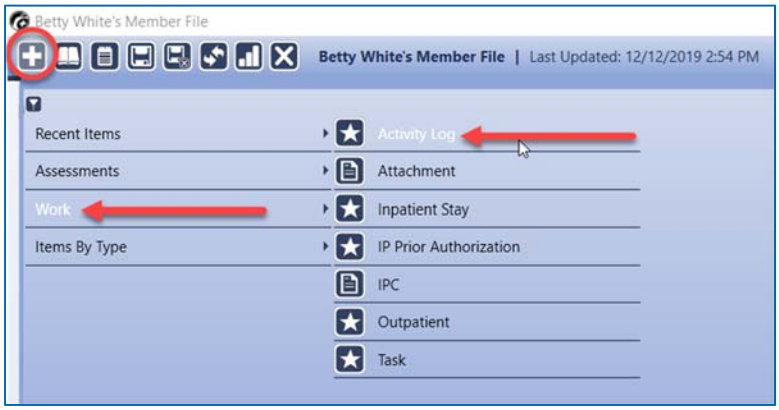
GSSC Regular Assessment Clinical Note Requirements

Using the Clinical Note Template in CTD

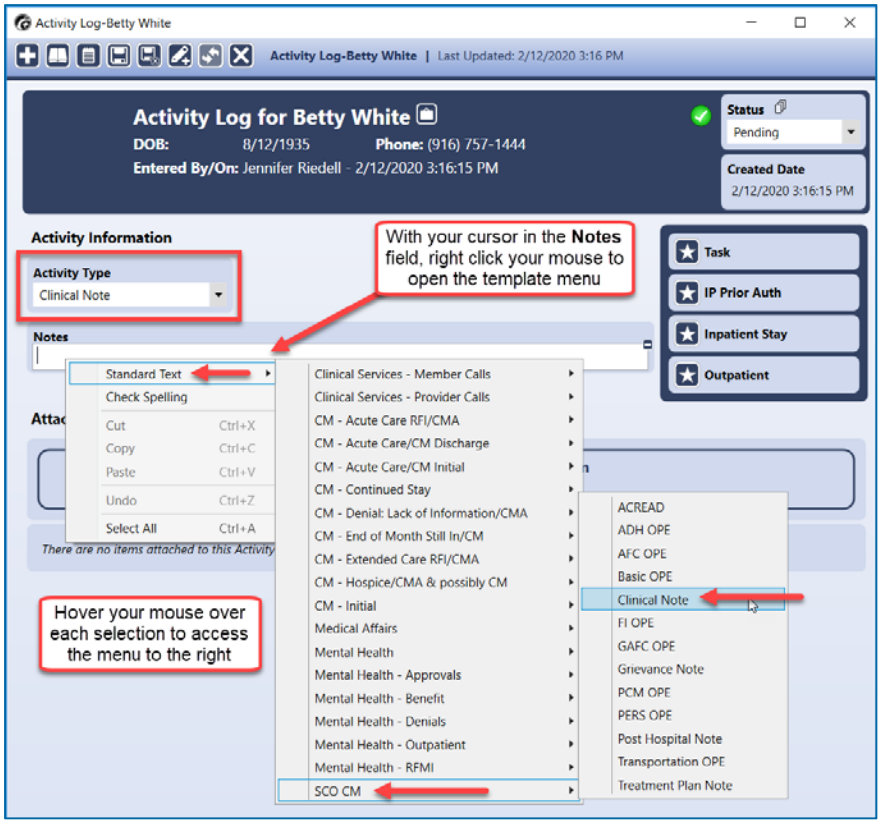
A Clinical Note is required for all member visits and serve as a narrative account of your assessment; questions and concerns from the member and/or caregiver; follow-up for future visits and documentation of your coordination with the member's Primary Care Team (PCT). In CaseTrakker, the Clinical Note template will provide documentation guidance for GSSCs after they complete a regular assessment visit.

1. In the upper left-hand corner of the screen, click the icon, then **Work** and **Activity Log**.



You can create an Activity Log from the **Activity Log Summary** screen, but it will not have the additional option to create Tasks from the Activity Log.

