVIDES THE ONLY ENDURING VERSION OF THE PARTICIPANTS STATUS AND NEEDS AS IT EVOLVES OVER TIME

WRITING MORE IS NOT THE SOLUTION; SIMPLY WRITING WITH GREATER EFFICIENCY WILL CUT DOWN ON TIME SPENT IN DOCUMENTATION

Meeting the CBAS Program Objectives



CBAS Documentation Flow

Initial Assessment: gathering knowledge based on individualized needs related to how their health conditions and psychosocial status affects them

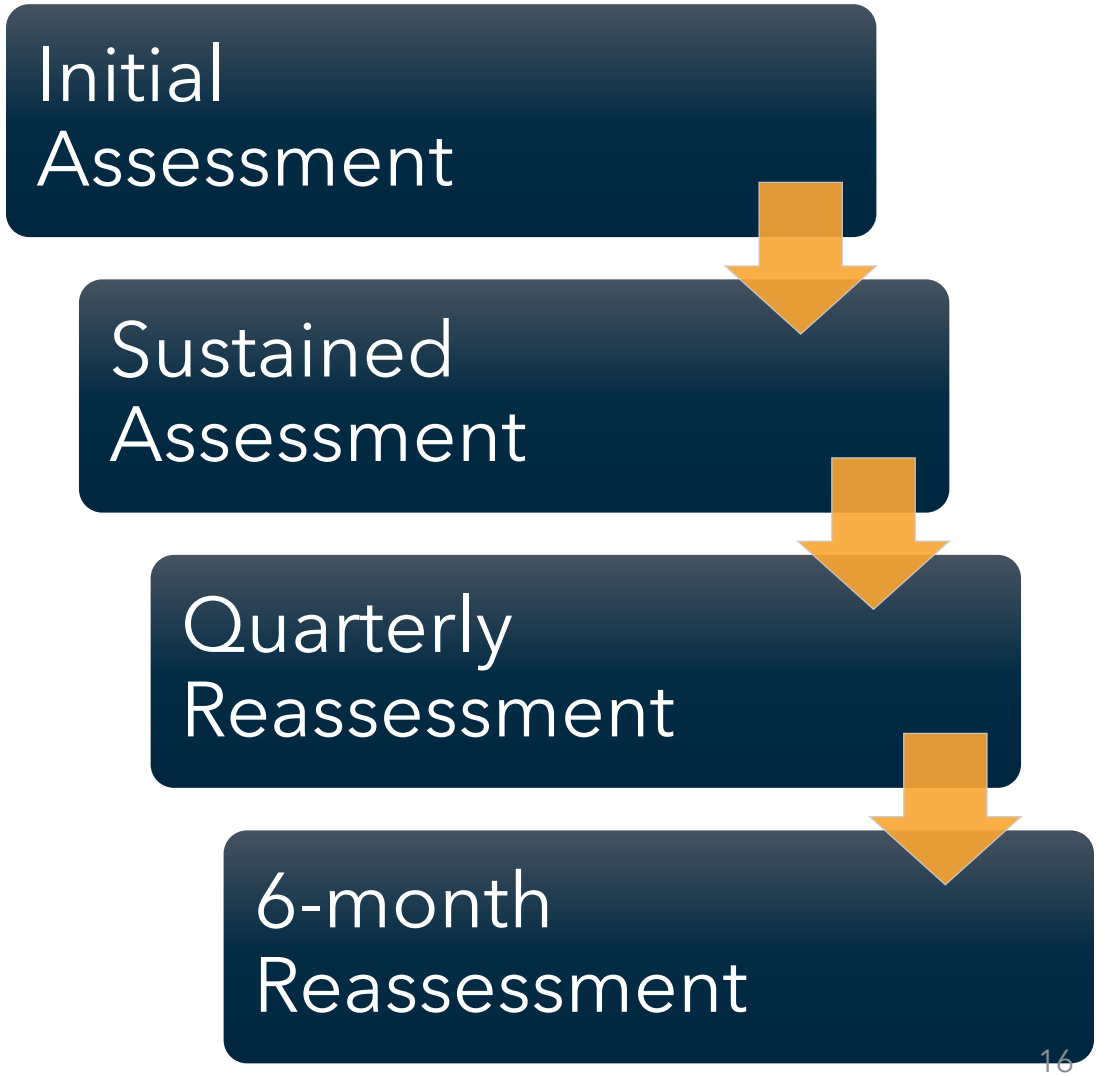
IPC

Sustained Assessment: daily assessment outcomes and observations documented over time (flow sheets, progress notes)

Reassessment: Based on mean data gathered from sustained assessments. Data used to develop baselines and informs the evaluation of goals

IPC

Sustained Assessment ….



First Place Winner in The CBAS Documentation Challenge

Title 22, CCR, Section 54425(a)(4)

- **Participant Records**

- **PARTICIPANT RECORDS**

(a) Each center shall maintain a complete health record for each participant in the program in the format established by the Department. Each medical record shall include, but is not limited to:
(4) Daily records of participant's attendance and services utilized, including transportation.

- Insufficient documentation or '**check mark charting'** is one of the biggest challenges around documentation in the Health Record and is one of the most common citations written.
- The documentation does not provide enough information to demonstrate that services were provided and/or provide significant information about the participant's status or response to the intervention.
- The documentation does not give any indication of the participant's status or response to the intervention as it relates to the objective/goal of the intervention

How to Avoid Check Mark Charting: The IPC Care Plan

1

Do address the individualized measurable needs/problems of the person, not the diagnosis, but ***how*** the condition impacts the person. What do they need as a result?

