MODULE 8: DOCUMENTATION AND REPORTING
OUTLINE FOR THIS MODULE

- Documentation and Reporting
- Review and Assessment
- Service Learning
What did we learn last week?
What stands out from the last few modules?
What has been reinforced through your Service Learning experiences?
DOCUMENTATION AND REPORTING
LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Understand the importance of collecting and documenting health information accurately.
- Explain the purpose of various types of collection tools and methods for health and social information.
- Participate in the collection and documentation of health and social information.
- Understand common medical terminology.
INTRODUCTION TO CLINICAL DOCUMENTATION
WHY DOCUMENT?

- Goes in a formal record.
- Helps ensure continuity of care.
- It's a communication tool among service providers.
- Facilitates research.
- Allows for billing insurance.
- Jogs memory.
- Helps you justify care and services provided.
You are helping to relay a story.

Clients deserve to have their story told accurately.

Your relationship with the client may reveal important information that has not previously been shared.

You are a steward of information that is discussed.
CULTURAL HUMILITY AND DOCUMENTATION

Cultural humility includes:

- **Reflection**: What do I learn from each person that I encounter?
- **Respect**: Did I treat everyone involved in my encounter with respect?
- **Regard**: Did any unconscious bias drive this interaction?
- **Relevance**: How was cultural humility relevant in this interaction?
- **Resiliency**: How was my personal resiliency affected by this interaction?

What effect does this have on documentation?
GOOD DOCUMENTATION PRACTICES

Check with your employer to ensure you are complying with their standards.

- Be sure to include date, time and your signature.
- Make entries immediately or soon after visit with client.
- Write legibly (check spelling, too!).
- Be thorough, accurate and objective.
TYPES OF DOCUMENTATION

- Clinical.
- Non-clinical.
- Summaries.
- Home visits.
- SOAP notes.
- CHW form created by agency.
### CURRENT CONDITION

**Patient Name:**

**Relevant Area:**

**Diagnosis:**

**Ordering Information:**

**Provider Name:**

**Patient Information:**

**Service Date:** (dd-mm-yyyy)

**Visit Number:**

**Family Name:**

**Street Address:**

**City:**

**State:**

**ZIP Code:**

**Phone:**

**Insurance:**

**Insurance Number:**

### GOALS

1. Pt. will demonstrate productive cough in seated position, 3x times.
2. Pt. will maintain 100% with oxygenation, no exercise shortness, on oral nebulizers.

### ASSESSMENT FINDINGS:

- Patient attended all previous PT labs. All PT goals were met and will review again.
- Patient performed a weak cough technique and coughed enough that he was oriented to space and time.
- Patient performed his full ROM and strength exercises with no assist. He maintained his posture while sitting and standing.
- Patient performed his full ROM and strength exercises with no assist. He maintained his posture while sitting and standing.

### OXYGEN THERAPY

- Patient continues to present with 21% oxygen therapy at home. Patient has been compliant with oxygen therapy and has no problems with the equipment. Patient has been discharged from the hospital and is now living at home.

### TREATMENT PLAN

- Patient will continue with strengthening exercises and activities of daily living.
- Patient will continue to attend physical therapy appointments.

### GLOSSARY OF ASTHMA TRIGGERS

**Combustion by-products**

Triggers that are formed when fuel is burned.

**Posts**

-Asthma inhalers—Body parts and shavings. Sputum—For skin, flannel, and unused.

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**CHECKLIST FOR HOME VISITORS**

Using this Home Assessment Can Help Make Homes Healthier.

A trained home visitor can help find common asthma triggers in homes and discuss ways to reduce and remove triggers. Removing asthma triggers in the home, along with proper medical care can improve health.

The checklist is organized into a Home Assessment and two appendices: Dust Mite Module and Mold and Moisture Module. The Home Assessment can be used for all types of housing and climates, but the additional modules can be used if dust mites or mold/moisture issues are suspected by the trained home visitor. The suggested action items in this checklist are generally simple and low cost.
**Department Policy and Procedure**

**Department Name:** Care Coordination  
**Policy/Procedure Name:** CHW Documentation Procedure  
**Effective Date:** 05/01/14  
**Revised Dates:** 09/01/17, 09/28/18, 08/30/18, 05/06/19

