California Department of AGING

Fundamentals of CBAS Documentation: Best Practices

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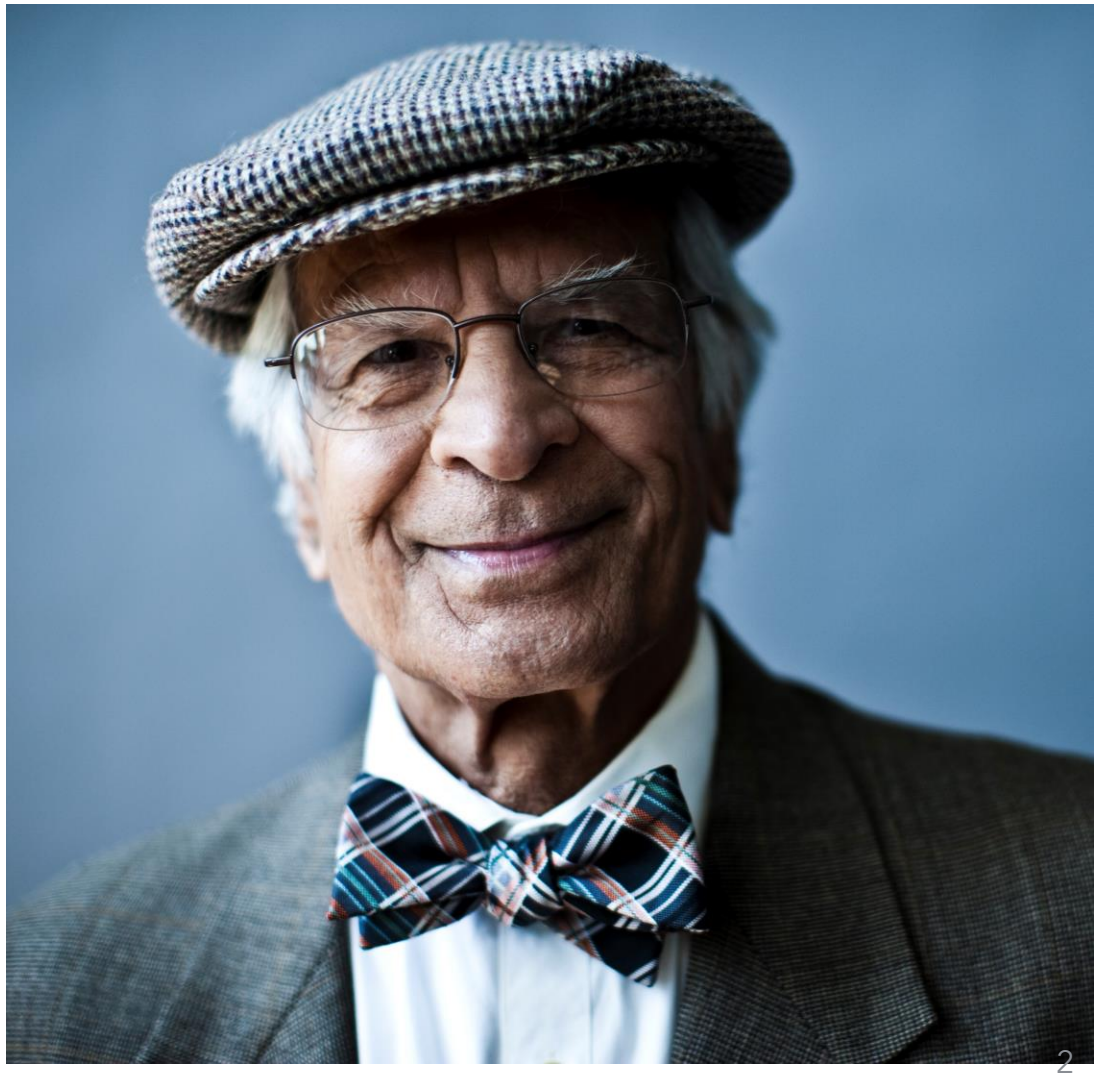
Today's Focus

- Health Record Documentation and Best Practices
- Initial Assessments
- Individual Plans of Care (IPCs)
- Daily Notes (Flowsheets and progress or narrative notes)
- Reassessments (three and six month)
- Quarterly Progress Notes



California Department of AGING

Who is in The Audience Today?