2

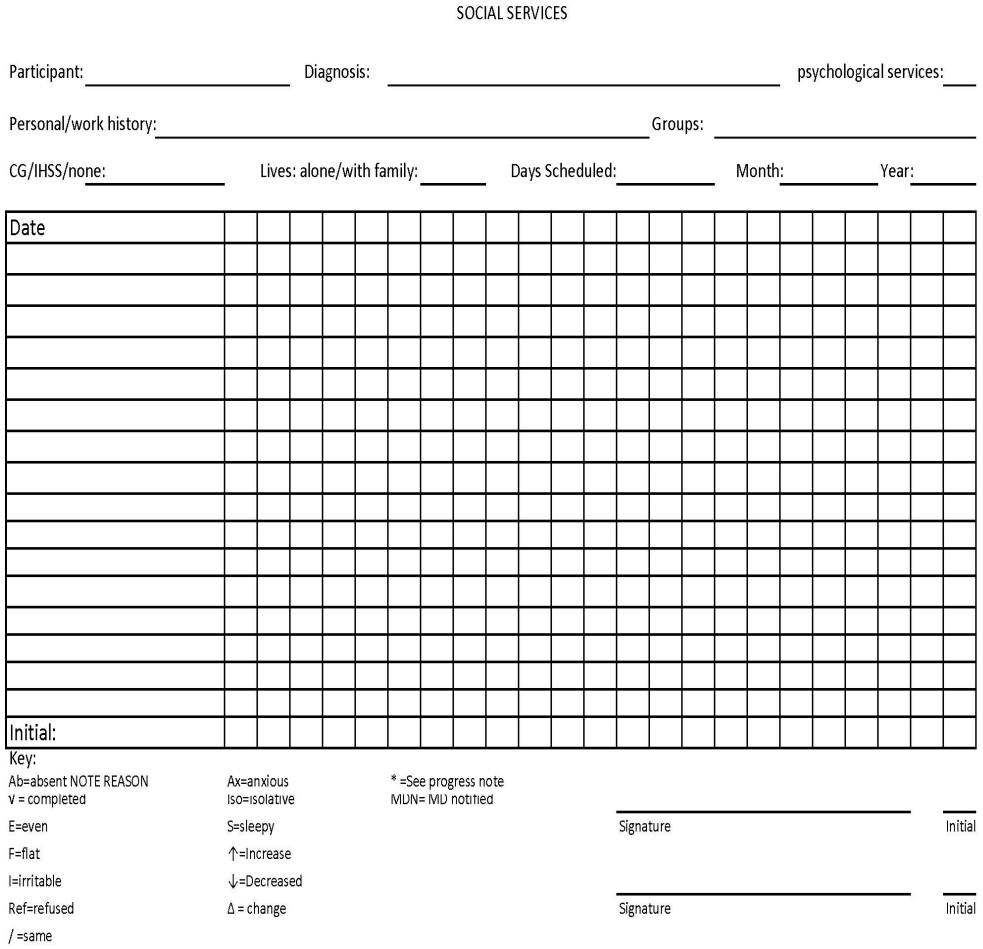
Do include interventions that will resolve or mitigate the needs/problems ***and*** include actions taken in the event they occur

3

Do ensure the goal relates to the needs/problems of the individual, can be measured by documentation, and is attainable

How to Avoid Check Mark Charting: The Flow Sheet

- **Do** start with the reason (Goals) you are providing the intervention
- **Do** conceptualize what outcomes you will need to document to evaluate if the goal is met or not
- **Do** document the observations and outcomes that provide the data to establish baseline measurements that will inform the evaluation of the goals during the reassessment process
- **Do** document by exception



SOCIAL SERVICES

Participant: _____ Diagnosis: _____ psychological services: ___

Personal/work history: _____ Groups: _____

CG/IHSS/none: _____ Lives: alone/with family: _____ Days Scheduled: _____ Month: _____ Year: _____

Date																							
Initial:																							

Key:

Ab=absent NOTE REASON
v = completed
E=even
F=flat
I=irritable
Ref=refused
/ =same

Ax=anxious
Iso=isolative
S=sleepy
↑=Increase
↓=Decreased
Δ = change

* =See progress note
MDN= MD notified

_____ ___
Signature Initial

_____ ___
Signature Initial

Charting by Exception:

