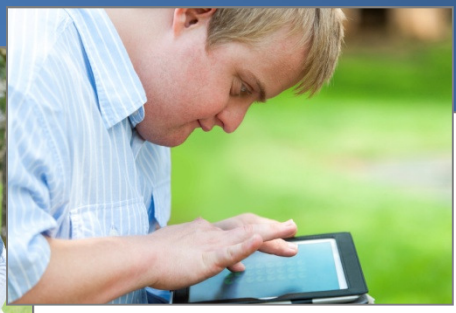
QIDP Professional TRAINING



Illinois Department of Human Services

Module Overview

Module 5 Introduction

Why is documentation important to you, as a QIDP?

QIDPs are typically responsible for maintaining the individual record. As a QIDP, you will document services provided to each person probably more than any other professional at your agency. Additionally, QIDPs frequently hold the responsibility for collecting documentation from other professionals such as physicians, psychiatrists, etc. and ensuring that those records are kept within the record according to agency policy.

Objectives

Participants will be able to:

- Apply principles of documentation to the responsibilities of a QIDP.
- Identify the importance of record keeping and documentation in the human services field.
- Recognize the importance of effective record keeping strategies and confidentiality agreements as they pertain to a QIDP and the staff he/she is responsible for.
- Demonstrate an understanding of accurate documentation.
- Describe and explain the significance of the documents that may be found in an individual's file.
- Demonstrate an understanding of record retention principles, regulations, and requirements.

DOCUMENTATION

"Accuracy of statement is one of the first elements of truth; inaccuracy is a near kin to falsehood."

-Tyron Edwards

Why is documentation important?

- **Records provide a history:**
  - Records of previous services and supports may assist with the development of current services and supports.
  - Historical health, educational and service records are sometimes needed for future health, educational and service needs.
  - Maximizing a person's health is much easier to do when you have knowledge of prior health needs and familial patterns of health.
- **Records assist with continuity of services and supports:**
  - Although service planning is reviewed annually, learning occurs over time. Skills, learning and personal interests do not naturally start and stop every twelve months but rather ebb and flow over time.
  - Infrequent concerns may be overlooked if not documented. Patterns and trends can be more easily identified over time.
- **Records help us comply with rules and regulations:**
  - Funding and governing bodies have specific requirements regarding record keeping. Most agencies are reviewed by such bodies annually. Failure to meet record keeping standards may jeopardize an agency's funding and capacity to provide services.
- **Records can help us evaluate organizational outcomes:**
  - Records and analysis of the information in those records can assist an agency with evaluating its performance across time. Maintaining and increasing quality of service relies upon an agency's understanding of many factors and details that can only be known through documenting and recording.
  - Records provide accountability.

Confidentiality

With the enactment of the Health Insurance Portability and Accountability Act (HIPAA) staff must be diligent in assuring that their practices remain in accordance with state HIPAA regulations. The intent of this statute is to assure that an individual's personal information is not shared without permission. A central aspect of the Privacy Rule is "minimum necessary" use and disclosure. A covered agency or person must make reasonable efforts to request, use, and disclose only the minimum amount of protected information needed to accomplish the intended purpose of the request.

Confidentiality is an important component of a person's plan. Conversations should be kept confined to the meeting room and care must be taken to assure topics are not discussed in hallways, parking lots, etc. Likewise, after the meeting, care must be taken that papers containing identifiable information are not left lying about.

When discussing an individual supported during a meeting, such as Human Rights Committee, some organizations use initials, identification numbers, etc. to keep complete anonymity even from the committee members. It is agreed that if discussion includes someone who is not receiving services at the agency, the person's identity must be kept confidential.

When records are shared or requested, informed, written consent must be obtained. Consents should be written in plain language that is easy for the individual served to understand. The use of pictures may be necessary. According to the Mental Health and Developmental Disabilities Confidentiality Act, the consent should be in writing and contain the following elements.

- The person or agency to which disclosure is to be made.
- The purpose for which disclosure is to be made.
- The nature of the information to be disclosed.
- The right to inspect and copy the information to be disclosed.
- The consequences of a refusal to consent, if any.
- The calendar date on which the consent expires.
- The right to revoke the consent at any time.

Record Retention

As a general rule, records in individual files that contain HIPAA information should be retained 6 years after the record is closed (e.g., individual moves, death etc.). Records may be stored in inactive or closed files or in forms other than paper such as electronic or online, digital or analog media.

What is "PHI"?