CBAS Program Objectives and Philosophy

CBAS is a program designed to:

Restore or maintain optimal capacity for self care

Delay or prevent inappropriate or undesirable institutionalization

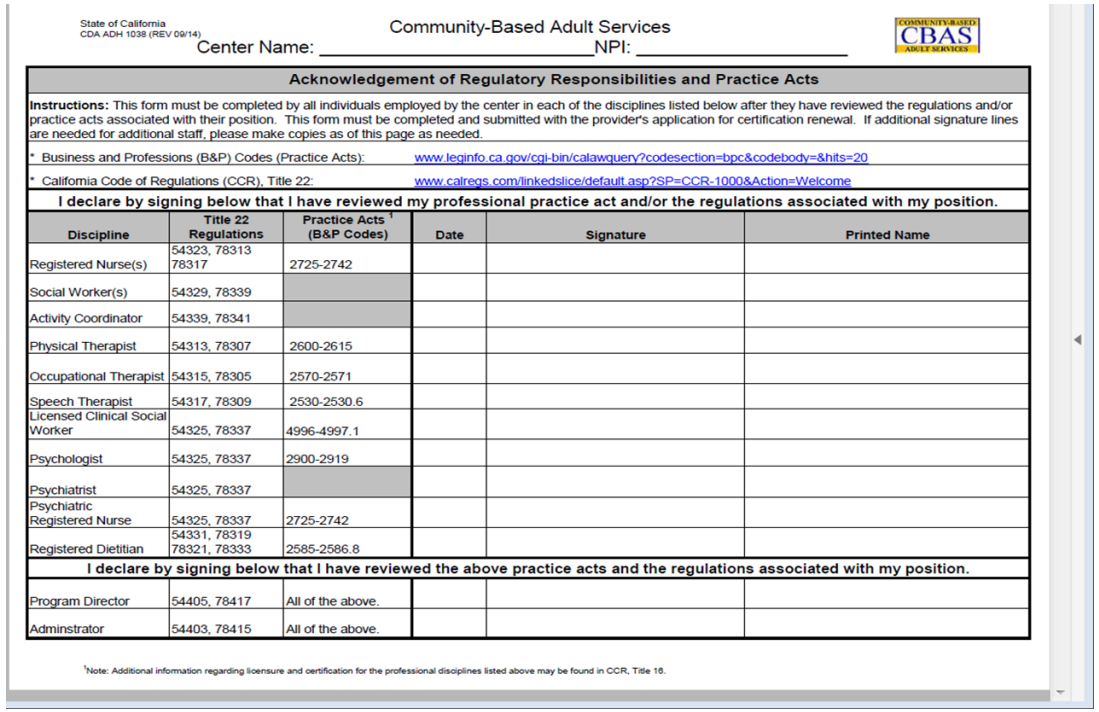
Maintain individuals in their own homes and communities for as long as possible

CBAS Model and Vision: The Participant is at the Center of Care

- CBAS is intended to be rehabilitative, holistic and person centered, using a collaborative and interdisciplinary approach
- Laws and regulations create a comprehensive structure for the CBAS framework of care and support

Documentation and Scope of Practice

- Know the Scope of Practice for your MDT:
- Every MDT member has a Scope of Practice; i.e., the standards set by the licensing body, such as the Board of Registered Nursing, or the Physical Therapy Practice Act.
- Failure to act within their scope of practice can have consequences for licensed professionals.
- Center administrators and Program Directors need to understand the scope of practice for each MDT member.



State of California
CDA ADH 1038 (REV 09/14)

Community-Based Adult Services

Center Name: _____ NPI: _____

Acknowledgement of Regulatory Responsibilities and Practice Acts

Instructions: This form must be completed by all individuals employed by the center in each of the disciplines listed below after they have reviewed the regulations and/or practice acts associated with their position. This form must be completed and submitted with the provider's application for certification renewal. If additional signature lines are needed for additional staff, please make copies as of this page as needed.

* Business and Professions (B&P) Codes (Practice Acts): www.leginfo.ca.gov/cgi-bin/calawquery?codesection=bpc&codebody=&hits=20

* California Code of Regulations (CCR), Title 22: www.calregs.com/linkedslice/default.asp?SP=CCR-1000&Action=Welcome

I declare by signing below that I have reviewed my professional practice act and/or the regulations associated with my position.