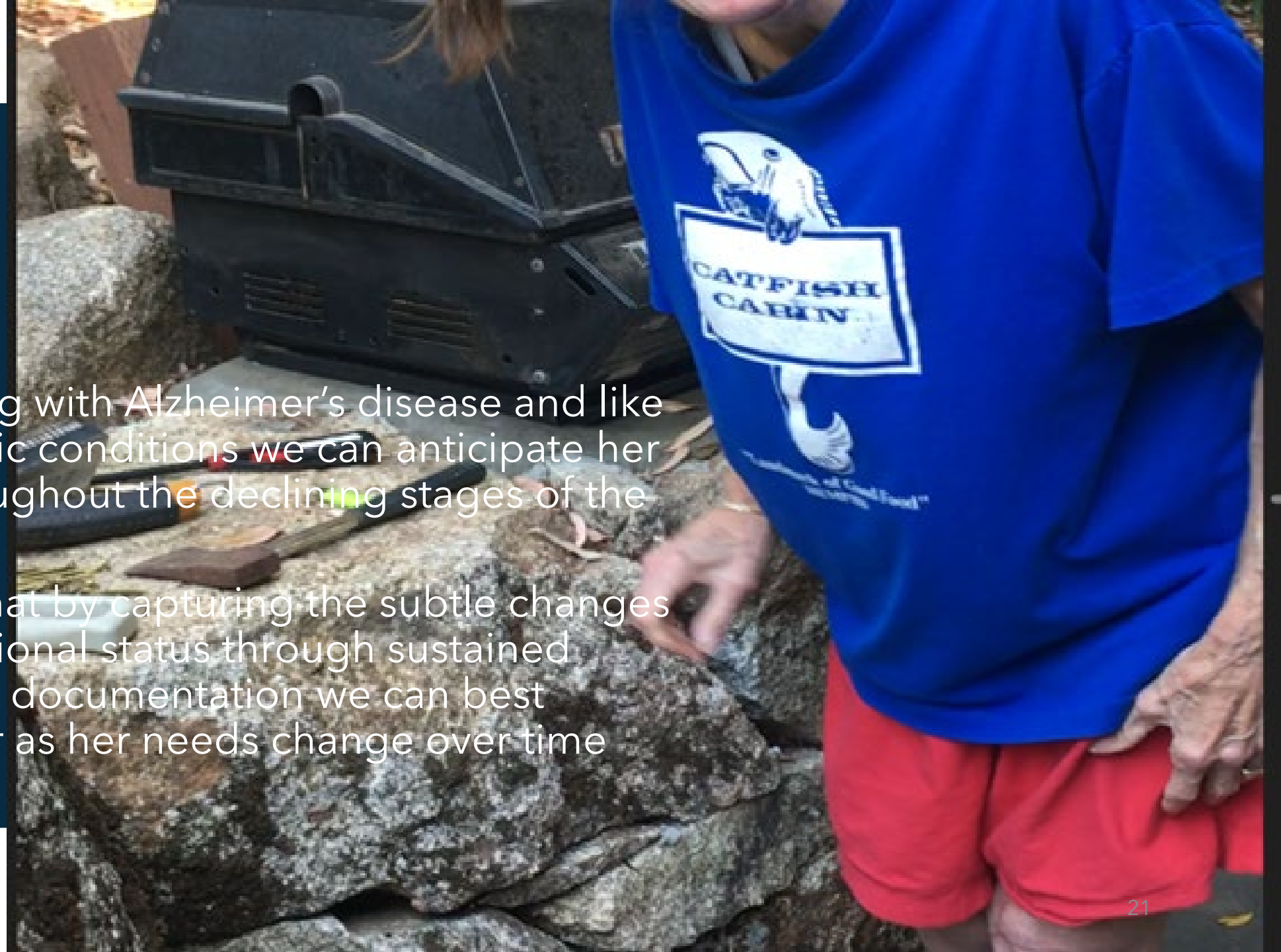
- A method of charting designed to minimize time spent documenting
- An additional notation is made **only** when there is a deviation from the established baseline or expected outcome
- Based on data and only works when properly carried out
- Progress note may need to be written when outcome is outside established baseline or there are new symptoms, medications, situations, or hospitalizations

Using individualized established baselines:

√ = Cue for BR 2x/d note incont episodes
√ = even mood
√ = Non-reality-based thinking 70% of day
√ = No observable s/s hyper/hypo glycemia

Julie

- Julie is living with Alzheimer's disease and like most chronic conditions we can anticipate her needs throughout the declining stages of the disease
- We know that by capturing the subtle changes in her functional status through sustained assessment documentation we can best support her as her needs change over time



The Care Plan: Need/Problem

IPC Documentation Problem Statement Requirements

The need/problem is identified in collaboration with the participant during the assessment process **and** anytime there is a change requiring interventions

Describes the symptom or demonstrated behavior not the diagnosis

Is related to the diagnosis or condition and describes how it affects their life situation

Must have a measurable starting point such as how often, how severe, the degree of impact, percent of time, level or range

IPC Documentation Example: Problem Statement

- Julie is independent with toileting tasks however she needs supervision 100% of time to ensure she finds the bathroom, accomplishes tasks, including hand washing, and can find her seat upon return from bathroom due to predictable decline of Alzheimer's disease, At risk for decline in functional abilities.

The Care Plan: Addressing the needs

Documentation of Interventions and Treatments

- The treatment/intervention/action plan provides a means to resolve or mitigate the need or problem
- Must reflect the assessments
- Must be related to the problem
- Must be practical to provide in the CBAS setting
- Must address the specific need of the individual not anyone with the diagnosis or condition
- Must include the estimated frequency needed to reach the goal

IPC Documentation Example: Interventions

- Provide Julie with cue and supervision for toileting (visit to the spa) every 2-3 hours between planned activities QD of attendance
- Observe and document any changes in functional status/assist with incont episodes QD of attendance
- Escort back to seat and introduce next activity QD.

The Care Plan: Expected Outcomes

Goal of the Treatment/Interventions

Must reflect the assessment, the health record, and the desired outcomes expressed by the participant and/or caregiver