It is Protected Health Information about a patient/consumer held by health care providers (includes CILAs) and health plans. Examples include:

- Patient's medical record number
- Patient's demographic information (e.g. address, telephone number)
- Information doctors, nurses, other health care providers put in a patient's medical record
- Images of the person
- Conversations a doctor has about a patient's care or treatment with nurses and others
- Information about a person in a doctor's computer system or a health insurer's computer system
- Billing information about a patient at a clinic

Thinking about it another way, PHI is any health information that can lead to the identity of an individual or the contents of the information can be used to make a reasonable assumption as to the identity of the individual.

For more information on record retention and privacy rules see:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/

Record Keeping Guidelines

- To make a correction, draw a single line through the error, initial, and then write the corrections. White out should not be used.
- If not typed, entries should be written neatly and legibly.
- When referring to people, proper names should be used.
- Documents should only be signed after checking accuracy.
- Blue or black ink should be used as colored ink is not considered professional.
- Care and consideration should be given to content. Content should be accurate, free of slang and unnecessary editorial comments.
- Information should be recorded chronologically.
- Be factual: Only document what you personally observed. Use quotes when possible.
- Be Precise: Specific objective language should be used. General terms should be avoided.
- When possible, measurable quantities should be used. Phrases such as “a lot” or “hardly ever” should be avoided.
- Unused space should be filled with a single line to indicate no further information.
- Signatures should be consistent with each signatory’s legal name and should indicate title.
- Signatures should be dated.

Insert agency specific information here.

Accurate Documentation?

Directions: Rewrite the subjective sentences using required record keeping guidelines.

Subjective Documentation	Objective Documentation
Bob seems to have a stomach ache.	
Courtney acted out.	
Sarah fell on the driveway.	
Joseph appears restless.	
Hillary would not eat.	
Steven should go to the doctor for a physical soon.	
Robert would not get out of bed.	
Jorge attacked Frank.	

Types of Records

The Individual/Clinical File/Case Record

While the format of the clinical file will differ from agency to agency, much of the content will be the same. Below are the eight most common inclusions.

Admission Information

This section includes such documents as the application, placement award letters, Medicaid waiver redeterminations, IDHS referral information, personal property list, IDPA notice of change, admission, transfer, and ISC reviews.

Medical Information

This section includes documents such as medical and psychiatric visits, physician orders, and a list of current medications. Annual physical, dental, vision, nutritional reports, and nursing notes, if available, should be filed in this section. Given the amount of documentation that this section sometimes has, it is sometimes filed in a separate record.

Clinical Referrals, Assessment, and Ancillary Service Reports

This section includes documents such as assessment reports or monthly updates from various therapies, diagnostic results, and current levels of functioning.

Current Programs

This section includes documents such as the ISP, individual's planning meeting documentation, caseload assignment sheet, monthly summaries, and visit reports.

Behavioral Information

Behavior plans, programs, and functional assessments are placed here.

Legal Documents and Consent Forms

Documents might include guardianship papers, birth certificate, information releases, restraining orders, medical treatment and authorization forms, and power of attorney papers.

Correspondence

Other types of correspondence should be included in this section of the records.

Vocational

Documents relating to an individual's work including any meetings, summaries of work shifts, and Job Coach information are placed here.

Insert agency specific information here.

QIDP Monthly Summary

In accordance with state and federal law, the QIDP must provide a monthly summary which describes progress on goals and objectives in the service plan, as well as information on the overall status of the person.

The monthly summary should address current program status including progress or lack thereof for each objective; and if no progress is being made, the reason must be indicated. This information should be specific enough so that it directly relates back to the overall outcome that the person desires.

Purpose of Monthly Summary

- Comply with federal and state law
- Communication of relevant information
- Reflect current status of progress and needs
- Reflect changes that have occurred since last summary

The Monthly Summary must include…

- Behavioral concerns
- Comments on whether the behavior plan is working
- Family activities and involvement including Family/Guardian contact, visits
- Health and medical information including doctor appointments, medication changes, general health changes, weight changes and health concerns
- Overnight visits
- Community involvement
- Overall program progress, concerns, or changes needed
- Comment on whether the current plan continues to meet the person's needs

Insert agency specific information here.

The Individual Service Plan

The individual service plan is often referred to as the ISP.

