ST PETER'S HEALTH PARTNERS	**Effective Date:** October 1, 2017

Category: **C. Care Coordination**

Title: **4. Care Note Documentation**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Capital Region Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

Contents

PURPOSE

The purpose of this policy is to provide a standard set of expectations regarding Care Notes regardless of the Care Coordinator and to ensure that all Health Home Candidates and Members have an electronic health record with the same basic information.

POLICY STATEMENTS

It is the policy of Capital Region Health Connections that all interactions with or on behalf of a Member or Candidate be entered as a Client Search Note, Contact Note or CareManager Note in the Member or Candidate's electronic health record in a timely manner. In addition, Care

Notes should be unique and detailed. Care Notes are critical to Health Home Services for two major reasons described below.

1. Care Notes document when Core Services are provided to an enrolled Health Home Member or a Health Home Candidate in Client Search (Outreach) status. The notes provide the "proof" to the State and Medicaid that a billable service was provided. Without this critical documentation a service cannot be billed for, even if provided. Care Notes can be carefully reviewed during State and Medicaid audits. If services are billed for and the Care Notes do not specifically reflect the delivery of that Core Service, the Per Member Per Month rate paid for that Core Service may need to be paid back.

2. Care Notes capture the unique situations experienced by each Member and Candidate. No two Members or Candidates are the same and nor should their documentation be the same. Care Notes should be detailed and specific enough that any Care Coordinator or Health Home employee can pick up another Care Coordinator's Care Notes for a Member or Candidate, read them in their entirety and have a relatively complete and up-to-date picture of that Member or Candidate. In essence, the Care Notes should show the Member's progress towards meeting the goal and objectives outlined in the Plan of Care. Without detailed and specific Care Notes for each Member, services can be interrupted or delayed if a Care Coordinator is unexpectedly on leave and the new Care Coordinator needs to spend time trying to piece the case together.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Capital Region Health Connections Health Home program.

DEFINITIONS

Care Notes: The documentation housed in the electronic health record detailing every contact, successful or attempted, with a Candidate in Client Search (Outreach) or an Enrolled Member or a collateral on his or her behalf; contacts include phone, text, email, in-person, letters and faxes; in CareManager these can be Client Search Notes, Contact Notes or CareManager Notes

DOH 5055**:** Health Home Patient Information Sharing Consent Form; the State produced form for capturing consent for other providers as well as natural supports

Electronic Health Record (EHR): A digital record of Care Coordination efforts, contact with and services delivered to a Health Home Member or Candidate; the record provides real-time information for all Health Home Members and Candidates and houses all information relative to that Member or Candidate; CareManager is the Electronic Health Record used by all agencies in Capital Region Health Connections

Health Home Candidate: An individual who is in active Client Search (Outreach) status, but who has not yet been enrolled in Health Home services

Health Home Member: An individual who is enrolled in Health Home services

PROCEDURE

A. Electronic Health Records

1. A separate electronic health record must be maintained for each Health Home Candidate or Member. When a Health Home Candidate is enrolled, and thus becomes a Health Home Member, a new electronic health record must **not** be created; the same record will follow individual from Health Home candidacy to membership.

2. All electronic health records must be in CareManager, the electronic health record platform used by Capital Region Health Connections.

3. In addition to all Care Notes, the electronic health record must contain, at a minimum:
   - a copy of the Member's signed consent (DOH 5055);
   - a copy of the Member's signed Bill of Rights;
   - an initial Comprehensive Assessment and subsequent updates;
   - the initial Plan of Care and subsequent updates;
   - copies of any releases signed by the Candidate or Member; and
   - medical, behavioral health or substance use diagnoses verification.

B. Care Note Documentation

1. Any and all contacts with a Member or Candidate must be documented in the electronic health record in CareManager. This includes face-to-face contacts as well as phone, text, email, letters, faxes, research to locate Candidates or Members, and Case Conferences or Plan of Care presentations.

2. Any unsuccessful or attempted contacts must be documented in the Member's or Candidate's electronic health record.

3. Any contacts or attempted contacts with collaterals such as providers or relatives must also be documented in the Member's or Candidate's record, including Case Conferences.

4. Any providers, collaterals or others referenced in a note should be defined by first and last name and affiliation with the case for context purposes. For example,

"…Maria Smith, mental health provider at Samaritan Outpatient stated…" should be used instead of "…Maria stated…" If providers are involved in the contact being documented, they should also be identified as a participant in the note via the "Other Participants" search box in the Participants section of the note.

5. If a Care Coordinator has multiple exchanges with a Member in one day, all relative to the same topic (i.e., texting back and forth, an email chain, episodes of "phone tag"), the Care Coordinator may document those exchanges as one Care Note at the end of the exchange. Care Coordinators and Supervisors should use their professional judgment to determine if certain exchanges require separate Care Notes, based on the content and information shared.

6. Care Notes must be written in the third person (i.e., "this writer"); the use of first person (i.e., "I," "we," "me" or "my") is not acceptable.

7. Abbreviations should not be used in Care Notes unless they are defined within the note, or are commonly used abbreviations in the field of Care Coordination, such as CRHC for Capital Region Health Connections or PCP for Primary Care Physician.

C. Care Note Content

1. The narrative section of the Care Notes must reflect:
   a. the content of the discussion or activity with the Member, Candidate or collateral,
   b. what Plan of Care interventions were addressed during the contact as well as any barriers relative to the interventions (for enrolled Members only), and
   c. the outcome or any actions that need to be taken as a result of the contact.

2. Care Notes should end with an action statement, reflecting the appropriate follow-up or next steps to be taken.

3. All Care Notes must be finalized electronically in CareManager.

D. Timeliness of Care Notes

1. Care Coordinators should make every effort to complete documentation for any successful or unsuccessful contacts the same day as the contact.

2. As a best practice, Care Notes must be documented within two business days of the contact or attempted contact.

REFERENCES

New York State Department of Health (January 9, 2014). Health Home Provider Manual: Billing Policy and Guidance. (https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf)

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