Must be logical and relate to the problem and the intervention

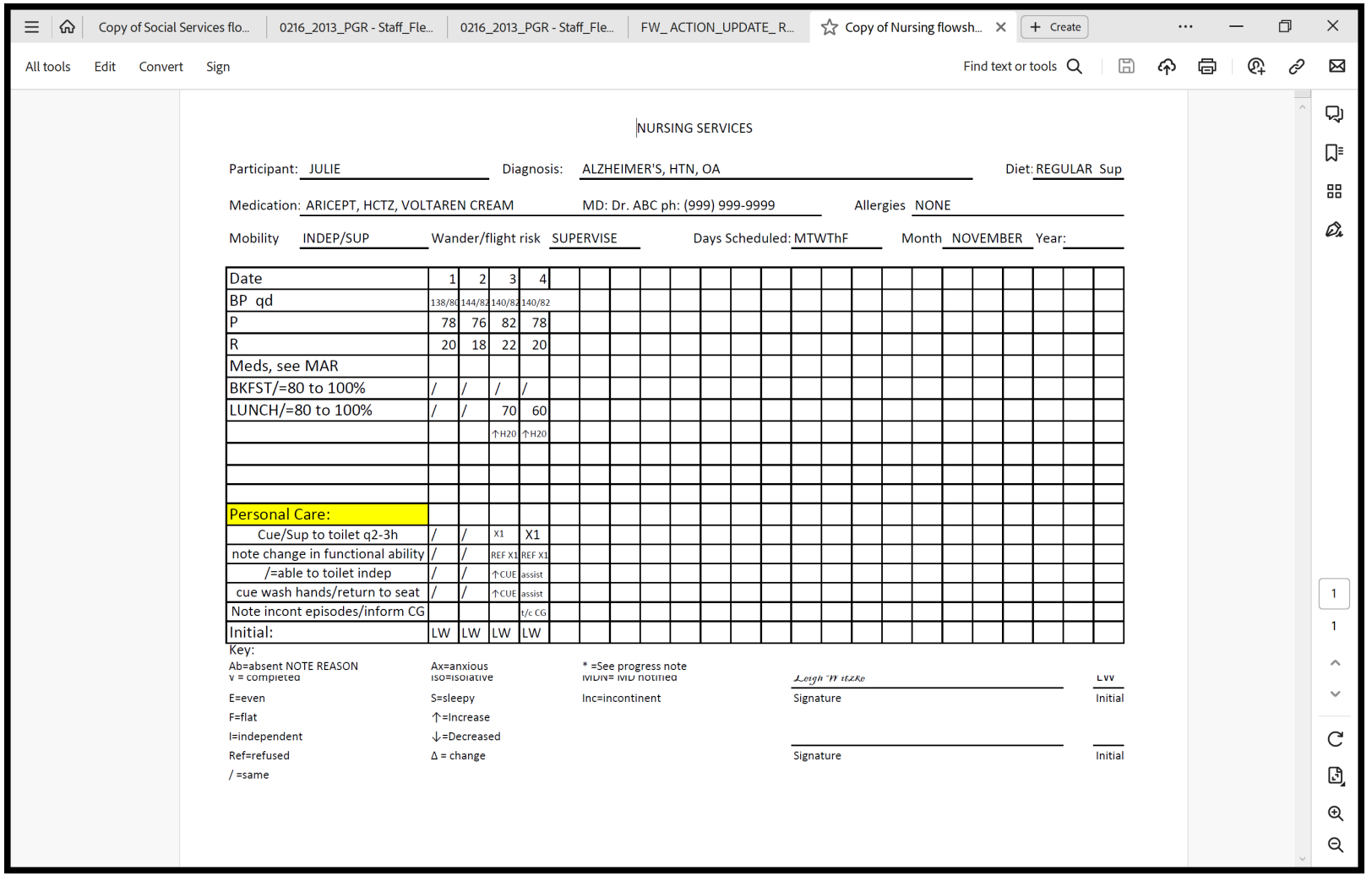
Must be attainable

Must be trackable and measurable

IPC Documentation Example: Goal

- Julie will have prompt attention for changes in functional status and needs as they occur
- Julie will avoid incontinent episodes and maintain hygeine 100% of time

Julie's Flow Sheet



NURSING SERVICES

Participant: JULIE Diagnosis: ALZHEIMER'S, HTN, OA Diet: REGULAR Sup

Medication: ARICEPT, HCTZ, VOLTAREN CREAM MD: Dr. ABC ph: (999) 999-9999 Allergies NONE

Mobility INDEP/SUP Wander/flight risk SUPERVISE Days Scheduled: MTWThF Month NOVEMBER Year:

Date	1	2	3	4
BP qd	138/80	144/82	140/82	140/82
P	78	76	82	78
R	20	18	22	20
Meds, see MAR				
BKFST/=80 to 100%	/	/	/	/
LUNCH/=80 to 100%	/	/	70	60
			↑H20	↑H20
Personal Care:				
Cue/Sup to toilet q2-3h	/	/	X1	X1
note change in functional ability	/	/	REF X1	REF X1
/=able to toilet indep	/	/	↑CUE	assist
cue wash hands/return to seat	/	/	↑CUE	assist
Note incont episodes/inform CG				t/c CG
Initial:	LW	LW	LW	LW

Key:

Ab=absent NOTE REASON
v = completed
E=even
F=flat
I=independent
Ref=refused
/ =same

Ax=anxious
Iso=isolative
S=sleepy
↑=Increase
↓=Decreased
Δ = change

* =See progress note
MDN= MD notified
Inc=incontinent

Leigh Witzke
Signature
LW
Initial

Signature
Initial

Avoid Check Mark Charting: The Flow Sheet

- **IPC Social Services need/problem:**

  Ptp unable to sit still and remain calm when anxious. Tends to self isolate and avoid interactions during episodes