Discipline	Title 22 Regulations	Practice Acts [1] (B&P Codes)	Date	Signature	Printed Name
Registered Nurse(s)	54323, 78313 78317	2725-2742			
Social Worker(s)	54329, 78339				
Activity Coordinator	54339, 78341				
Physical Therapist	54313, 78307	2600-2615			
Occupational Therapist	54315, 78305	2570-2571			
Speech Therapist	54317, 78309	2530-2530.6			
Licensed Clinical Social Worker	54325, 78337	4996-4997.1			
Psychologist	54325, 78337	2900-2919			
Psychiatrist	54325, 78337				
Psychiatric Registered Nurse	54325, 78337	2725-2742			
Registered Dietitian	54331, 78319 78321, 78333	2585-2586.8			
I declare by signing below that I have reviewed the above practice acts and the regulations associated with my position.					
Program Director	54405, 78417	All of the above.			
Adminstrator	54403, 78415	All of the above.			

[1]Note: Additional information regarding licensure and certification for the professional disciplines listed above may be found in CCR, Title 16.

Health Record Requirements

T-22, CCR, Section 54425

"Each center shall maintain a complete health record for each
participant in the program in the format established by the Department. The medical record shall include, but is not limited to: . . . "

Medi-Cal 2020 Waiver, SOP H.13

"Documentation – Maintenance of a health record for each CBAS participant that shall be available to appropriate DHCS/CDA and managed care plan staff for any scheduled or unscheduled visits. This record shall include documentation of all services provided and refused, the current IPC, referral requests and outcomes of said referral(s).

Health record documentation shall be maintained in compliance with applicable Federal and State laws and shall be retained by the CBAS provider for a minimum of seven years. Health records shall be stored so as to protect against loss, destruction, or unauthorized use."

Documentation of Services Provided

- **Documentation must include:**
- All required core services provided on each day of service
- Services provided as scheduled on the IPC
- Documentation of services completed, initialed, signed and dated on the day services are provided
- Documentation sufficient to show service was provided, and the outcome (i.e., response, status, result)

Multidisciplinary Team Process:

- The coordination of the MDT to foster a holistic approach to care planning that includes working together, effective communication, interdisciplinary referral processes, regular meetings, coordinating assessment outcomes and care plans to meet the needs of the participant.

- Must be reflected in the participants Health Record documentation.

A Well Functioning MDT …

- Shares information about the participant's clinical needs, and also builds awareness of the participant as a unique person
- Meets regularly
- Communicates routinely about participants, both formally and informally
- Discusses openly
- Reaches consensus before acting
- Documents the process

A Well Functioning MDT: Best Practices

- **Best Practices include:**
- Nurse, Social Work, Activity Coordinator, PT & OT in attendance
- Ensures each MDT member summarizes the Participant status
- Includes a discussion regarding transportation status (>1hour)
- Follows the same format for each Participant on the reassessment list
- Ensures initial assessments are discussed and MDT is consistent with findings
- Ensures presenting problems for participants not on the reassessment list are discussed (and it is documented!)

Initial Assessments

Documentation will reflect

- ✓ Medical
- ✓ Psychosocial
- ✓ Functional status
- ✓ Person-Centered interests

. . . As assessed by each MDT member within his/her scope of practice

Includes at least:
Personal or Staff Physician
Registered Nurse
Social Worker
Physical Therapist
Occupational Therapist
…If need identified:
Registered Dietitian
Behavioral Health Consultant
Speech Therapist

Reassessments

Documentation *must* include:

- ✓ Progress achieved on previous IPC goals
- ✓ New or significant changes in condition
- ✓ Revisions and adjustments in care plan when needed to be congruent with current condition

Reassessments must be supported by/consistent with documentation in the daily documentation for the prior three and/or six months.

MULTIDISCIPLINARY HEALTH TEAM

(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.

Title 22, CCR, Section 54215 states that reassessments shall include: "(1) Progress achieved. (2) Review and revision of goals and objectives. (3) Revision or continuation of the individual plan of care."