Purpose of ISP

- Ensure compliance with standards and rules established by various licensing, certifying, and accrediting bodies
- Utilized to establish reimbursement rates based upon the services and supports required by the individual
- Document the personal goals of the individual and the supports and services needed to accomplish those goals

- Record the results of assessments and reassessments
- Create a snapshot of the person's progress made toward achieving goals and objectives
- Record the Community Support Team's deliberations and decisions about the appropriateness of the plan, as well as recommended revisions and/or additions

The ISP must be…

- Data-based
- Goal-directed
- Monitored
- Reviewed annually by the individual's support team

Insert agency specific information here.

<u>Legal Documents</u>

The QIDP is responsible for assuring that all legal documents are present and handled according to agency policy and procedure. The following documents are examples of what might be found in the file:

- Guardianship
- Birth Certificate
- Restraint Orders
- Do Not Resuscitate Order
- Releases of Information
- Receipt of Personal Property
- Individual's Review of Human Rights
- Restriction of Rights
- Change in Legal Status
- Incident Reports
- Power of Attorney
- Information about funeral arrangements, burial/cremation, etc.
- Voter Registration
- Social Security Application

Consent and Authorization for:

- Treatment
- Special Behavior Programs
- Medications
- Emergency Treatment
- Living Will
- Advance Directives
- Release of Information
- Marriage/Divorce

Communication Log Books

Some agencies use a communication log book to highlight information for the next shift coming on duty. Significant events such as behavioral, environmental, and/or health issues can be highlighted here as a quick reference for staff to read at the beginning of their shift.

Daily Service Notes

The daily service note, sometimes called a progress note, is another means of sharing information about services and supports provided. Designated staff will usually complete the note on each shift. These progress notes are an important reference for the QIDPs monthly summary.

Daily Service notes are also used for:

- Staff to convey important information about the person for the next shift
- Keeping staff up to date with daily activities; day trips, medical visits, etc.

Incident and Event Reports

Documentation about particular types of incidents and events is required by Agency policy and or state governing/funding entities. These incidents include employee injury, injury of person served, serious illness, hospitalizations, accidents, unusual behaviors, severe maladaptive behavior, use of restrictive interventions, missing persons, bloodborne pathogen incidents and other similar events.

On occasion in addition to documentation it is necessary and required to contact the guardian and/or OIG, IDPH or other agency providing oversight. A timeline for completing documentation and reporting is associated with events of particular types.

Insert agency specific information here.

Documentation Guide

Directions: With the class, complete this documentation guide as it relates to your particular agency. The first example has been completed for you.

Issue	Example	Where to Document	Other Necessary Action
Work Related	*Difficulty with Job*	*Progress Note*	*No*
Elopement			
Vehicle Accident			
Yelling			
Physical Aggression			
General Upset			
Fall (No Injury)			
Burn (While Cooking)			
Unusual Crying			
Report of "Not Feeling Well"			
Seizure with Injury			
Blood Exposure			
Fall (Bruise on Leg)			
Alcohol or Drugs			
Sexually Inappropriate Behavior - Self			
Sexually Inappropriate Behavior - Others			
Parent Phone Call with Message for Staff			
Newly Scheduled Family Visit			

Documentation Orientation

Mario works as a DSP in a residence and helps support Tom who lives there. Yesterday, Mario noticed that Tom was acting differently from his 'usual self.' Below is the documentation that Mario wrote about Tom.

Can you find any errors in Mario's documentation?

8:15 Sunday, 1/8/14

Tom seems crabby and he's complaining a lot. He's complaining that his stomach aches. He didn't eat most of his dinner. He just wants to lay down and watch TV. I think he probably has heartburn because of what he said. I told him to just go to bed early and maybe he'll feel better tomorrow.

Can you make some suggestions to help Mario with his documentation? Write your suggestions below.

-
-
-
-
-
-

You might choose to review several agency specific documents to discuss and practice the information learned above. Possible documents to review: Seizure Reports, Accident Reports, Medical Visit Summary, etc.

Recommended Reading & Resources

Although we will try to cover a great deal of material with you today in class, the topic of record keeping is a broad one that requires continued study and attention throughout your career. We recommend the following resources as good places to start with regard to furthering your knowledge and understanding of this important process.

- Fundamentals of Case Management Practice: Skills for Human Services by *Nancy Summers*
- Individualized Service Plans: Empowering People with Disabilities by *Paul Spicer*
- Legal and Ethical Aspects of Health Information Management by *Dana McWay*
- Treatment Planning for Person-Centered Care: Shared Decision Making for Whole Health by *Neal Adams and Diane Grieder*