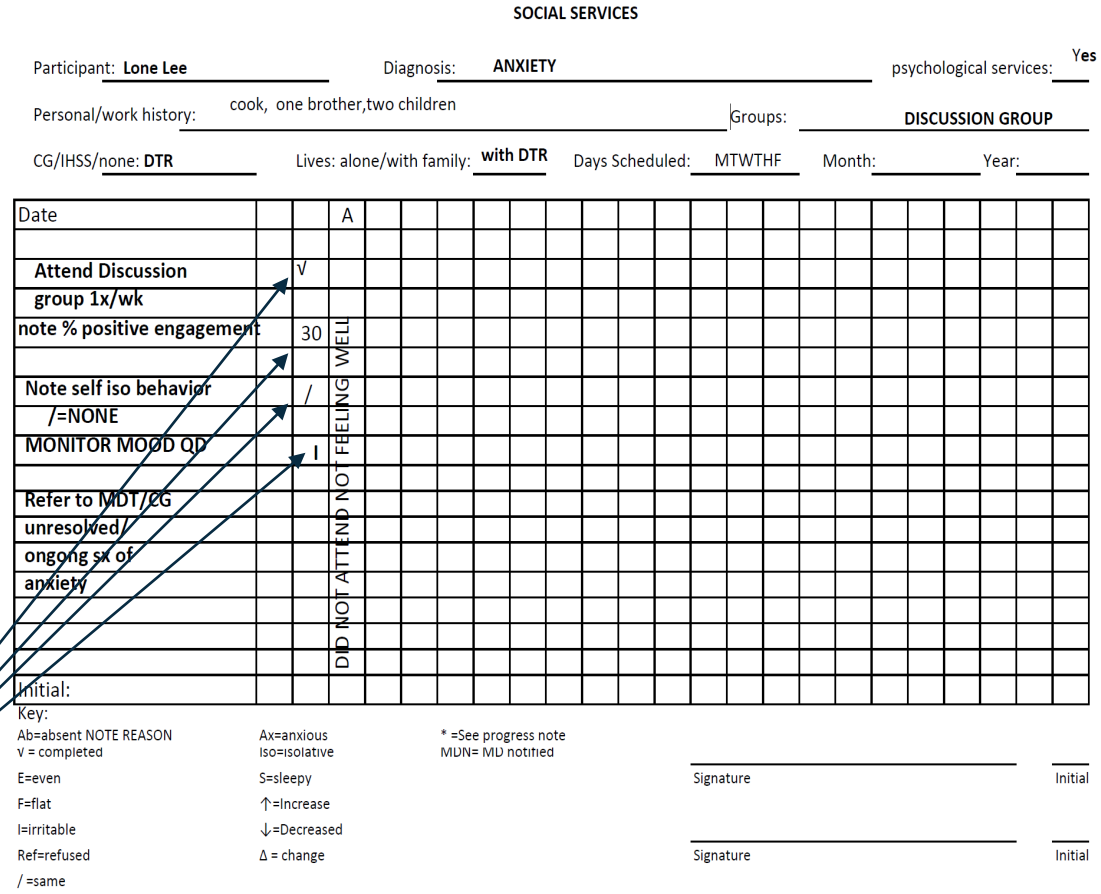
- **Interventions:**

  Social Work Group: Discussion group 1x/wk. Daily monitoring for engagement vs isolative behaviors. Provide structure and routine. Provide 1:1 during episodes of anxiety and note severity and resolve. Liaison with CG, PHCP, Psychiatrist and MDT for unresolved or persistent episodes

- **Goal:**

  Will have prompt attention for symptoms of anxiety. Attend all discussion groups. Engage in positive interactions and avoid isolative behaviors 100% of time.

- **Outcomes the documentation needs to show to measure progress toward the goal**



SOCIAL SERVICES

Participant: Lone Lee Diagnosis: ANXIETY psychological services: Yes

Personal/work history: cook, one brother,two children Groups: DISCUSSION GROUP

CG/IHSS/none: DTR Lives: alone/with family: with DTR Days Scheduled: MTWTHF Month: Year:

Date			A
Attend Discussion group 1x/wk	√		
note % positive engagement	30		
Note self iso behavior /=NONE	/		
MONITOR MOOD QD	I		
Refer to MDT/CG unresolved/ ongong sx of anxiety			
			DID NOT ATTEND NOT FEELING WELL
Initial:			

Key:

Ab=absent NOTE REASON
√ = completed
E=even
F=flat
I=irritable
Ref=refused
/ =same

Ax=anxious
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Signature Initial

Signature Initial

IPC Goal: Changes in mood caused by sadness will be monitored and treated. Will report sadness less than 1x/wk

IPC Goal: Any change in the degree of cognitive functioning will be addressed while the Pt. receives monitoring.

SOCIAL WORKER PROGRESS NOTES

Date	December 2022
12/7	Patient was educated on coping skills to deal with low mood or depression. Patient has no dx. of depression.
12/19	Patient is encouraged to participate in puzzles and word searches provided by the Center.

SOCIAL WORKFLOW SHEET

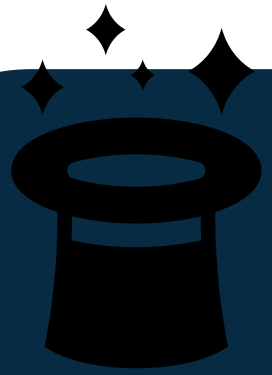
Month: December 2022	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Mode of Contact: P=Phone, C=Center		C					C						C						C	
Cognitive enhancing activities/education for memory Dx/and/or decline		EN					EN						EN						PN	
Educate/Teach coping skills for dx of depression/and/or sadness/low mood		P					PN						ONS						OI	
Educate/Teach coping skills of anxiety/anxious feelings or worries																				
Isolation/loneliness/ withdrawn																				
Community Resources																				
Initials																				

Observed Monitoring of Mood: OS, Observed Sadness; OT= Observed tearful beh.; OS= Socializing,; OC= Observed Compliance; OA= Observed agitation/anx.; OB= Observed beh. communication; OI = Observed Involved; ONCS= Observed Neg. Coping Skills; OO= Observed other (no OSP= Observed Symptoms Present; T =Treated (NOTE); ONS= Observed No Sympt. Present; OI= Isolating self

Verbal Report of Mood: VS= Sadness/Depression, VT= Verbalized tearfulness; VH = Verbalized Happiness; VA= Verbalized anxiety/nervousness; VNCB= Verbalized Negative Coping; VPC= Verbalized Positive Coping; VL = Verbalized loneliness.

Treatment(s) Provided: PF= Positive Feedback, EN= Encouraged; P= Praised, AL= Active Listening; VF= Venting of Feelings, ES=Emotional support; RF= Reinforced; CM = Case Management; RM= Remove; D= Distract; RD= Redirect; SU= Support; PN= See Progress Notes; G= Group

Reaction to Treatment/Intervention: E= Engaged; R= Refused, AI = Active Involvement, PI= Passive Involvement



The Magic of Flowsheets

SOCIAL SERVICES

Participant: Lone Lee Diagnosis: Schizophrenia psychological services: Yes

Personal/work history: cook, janitor , lives in B & C, one brother Groups: social skills and relationships

CG/IHSS/none: none Lives: alone/with family: B & C Days Scheduled: MTWTHF Month: Year:

Date			A																						
Attend social skills		√	*																						
group 3x/wk																									
note % positive engagement		30																							
Note % self isolative		NC																							
behaviors/eye contact																									
baseline=70 %/d																									
# cues for		5*																							
engagement																									
or redirection.																									
baseline=1-2x/d																									
MONITOR MOOD QD		I																							
Initial:																									

* fight w/ roommate did not want to attend

Key:

Ab=absent NOTE REASON
V = completed
E=even
F=flat
I=irritable
Ref=refused
/ =same

Ax=anxious
Iso=isolative
S=sleepy
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Δ = change

* =See progress note
MDN= MD notified

Signature Initial

Signature Initial

Questions?