Individual Plan of Care Documentation

The resulting documentation includes:

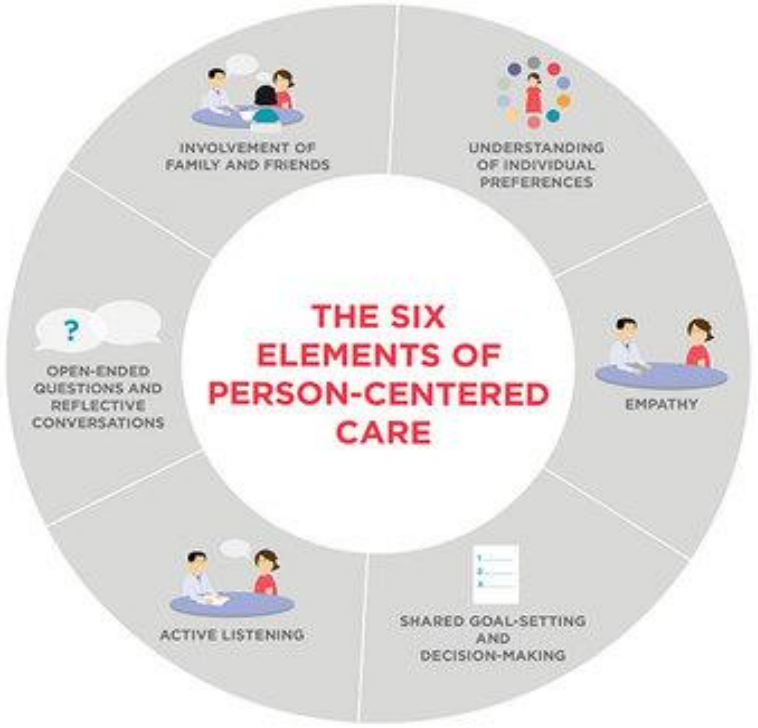
- ✓ Individualized, specific, and measurable goals, objectives and services → related to assessed need, medical necessity, and risks → designed to meet participant needs

- ✓ Documentation that federal person-centered planning regulations are met

A Person-Centered Plan and Process

Person-Centered Planning regulations address:

- Person-centered planning **process**
  - Led/directed by participant to extent possible
  - Includes individuals chosen by participar
  - Offers informed choices regarding servic and supports
- Person-centered **plan**
  - Reflect individual's strengths, preference goals, desired outcomes, choices
  - Reflect risk factors/measures in place to minimize them
  - Finalized and agreed to with informed consent of participant
- **Review** of the plan
  - Reviewed and revised upon reassessmer (at least every 12 months), when participant's circumstances/needs change significantly, or at participant's request



"What does CDA want to see….."

Providers ask us this all the time.

It's not about us!

- Of course, documentation

  must reflect requirements
- Most importantly, what do *you* want/need from your documentation in order to provide quality care?

Health Record Documentation: Telling the Story

Starts with the Care Plan

Identify the unique needs the participant has as a result of their diagnoses, condition, situation

Identify why the person needs the services of a CBAS program what would happen without them

To create a person-centered plan, have the conversation and drill down to the individual level

- Assessments and IPC must reflect each other
- Primary problems and needs identified in the assessments should be addressed in the IPC
- Problems addressed on the IPC should be supported by what is contained in the assessment/reassessments

The Care Plan: Problem Statements

- The care plan should be participant centered and problem driven. The problem statement should be clear, concise and show the extent of the problem and need. It should describe how the condition, symptom, diagnosis, situation affects the individual.

Care Plan Problem Statements: Example:

- There is a clear distinction between a diagnosis and a problem statement. For Example:

- **Problem #1**
- Hypertension is a diagnosis, not a problem statement; however, “Labile BP, checked QD X5/wk with range in past 6 mos 204/96 to 130/78. Required prn medication administration x3 with PHCP liaison

- This example adequately describes a problem and indicates why the blood pressure needs to be monitored every day.

Care Plan Problem Statement Example:

- **Problem #2**

- "Dementia" is a symptom of an underlying disease process, it is not a problem statement; however, "Poor judgment and unsafe behavior, i.e. eating with a knife or exit seeking, up to 3x/d during the past 6 months related to Alzheimer's disease. Becomes agitated with redirection 2-3x/wk.

- This description adequately describes how "dementia" is affecting this individual

Care Plan Interventions

Interventions should be related to the problem statement, within the abilities of the participant and realistic for the staff to provide. Interventions must include the frequency needed to reach the goals

Care Plan Interventions Example:

Problem #1
Labile BP, checked QD X5/wk with range in past 6 mos 204/96 to 130/78. Required prn medication administration x3 with PHCP liaison

Interventions: Problem #1

- Monitor Bp QD q a.m. upon arrival at center, administer prn medication per MD order HCTZ 25 mg q a.m. for Bp > 150/90
- Recheck Bp after 1hour to monitor med effectiveness
- Report Bp range to MD q3mos and prn if >150/90 or med effectiveness not achieved

Care Plan Interventions Example:

Problem #2
Poor judgment and unsafe behavior, i.e. eating with a knife or exit seeking, up to 3x/d during the past 6 months related to Alzheimer's disease. Becomes agitated with redirection 2-3x/wk.