**Policy and/or Procedure: Procedure**

**General Guidelines:***
- Document every encounter or attempted interaction with a client or on behalf of the client (direct and indirect) in Care Coordination EMR. This includes an encounter for enrollment and discharge notes.
- Log applicable travel time on every encounter.
- If you accompanied a CHW during a home visit, create an encounter to reflect time spent and reason of visit. Additionally, if encounter is billed, CHW will need to select the right payor grant.
- For bilateral encounters, travel time needs to be added to the encounter time and also listed separately.
- If you are onsite at a hospital or clinic with an EMR, you will document the following in their system—outcome of the referral you received, enrollment note and, discharge note.
- Documentation must occur within 48 hours of the encounter.
- You must contact your clients at a minimum of every two weeks during the first six months of enrollment. After 6 months of enrollment, you must contact your clients at least once a month.
- Every note that goes into a partner EMR should include your signature, title, and cell number.
- If client is re-enrolled in program, add new enrollment with new date on enrollment note section above original enrollment note. Add new discharge with new date on discharge note section above original discharge note.

**Documentation Types – Quick Note, Enrollment Note and Discharge Note:**

**Quick Note:**
- When to use: Any encounter outside of an enrollment or discharge note.
- What to include: What was the plan (what was the purpose of the encounter), what intervention occurred (what did you discuss or accomplish), and what is the follow up (next steps).

**Plan:** CHW met at the client’s home to fill out a Medicaid application.

**Intervention:** CHW and client filled out Medicaid application and faxed it into the Medicaid office. Client needs to collect a copy of his medical records and bank statements to send to Medicaid.

**Follow-up:** Client will collect his medical records and bank statements and call CHW in one week to set up another meeting time. CHW will then fax those documents at that time.

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**Department Policy and Procedure**

*Exceptions to this are when you didn’t reach the party you were attempting to call. You would only note the plan (who you were attempting to contact and why) as well as the follow-up plan.*

**Example:** CHW called client to discuss the outcome of his medical visit. Client did not answer. CHW left a message. CHW will call client back in two days.

**Enrollment Note:***
**Enrollment note might be slightly different according to specifics of each of the programs.***

**When to use:** When a client is enrolled into the program.

**What to include:** Client’s history, list the care plan items you will be working on, and then the follow-up plan for next steps with pt Ex: CHW will contact pt in two weeks to verify _was accomplished._

**Enrollment Note Template:**

**Example of Enrollment Note:**

<table>
<thead>
<tr>
<th>SUMMARY:</th>
<th>Community Health Worker (CHW) met with C and assessed needs. CHW is a therapist at KC CARE CHW but has not seen a physician in a long time. CHW wants help filling out her Medicaid application and help appealing her disability application. CHW received a grant program on 5/13/17 and discussed 3 different objectives they will work on.</th>
</tr>
</thead>
</table>
| CARE PLAN ITEMS: | 1. Description of Care Plan Item 1  
2. Description of Care Plan Item 2  
3. Description of Care Plan Item 3 |
| FOLLOW UP FOR CARE PLAN ITEMS: | (this is the summary of next steps) |
| CHW Name: | Date:  
Cell Phone: |
**SOAP NOTES**

| S  | • Subjective Data.  
  • What is the person experiencing or feeling, how long has it been a problem, what is the frequency, intensity, duration? |
| O  | • Objective Data.  
  • Your description of client’s status (such as psychological, health status), description of body language and affect. |
| A  | • Assessment of situation, session and client. |
| P  | • Plan for intervention, follow up, when you’ll speak again. |
GROUP ACTIVITY: SOAP CASE STUDY

- Try filling out a SOAP note using the information in the case study.
- Then partner with someone to discuss the following:
  - What additional information would you need to complete the SOAP note?
  - How might you share the information you gathered for the SOAP note with a supervisor or clinician?
  - Was there anything challenging about using the SOAP note?
  - What did you like about the SOAP note?
MEDICAL ABBREVIATIONS

- When you’ll encounter them.
- Discuss with your employer.
- Ask for a list of common terms.
GROUP ACTIVITY
PRACTICE TOGETHER USING THE
“TRANSLATING MEDICAL TERMS” HANDOUT
GROUP ACTIVITY 8.6
DEMONSTRATION TO PRACTICE NOTE-TAKING
GROUP ACTIVITY 1.3
GUEST PANEL OF CHW PRESENTERS
REVIEW – WHAT HAVE WE LEARNED TODAY?
SERVICE LEARNING