Second Place Winner in The CBAS Documentation Challenge

- **W&I Code, Section 14529(d)(1)(3)**
- **Multidisciplinary Health Team-Complete Reassessments**
- (d)The assessment team shall:
- (1)Determine the medical, psychosocial, and functional status of each participant.
- (3)At least biannually reassess the participant's individualized plan of care and make any necessary adjustments to the plan
- The multidisciplinary team (MDT) failed to ensure that reassessments included information regarding the participant's medical, psychosocial, and/or functional status and needs so that necessary adjustments could be made to the IPCs
- Failed to Address Progress or Indicate Whether the IPC Needed Revision
- Failed to Establish Current Medical, Psychosocial, or Functional status
- Inconsistent MDT Reassessments

Documentation Challenge #2 Reassessment

- **Documentation must include:**

✓ Medical, psychosocial, functional status: consistent across MDT

✓ Progress achieved on previous IPC goals: supported by sustained assessment data

✓ New or significant changes in condition identified in lookback review

✓ Evidence consistent with the determination of the goal met or not met

✓ Documentation stating the IPC will be revised or continued as written

Reassessments must be supported by/consistent with documentation in the flowsheets/progress notes for the prior three and six months

Reassessments fail to include changes in current status

Need for reassessment of current status may occur at any time and may require:

- MDT collaboration
- Monitoring and action plans
- An update to the care plan
- An update to the flow sheet interventions
- Liaison with family/home
- Liaison with Physician

Documentation may be in a progress note if it is not a scheduled assessment time

Reassessment For a Change in Status: Hospitalizations

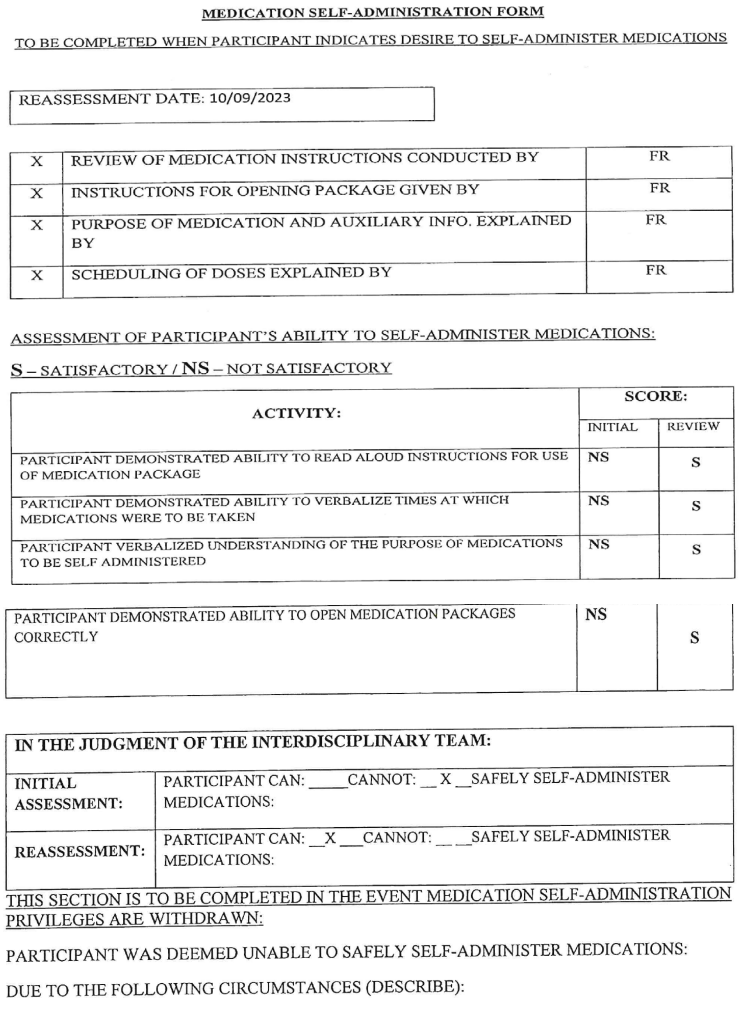
- **W&I Code, Section 14529(d)(1)(3)**

(d)The assessment team shall:
(1)Determine the medical, psychosocial, and functional status of each participant.
(3)At least biannually reassess the participant's individualized plan of care and make any necessary adjustments to the plan.

- **Prior to resuming services:**
- **Do obtain physician approval to resume services noting any restrictions**
- **Do assess the participants current status and amend interventions on flow sheet**
- **Do ensure all staff is aware of any new conditions or restrictions**
- **Do ensure the Hospitalization is documented on the upcoming IPC**

Documentation Challenge #2 Reassessment

Reassessment for Functional Status and Needs: Medication Self Administration



MEDICATION SELF-ADMINISTRATION FORM

TO BE COMPLETED WHEN PARTICIPANT INDICATES DESIRE TO SELF-ADMINISTER MEDICATIONS

REASSESSMENT DATE: 10/09/2023

X	REVIEW OF MEDICATION INSTRUCTIONS CONDUCTED BY	FR
X	INSTRUCTIONS FOR OPENING PACKAGE GIVEN BY	FR
X	PURPOSE OF MEDICATION AND AUXILIARY INFO. EXPLAINED BY	FR
X	SCHEDULING OF DOSES EXPLAINED BY	FR