Interventions: Problem #2

- Supervise for unsafe behaviors, provide/offer distraction
- Limit opportunities for unsafe behaviors through limiting utensils at meals
- Provide opportunities for safe wandering
- During attempts to exit seek provide 1:1 walk and talk

Care Plan Goals

- Goals should be participant centered, realistic, obtainable, measurable, and expressed in clear, specific and unambiguous language.
- Goals can relate to health maintenance or restoration, be educational or behavioral
- Goals must relate to the problem statement

Care Plan Goals Example:

Problem #1
Hypertension is a diagnosis, not a problem statement; however, "Labile BP, checked QD X5/wk with range in past 6 mos 204/96 to 130/78. Required prn medication administration x3 with PHCP liaison

- **Goals for Problem #1**
- Participant will have prompt med administration for elevated BP with BP maintained at <150/90
- Will maintain liaison with PHCP for unresolved BP exacerbations and use of PRN medication

Care Plan Goals Example:

Problem #2
Poor judgment and unsafe behavior, i.e. eating with a knife or exit seeking, up to 3x/d during the past 6 months related to Alzheimer's disease. Becomes agitated with redirection 2-3x/wk.

- **Goals for Problem #2**
- Limit unsafe behaviors to <1/day
- Participant will maintain safety 100% of time and avoid episodes of agitation

Canned Treatment Plans

Diagnosis driven with one size fits all

Standard interventions instead of person centered

Canned Treatment Plans

- **Standard interventions are applied to all participants with the same diagnoses. For example:**
  - Not everyone with Hypertension requires diet education or Bp monitoring every day. Many are stable with medication and diet interventions
  - Not everyone with depression would benefit from education on coping skills. Those with concurrent cognitive impairment may not have the short-term memory to retain new information.

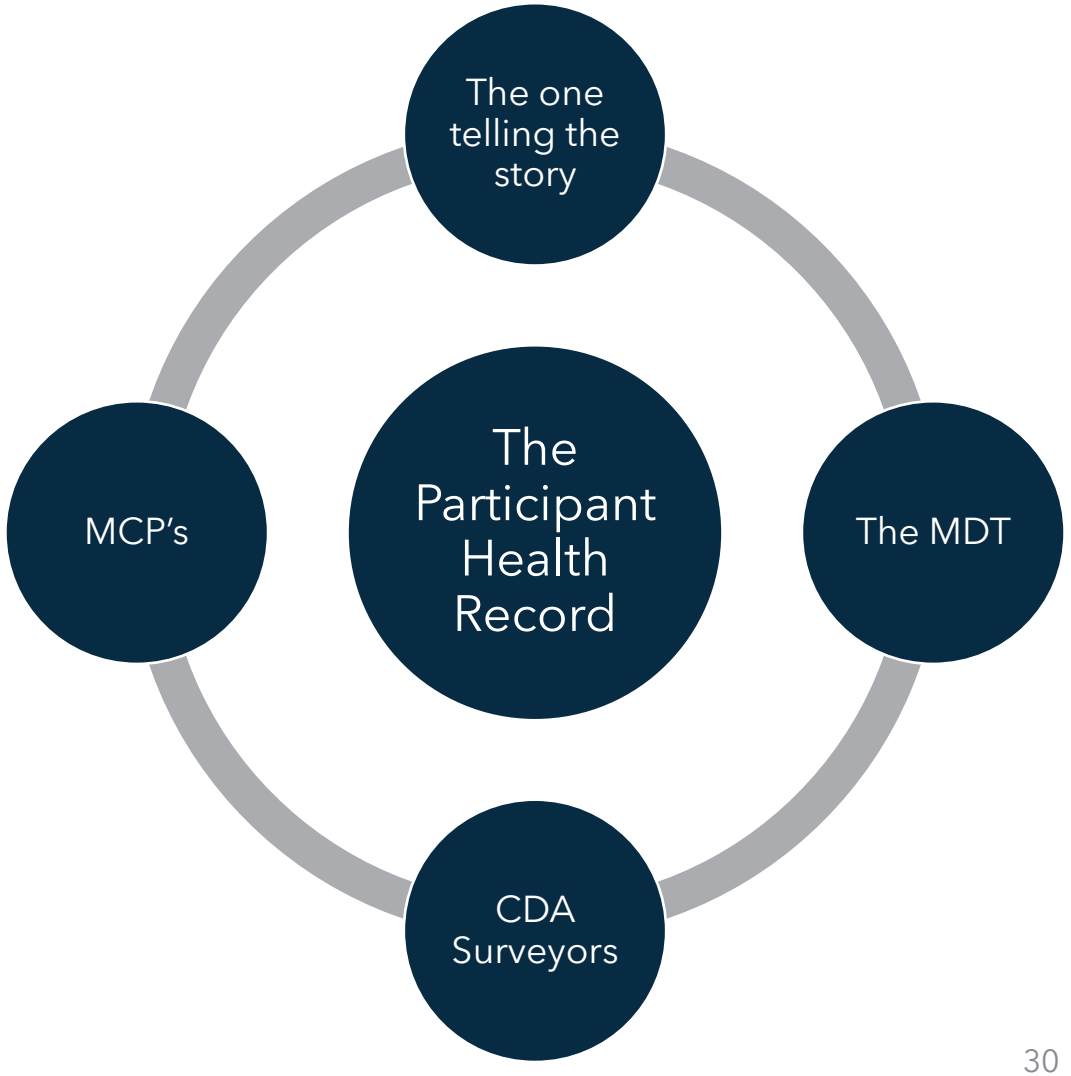
Documenting Services and Driving Quality

