

A Resource Guide for Independent Case Managers for the Developmental Disabilities Waiver



Developed by:

**The New Mexico
Department of Health
Developmental Disabilities Supports Division**

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Use of this Guide



A Resource Guide for Independent Case Managers for the Developmental Disabilities (DD) Waiver was designed as a resource for New Mexico independent case managers (CM) who serve individuals with developmental disabilities. It serves as a ready-reference to information, resources, and tools you can use to enhance individuals' experiences with the service system and, most importantly, to support attainment of outcomes they personally seek to achieve.

This guide is structured in such a manner as to represent key aspects of the CM's role in his/her relationships with individuals and their families, guardians, advocates, all types of service providers, and others involved in the individual's life. Each chapter addresses a different process that the CM and team assist individuals to complete to secure and receive services and supports that are personally important to their health, safety, and growth as human beings. All chapters describe the rationale(s) for the activities described, the necessary procedures to complete them, and references to relevant policies and/or Regulations.

The guide is comprised of an **Introduction**, nine (9) **Chapters** and an **Appendix**.

Chapter	Title
I	How Individuals Become Eligible for Developmental Disabilities Waiver Services
II	Getting to Know the Individual
III	Making the Most of Meetings
IV	Planning with the Individual
V	Community Resources and Supports
VI	Keeping Things on Track
VII	Record Keeping on Behalf of the Individual
VIII	Creating the Individual's Budget & Billing for Services
IX	When an Individual Changes Services

The guide illustrates the role and responsibilities of CMs with the use of scenarios commonly encountered by individuals, their CMs and teams. These are real life examples of personal experience in services and supports.

The material in this guide can be used in different ways. The guide in its entirety can be used as a handy 'desk reference' for guidelines, protocols, tips, and samples of forms a CM uses on a regular basis. In addition, sections within chapters can serve to refresh knowledge and skills of a particular case management function, particularly those that address situations that arise only on occasion.

This guide can also be made available to colleagues, especially provider agency service coordinators, as well as other team members who play different roles in the lives of individuals. It can expand their understanding of CM interactions with and on behalf of individuals served.

Note: *To review regulatory citations, refer to the hyperlink entered by each reference.*

Chapter VII

Record Keeping on Behalf of the Individual



- ◆ Primary Record Contents
- ◆ Required Information Maintained in the Case Management File
- ◆ Documentation Procedures and Standards
- ◆ Documentation Guidelines
- ◆ Accountable Documentation Practices

Chapter VII

Record Keeping on Behalf of the Individual

Primary Record Contents

Record keeping is an essential part of case management. Personal information is critical for evaluating the effectiveness and efficiency of services, for providing accountability to funding sources (DOH, CMS, etc.), and for reimbursement purposes. The case manager (CM) is required to comply with agency, state and federal requirements regarding documentation. The primary case management record is a unified, confidential collection of documents. This record is to be considered the master file for all information pertaining to assessment, evaluation, finances, service planning, medical information, incident management, case notes, progress reports, meeting minutes and all other collateral information regarding the individual. Although providers should also maintain agency files regarding the individual, essential information identified above must be submitted to the CM in a timely manner for inclusion in the primary file. When information is not submitted in a timely manner, the CM should document all requests in his or her notes and submit the Developmental Disabilities Support Division (DDSD) Request for Regional Office Intervention form.

⇒ ***DOH Policy Governing Primary Record Requirements, Section IV.9***

DDSD and members of the team are “covered entities” according to the Health Insurance Portability & Accountability Act (HIPAA) and therefore releases are NOT needed to share documents between these entities. This applies as well when individuals select new providers through the Freedom of Choice (FOC) process.

Information about an individual must be kept confidential and secure at all times, in compliance with HIPAA Requirements. The CM may use a working file when in the field. However, the working file must be kept in a secure place such as a locked briefcase or a file box to ensure that only the CM has access to that information when in the field.

HIPAA Regulations must always be followed. Contact the HIPAA officer at your local DDSD Regional Office for more information.

Guidelines for Primary Record Contents

- 1) The CM must maintain a separate file or record at the CM agency for each individual
- 2) The CM must maintain privacy and confidentiality of individual records.
- 3) Primary Records must be made available to representatives of the State for auditing purposes and upon request.
- 4) The CM must ensure the record contains complete and up-to-date documentation of the individual's care and services.
- 5) The CM must maintain and archive records according to all appropriate laws and regulations.
- 6) The primary record must include sufficient information to demonstrate CM monitoring of team roles and responsibilities. When issues are identified, the case record must contain documentation to support monitoring and action by the CM and other team members through resolution of the issue(s).