ASSESSMENT OF PARTICIPANT'S ABILITY TO SELF-ADMINISTER MEDICATIONS:

S – SATISFACTORY / NS – NOT SATISFACTORY

ACTIVITY:	SCORE: INITIAL	SCORE: REVIEW
PARTICIPANT DEMONSTRATED ABILITY TO READ ALOUD INSTRUCTIONS FOR USE OF MEDICATION PACKAGE	NS	S
PARTICIPANT DEMONSTRATED ABILITY TO VERBALIZE TIMES AT WHICH MEDICATIONS WERE TO BE TAKEN	NS	S
PARTICIPANT VERBALIZED UNDERSTANDING OF THE PURPOSE OF MEDICATIONS TO BE SELF ADMINISTERED	NS	S
PARTICIPANT DEMONSTRATED ABILITY TO OPEN MEDICATION PACKAGES CORRECTLY	NS	S

IN THE JUDGMENT OF THE INTERDISCIPLINARY TEAM:	
INITIAL ASSESSMENT:	PARTICIPANT CAN: ____CANNOT: __ X __SAFELY SELF-ADMINISTER MEDICATIONS:
REASSESSMENT:	PARTICIPANT CAN: __X __CANNOT: __ __SAFELY SELF-ADMINISTER MEDICATIONS:

THIS SECTION IS TO BE COMPLETED IN THE EVENT MEDICATION SELF-ADMINISTRATION PRIVILEGES ARE WITHDRAWN:

PARTICIPANT WAS DEEMED UNABLE TO SAFELY SELF-ADMINISTER MEDICATIONS:

DUE TO THE FOLLOWING CIRCUMSTANCES (DESCRIBE):

Every six months and as needed

- **Do** use an industry standard tool
- **Do** liaison with family and home for changes in functional status
- **Do** ensure MDT assessments align with determination
- **Do** save time if the participant is already determined to need medications administered by others

Questions?

Third Place Winner in The CBAS Documentation Challenge

- **W&I Code, Section 14529(d)(2) Multidisciplinary Health Team**
- **(d) the assessment team shall**
- **(2) Develop an individualized plan of care, including goals, objectives and services designed to meet the needs of the person…**

- Problems in the assessment or the health record were not addressed in the IPC
- IPC Problem statements/Interventions are not supported by assessed need and/or the health record
- IPC Problem statements and goals are not measurable or attainable
- Interventions do not mitigate or resolve the problem/need they are addressing
- IPC care plan is illogical, problem and goal do not relate, or no goal is identified

IPC Need/Problem Documentation

The IPC must be individualized and person-centered, reflecting how the condition affects their life situation and how the needs, interventions, and goals address their needs and preferences to avoid a "cookie cutter" approach to care planning as seen in canned care plans

IPC Need/Problem Documentation

Ask yourself this question……

What does this person need from your program as opposed to others with diabetes or hypertension who do not need CBAS services?

The Need/Problem Must:

- Describe the symptom or demonstrated behavior but is not the diagnosis.
- Relate to the medical or mental health diagnosis or condition.
- Be amenable to intervention(s) available at the CBAS center.
- Be specific to the individual (not a group or classification of recipients; e.g., recipients with a history of falls or all recipients with diabetes)
- Provide a measurable starting point, current status from which to measure change
- Specify ONE need/problem at a time, not the additional and lengthy assessment information

IPC Documentation:
Treatments & Interventions to Address the Need/Problem

Ask yourself this question....

How will these interventions and treatments help resolve the problem or how will they keep the problem from getting worse, and what actions will we be providing in the event it does?

The Treatment or Intervention must:

Be	Be the prescribed, proposed and/or recommended means of resolving or mitigating the recipient need/problem. The intervention may reflect how the recipient, family and/or caregiver(s) will be engaged in the recipient's care.
Reflect	Reflect both the assessment completed by the recipient's personal health care provider(s) (or the CBAS center physician) and the assessment completed by the MDT.
Be	Be related to the need/problem.
Be	Be practical for implementation in the CBAS center setting.
Be	Be specific to the individual recipient (not a group or classification of recipients).
Include	Include whether the treatment/intervention is individual or taking place within a group and any out-of-center activities.
Indicate	Indicate the specific type, frequency, duration of the treatment/intervention.

IPC Documentation:
Treatments & Interventions to Address the Need/Problem

Ask yourself this question....

How will I measure this goal, and what information will I need to know if it is met or not?

The Treatment or Intervention must:

Reflect	Reflect the assessment done by the personal health care provider
Reflect	Reflect the assessment done by the MDT
Reflect	Reflect the desired outcomes expressed by the participant, caregiver, or representative
Be	Be related to the need/problem and the intervention
Be	Be attainable by the participant
Include	Include timelines for achievement if not the authorization period
Be	Be measurable through health record documentation

IPC Social Services Care Plan

SOCIAL SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

Mr.Xyz is a 65 year old male living in a condo with his wife.1) Pt presents with sadness due to age related health issues and loss of indep. Reports feelings of sadness at least 1x/wk and his GDS score 5/15 indicating mild depression.
2) Mr. Xyz has mild cognitive impairment with MMSE score of 26/30. States he experiences memory decline/deterioration. in cog abilities claims forgets names when meeting new ppl and misplaces pers items. decreased STM and concentration.

Treatment(s)/Intervention(s)	Frequency	Goal(s)
1.a. Monitor for any change in mood related to sadness 2.a Monitor for any change in cognitive status	1.a. 5x/wk 2.a. 5x/wk	1. Any change in mood caused by sadness will be monitored and treated. At reassessment the pt will report sadness less than 1x/wk. and MMSE score will be equal or improved to previous score.
3.a. Support emotional well-being by encoutaging to participate in coping skills group 4.a Support highest level of cognitive functioning by encouraging participation in memory group	3.a. 1x/mo 4.a. 1x/mo	2. Any alterations in the degree of cognitive functioning will be addressed while the pt is monitored. existing level of cognitive function will be maintained or improved. MMSE score will improve.