➢ Documentation of Services : Flowsheets and Notes

- Is the foundation for determining services were provided and whether care plan goals are being met
  - Should be related to the goals and objectives on the care plan and demonstrate the participant's progress
  - Consists of daily sustained assessment/measurement of participant's status and response to interventions
  - Includes unplanned or PRN interventions, communications between MDT members and with caregiver, physician, psychiatrist, etc.
  - Includes reason for absences
  - May be on flow sheet and/or a narrative note

Health Record Documentation

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



Documenting Services and Driving Quality

➢ **Documentation of Services**

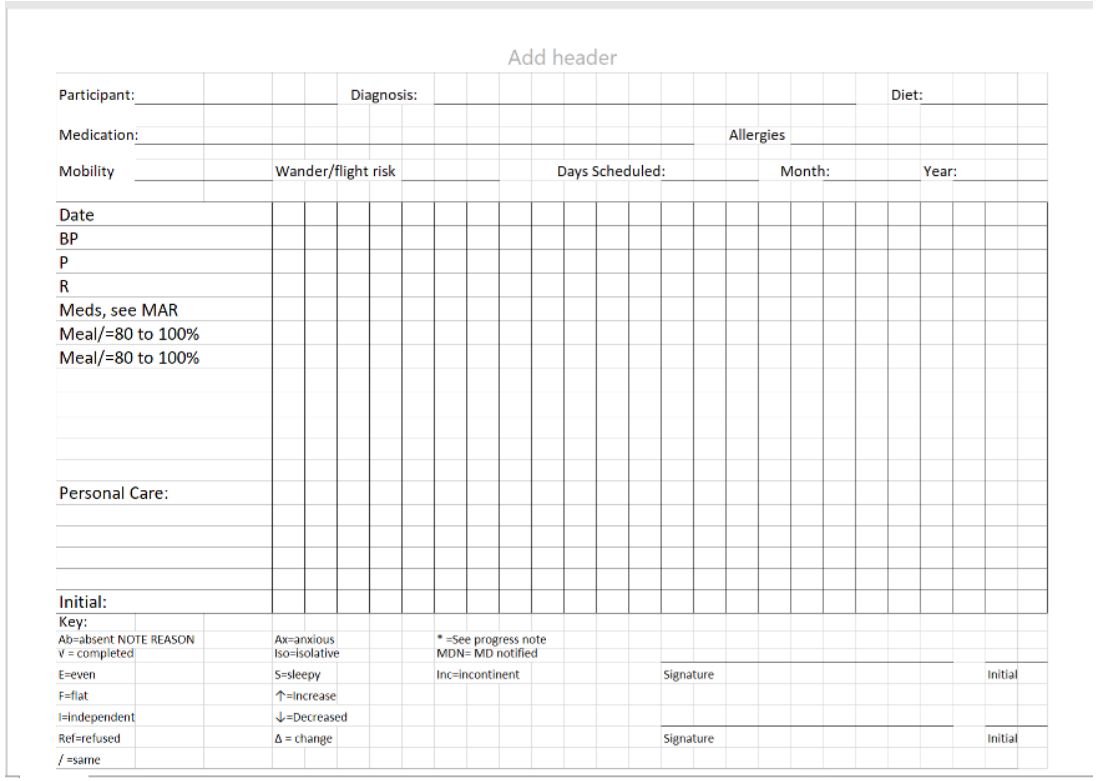
- Daily documentation should:
  - Identify and track interventions specified on the Individual Plan of Care (IPC)
  - Reflect the service provided and…
  - Document participant's status and response to interventions in measurable terms and inform the reassessment to evaluate whether the participant is meeting care plan goals