The CM must comply with all DDSD record requirements available from his/her supervisor. These include ***DOH Policy on Primary Record and Documentation Requirements***

(February 8, 1998) and *DDSD Memorandum, Records Retention Period* (January 15, 1998).

Required Information Maintained in the Case Management File

- 1) Individual Service Plan (ISP), amendments, revisions
- 2) MAD 046
- 3) Team meeting minutes
- 4) Progress notes from therapists and/or provider agencies
- 5) Quarterly reports from provider agencies and therapists
- 6) Assessments/evaluations from medical providers, therapists, and/or community provider agencies.
- 7) Adaptive Behavior Scale (ABS) (individuals over 16 years of age)
- 8) Vineland Adaptive Behavior Scales (children under 16 years of age)
- 9) CIA (Comprehensive Individual Assessment)
- 10) Support plans (e.g. behavior support plan, career development plan)
- 11) Medical information (i.e. annual exam, level of care, physician notes, and other relevant medical reports)
- 12) Medication documentation, incident reports and follow-up
- 13) Guardianship information
- 14) MAW (Medical Assistance Worker) letters and approval for Medicaid
- 15) Standard case notes written by CMs
- 16) Documentation of orientation provided to the individual and parent/guardian regarding client rights regulations, client complaint procedures, regulations, and dispute resolution process
- 17) Signed primary and secondary freedom of choice (FOC) forms
- 18) Programmatic correspondence applicable to services received by the individual

19) Site visit forms

⇒ **Appendix: *DDSD Site Visit Form***

Documentation Procedures & Standards

As stated above, the CM is responsible for maintaining adequate records to document all CM activities. The CM utilizes documentation practices in accordance with DDSD expectations, to capture pertinent and legal information clearly and concisely, as outlined below.

⇒ **Appendix: *DOH/DDSD DD Waiver Program Technical Assistance Document Recommended Practices: Service Delivery Documentation***

Documentation Guidelines

- 1) The CM must document in chronological narrative, each contact with the individual and service providers.
- 2) The CM must document that the individual's health and safety is monitored and ensured on a monthly basis.
- 3) The CM must maintain records in a standard format and sequence.
- 4) The CM must use clear and legible writing. Typing contacts or notes is preferred.
- 5) The CM must record facts only; in the case of information communicated directly/indirectly by any team member, including the individual receiving services, the CM should make a notation that identifies the source of the information.
- 6) The CM must sign his/her name after each record entry.
- 7) The CM will refrain from using correction fluid or erasures, written critical comments or judgments about the individual and leaving blank spaces in the case notes.
- 8) If an individual is physically unable to sign a document and does not have a legal representative, the CM documents verbal discussion with the individual.

- 9) When an individual changes CMs, the existing CM must provide the complete individual record to the new CM at the transition meeting. Documentation of the record transfer must be indicated in the record.

What Should the CM Document?

- 1) Status on outcomes and action plans
- 2) Quality of services
- 3) If the ISP is being implemented appropriately
- 4) Coordination of services, including referrals and access of services
- 5) Status of assessments
- 6) Any follow-up that is occurring regarding the ISP or general services
- 7) Medical/health update or medication information (e.g. changes in medications)
- 8) All visits and telephone contacts with individual, guardian and providers

Documentation Must Include:

- 1) Description and purpose of case management activity
- 2) Result or intended result
- 3) Continued service planning need
- 4) Content of contact/conversation and parties
- 5) Date and time of contact or call
- 6) Type of contact (e.g. phone, home, office, other)
- 7) Length of contact or call

Sample Contact/Progress Note

9-1-05/10:45 am: The CM received a call from a Leaders Service Coordinator (SC) to address placing Margaret H. on a PRN psychotropic medication, recommended by her psychiatrist to assist with aggressive behaviors. CM explained to SC that per DOH policy dated 3-1-03, there are requirements for the use of PRN psychotropic medications, e.g., Human Rights Committee review, BSP components, integration into ISP,

etc. CM told SC that a team meeting will be scheduled ASAP to address the psychiatrist's recommendation and assess the appropriateness of the medication as related to Margaret's needs and circumstances. CM will contact all team members to set up the meeting.

Accountable Documentation Practices

- ☒ “If you didn’t document it, you didn’t do it!” Remembering this important statement may 1) help you preserve an individual’s personal history and record of services and supports and 2) save you a lot of grief or legal repercussions.
- ☒ Chronological sequence is important.
- ☒ Ambiguity in wording can lead to misinterpretations. Be Clear!
- ☒ Use black ink and write legibly.
- ☒ Do not erase or use white out. Instead, draw a single straight line through the mistake. Then, write the word “error” and place your initials above the mistake.

Example:

Error JTL

I fix my ~~mystakes~~ mistakes this way.