Corresponding Social Services Flow Sheet

SOCIAL WORKFLOW SHEET

Month: December 2022	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Mode of Contact: P=Phone, C=Center		C					C						C						C	
Cognitive enhancing activities/education for memory Dx/and/or decline		EN					EN						EN						PN	
Educate/Teach coping skills for dx of depression/and/or sadness/low mood		P					PN						ONS						OI	
Educate/Teach coping skills of anxiety/anxious feelings or worries																				
Isolation/loneliness/ withdrawn																				
Community Resources																				
Initials																				

IPC → Outcomes → Assessment

IPC Social Services Care Plan

SOCIAL SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

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Corresponding Social Services Flowsheet Interventions

- Attend reminiscence therapy group 1x/wk note ability to track conversations and complete complex tasks

/=interacts with peers, tracks conversations,completes worksheets

- Attend coping skills group 1x/mo note attention and involvement levels to develop baseline

/=Quiet and focused but interacts with group 50% of time

- Observe mood qd and document to develop baseline

/= even mood, smiles on approach no sadness displayed

- Refer to MDT/LCSW/Home changes in cognitive function ie: needs more help with mail, new problems with judgement and reasoning or increased depressive symptoms

/= none noted

CBAS Documentation Flow

Initial Assessment: gathering knowledge based on individualized needs related to how their health conditions and psychosocial status affects them

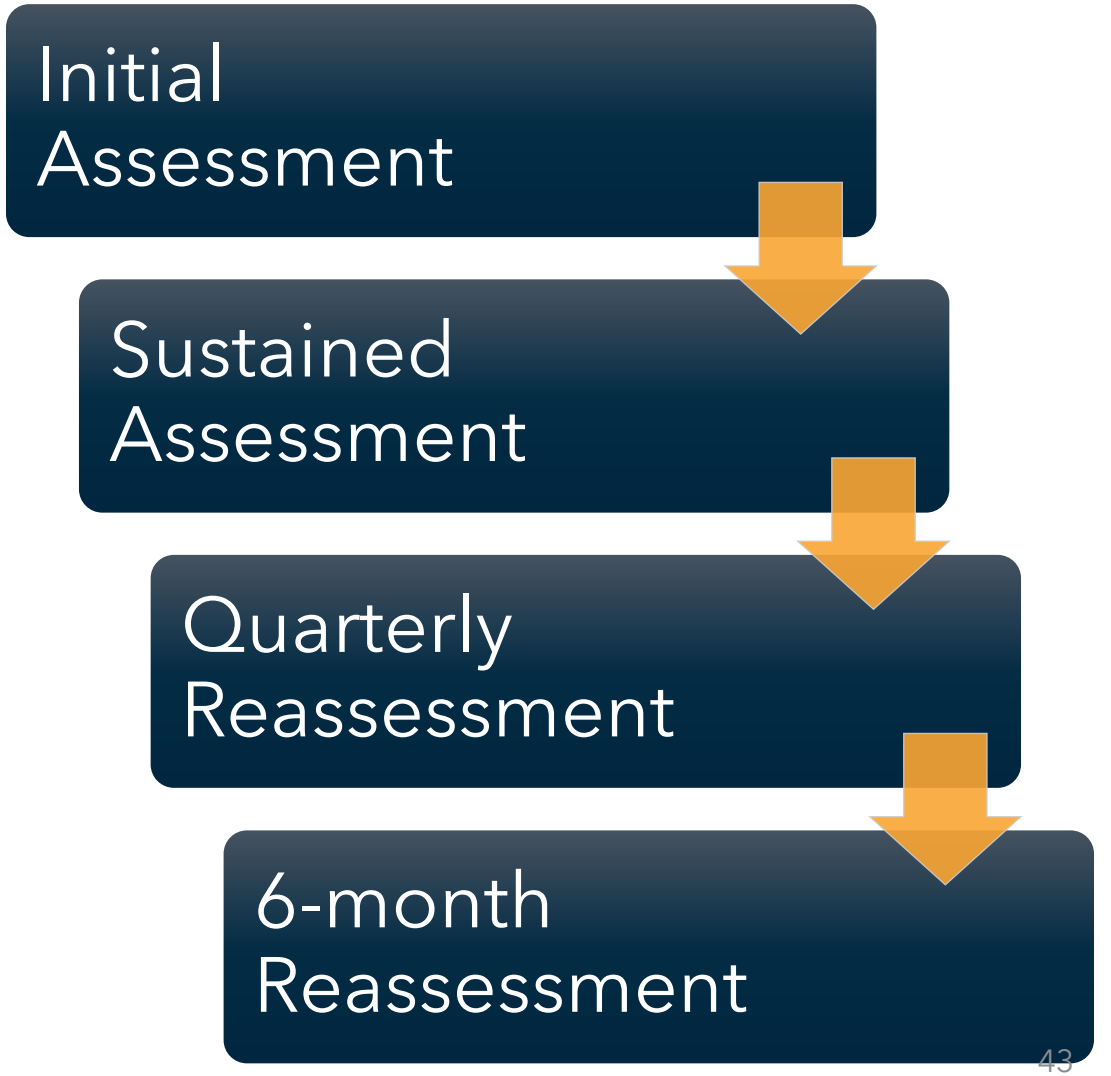
IPC

Sustained Assessment: daily assessment outcomes and observations documented over time (flow sheets, progress notes)

Reassessment: Based on mean data gathered from sustained assessments. Data used to develop baselines and informs the evaluation of goals

IPC

Sustained Assessment ….



The Role of Documentation-It's an Art

- Detailed
- Accurate
- Concise
- Functional
- Accessible

Questions?

California Department of AGING

Thank you for the work that you do each day