Documenting Services and Driving Quality

- **Documentation of Services shows trends and data from which to measure change**
- Effective care planning depends on comprehensive information
- Goal setting requires definition of the desired outcome
- To be able to measure outcomes, you must have *data*
- Data is preserved through documentation that creates a clinical audit trail allowing a lookback through sustained assessments

Flow Sheet Basics: Best Practices

- **Flowsheet Basics:**
- Participant name/DOB/ CG or lives alone
- Physician name and contact #
- Diagnoses/Medications
- Allergies
- Prescribed diet
- Mobility needs
- Days Scheduled
- Identified risks
- Vital signs and monthly weight
- Meal consumed breakfast and lunch
- Receiving Behavioral Health/Speech/PT/OT
- Legend/ Key
- Signature and Initials
- Month and Year



Add header

Participant: Diagnosis: Diet:

Medication: Allergies

Mobility Wander/flight risk Days Scheduled: Month: Year:

Date																														
BP																														
P																														
R																														
Meds, see MAR																														
Meal/=80 to 100%																														
Meal/=80 to 100%																														
Personal Care:																														
Initial:																														

Key:

Ab=absent NOTE REASON
√ = 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

Signature Initial

Signature Initial

Person Centered Flowsheets

Don't copy the intervention exactly as written in the IPC care plan: encourage participation in coping group

Don't use no change from baseline when a baseline has not been established

Don't combine multiple interventions on one line: pain management, monitor for s/s hypertension

Don't document symptoms without an action and result following –edema

Don't document your actions without specifics: provided, encouraged, observed

Do include

- Do include interventions as listed in the IPC care plan

Do anticipate

- Do anticipate what you will be looking for to evaluate the goal for the specific intervention

Do allow

- Do allow extra blank spaces to accommodate new interventions for temporary or ongoing changes in condition outside of reassessment periods

- 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 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

Documentation: More to DOS

Do follow up	• Do follow up on absences promptly * right away, immediately
Do document	• Do document absences on the flowsheet and note the reason for the absence
Do ensure	• Do ensure a nursing services follow up if the participant is ill and ensure medical attention is arranged if needed
Do follow up	• Do follow up if the participant was absent due to illness upon return to the center and document
Do include	• Do include attendance patterns in your quarterly progress note documentation (BEST PRACTICE)

Documentation Trail: Leaving Breadcrumbs

Auditable Trail of Documentation: **Example** --

- **During reassessment lookback, documentation is noted to include: respiratory problems and history of hospitalization occurring over several weeks.**
- **Problem from IPC reads: Impaired pulmonary function associated with COPD. At risk for repeat aspiration pneumonia.**
- **Goal reads: Will have no respiratory infection in 6-month period with prompt attention for sx of infection**

Documentation Trail: Leaving Breadcrumbs Example Cont..

- **Reassessment documentation reads: Goal not met due to hospitalization/aspiration pneumonia. Continue interventions**
- **Treatment plan (care plan) goals are then copied to the flow sheet as:**

  Assess respiratory function and note symptoms observed with careful assessment of cognitive changes, energy, fatigue, increased congestion, coughing, fever, shills, crackles, tachypnea. Check O2 SAT prn. Liaison with MD for sxs
- **Frequency is:** 4/x wk (every day of attendance)

Documentation of treatment:

-- Flow sheet is initialed for <u>each</u> treatment each time tx is provided.

- **Flow sheet is signed and initialed the first time a staff provides services**
- **Values are included when relevant (such as O2 SAT. BS levels, percent of day a cough was observed, percent of day tolerated, minutes of rest).**
- **Example: Note after tx reads: Tired after traveling to MD for chest x-ray. R & L lower lungs have inspiratory wheezes; moist cough. Pt. resting in recliner. Able to tolerate day with 20 min rest**
- **Longer progress notes are written when needed, and a related note is placed on flow sheet: *See progress note of 9/10/23.***

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

Best Practice: 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

Charting by Exception

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 Mitzke — Signature — LW — Initial

Signature — Initial

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Quarterly Progress Notes & Quarterly Reassessments

They are not the same thing!

Quarterly Reassessment vs Quarterly Notes

Quarterly Reassessment:

Title 22, CCR, Section 54215

States that Reassessments, at least Quarterly, shall include: (1) Progress achieved; (2) Review and revision of goals and objectives; and (3) Revision or continuation of the individual plan of care**.**

Completed three months following the IPC and prior to the 6-month reassessment

Provides an opportunity to evaluate the outcomes for the care plan in place and determine if any adjustments need to be made

Quarterly Progress Note:

Title 22, CCR, Section 54323(a)(3) (Nursing Services)

Title 22, CCR, Section 54329(a)(3) (Social Services)

Title 22, CCR, Section 54339(d)(2) (Therapeutic Activity Program Services)

Title 22, CCR, Section 54313(3)(B) (Physical Therapy)

Title 22, CCR, Section 54315(a)(7)(B) (Occupational Therapy)

……Listed under documentation requirements for each discipline

Best Practice: Quarterly Note Documentation

Best Practice:

Include a Quarterly Note at the end of the Quarterly reassessment to summarize the outcomes, rationale of unmet or partially met determinations, and general health status overview, such as attendance patterns, meal intake, weight change from prior 3 mos, transportation > 1h, indicators of health not included in care plan goals

***Label the note "Quarterly Note" for survey purposes!**

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Reassessment Process: Putting it All Together

What is your process?

What we hear from nurses and social workers during our surveys…

Reassessment Process

- The Reassessment requires a lookback over the previous six months documentation for the purpose of:
  - Assessing the sustained assessment documentation (flow sheets/progress notes) to determine how the participant has responded over time to the interventions provided
  - Comparing the data (outcomes) to the IPC goal to determine if the goal has been met or not met
  - Documenting the determination of each goal as met or not met
  - Conducting the lookback to determine if the participant had a status change and documenting if the care plan will be adjusted or remain as written
  - Assessing the participants current status and needs including medication reconciliation

Reassessment Process Continued

- Assessing the participants current status and needs including medication reconciliation
- Assessment to determine the need for Physical Therapy. Occupational Therapy, Speech Therapy or Behavioral Health interdisciplinary referrals
- Liaison with the PHCP to inform of the Participants status and progress.
- Liaison with the Participants personal Psychiatrist/Psychologist, if applicable, to inform of the Participants status and progress

Reassessment: Best Practice Documentation Format

Goal:	Met/Not met:	Why?	Care plan continue as written or revised?
Avoid incontinent episodes 100% of time	Not met Required assist with incont X8 in 6 mos	Decline in functional ability	Revise frequency of cue to bathroom
Prompt attn for hypertensive episodes with Bp <150/90	Met Bp range 138/80 to 144/88	Stable Bp	Cont. as written
Ptp will maintain safety and have prompt attn for unsafe behaviors at all times	Not met x2 required 1:1 walk outside to redirect from exit seeking behavior	Agitation due to loud activity	Add: provide quiet area and activity during loud events

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 ….

Initial Assessment

Sustained Assessment

Quarterly Reassessment

6-month Reassessment

Discharge Responsibilities: Title 22, CCR, Section 78345

Does your discharge documentation include all these components?

Title 22, CCR, Section 78345 states:

(a) A plan for discharge of each participant shall be based on the assessment of the participant by the multidisciplinary team and shall be reviewed and updated at the time of reassessment.

(b), "Each participant's health record shall include documentation of the plan for discharge which shall be completed by the time of the first reassessment.

(c) Referral of participants shall be made to outside resources by the multidisciplinary team or by an individual team member. Each referral shall be recorded on the participant's health record.

(d) Consultation shall be made available to a participant's family prior to discharge.

(e) Home visit shall be made by the appropriate multidisciplinary team member prior to discharge of the participant if recommended by multidisciplinary team and documented in the participant health record.

Questions and Sharing

Thank you for all that you do each day!