2. In the drop down under **Activity Type**, select "Clinical Note". With your cursor in the **Notes** field, right click the mouse to access the CTD templates. Hover your cursor over "Standard Text", then "SCO CM", and then click on "Clinical Note" to populate the template.



3. Complete the Clinical Note Template using the guidelines below. The left column contains the header as it appears in the Clinical Note Template, and the right column details the information that should be provided (as it applies to the member). Text appearing in **bold** can be copied into the Clinical Note and edited to match your assessment.

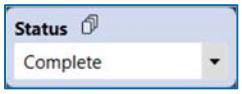
Header	Information to include:
Date of Assessment	• "**In-home assessment completed** [Date and time]**.**"
Brief Overview	• Document "**Obtained verbal consent from member to discuss PHI in front of family/caregiver** [name]**.**" if no AOR in place. • Description of member: Age; language spoken (include whether an interpreter used, family interpreted or CHW is fluent); pertinent medical/behavioral health diagnoses; appearance (obese, frail); nutritional status; cognitive status • Condition of living space (home or apartment; elevator or stairs; neat, cluttered, etc.); who lives with member; who provides support; any additional social supports • Activities involved in and how member spends their time • ADL/IADL function • Recent falls, hospitalization, ED visits and their current picture outcomes • How member is taking medications (on own, cueing, others admin); what do they use (pill box filled by daughter, MD2, pill bottles), and compliance with medications. • Member's concerns about their medical/behavioral health or their overall care • Document any teaching delivered to member and/or caregivers Don't forget to **Task** the SCO Clinical Consultant if the member reports: • Increased shortness of breath (SOB) when speaking or with mild activity • New onset of pain that is decreasing their ability to complete ADLs independently • Unsteady gait, dizziness, recent fall or abnormal gait test • Pain, if not controlled with meds
Current Services	• Include all services provided and the problems being addressed o Example: ADH 5 days/week to ensure med compliance, improve safety and manage depression

Header	Information to include:
	Don't forget to **Task** the Primary Owner (if not yourself) if the member is requesting additional services or has any questions/ concerns with their existing services.
Current DME	• List of all equipment in the home and if it is adequate • If not adequate, what is needed and why it is not present Don't forget to **Task** the Care Coordinator if the member is having any issues with their current DME. Don't forget to **Task** the Primary Owner (if not yourself) if the member is requesting additional DME or has any questions/ concerns with their existing DME.
Current Supplies	• Include all supplies, where they are being ordered from and what needs are met o Example: Pullups for urinary incontinence ordered through Byram. Don't forget to **Task** the Care Coordinator if the member is having any issues with their current supplies. Don't forget to **Task** the Primary Owner (if not yourself) if the member is requesting additional supplies or has any questions/ concerns with their existing supplies.
Treating Providers	• Include MDs the member has seen within the last 3 months, dates of next appointments and information on pertinent past visits • Identify how member gets to their appointments (family, escort, on own)
Plan / Areas of Concern / Next Steps	See examples below, which you can edit as needed to the member's situation. If there are no areas of concern, copy and paste the last entry in your Clinical Note. • **Area of Concern / Next Steps:** Risk for fall related to unsteady gait and report of uncontrolled pain. Telephone call to the RNCM from the member's home to report concerns. RNCM to follow-up with plan of action and review assessment. • **Area of Concern / Next Steps:** Member requesting additional HM services. RNCM notified via Task to review assessment and report member's request for additional services. • **Area of Concern / Next Steps: No areas of concern at this time. Member stable. RNCM notified via Task to review assessment.** Don't forget to include "**Verbal approval from member on Plan of Care and Service Plan.**"

Header	Information to include:
Allergies	Document any new allergies. If there are no new allergies, document "**No new allergies.**" If there are new allergies, be sure to add them on the main Member File screen.
Advanced Directives	Document changes to the member's Goal of Care (longevity, function, comfort, or member does not wish to answer), type of document, location of document and any additional notes. If there are no changes, document "**No changes to Goal of Care / Advanced Directives.**" Make sure the "Goal of Care" on the Member File screen matches your entry in the CA. If there are changes to the member's Goal of Care or new Advanced Directives, be sure to add them on the main Member File screen.

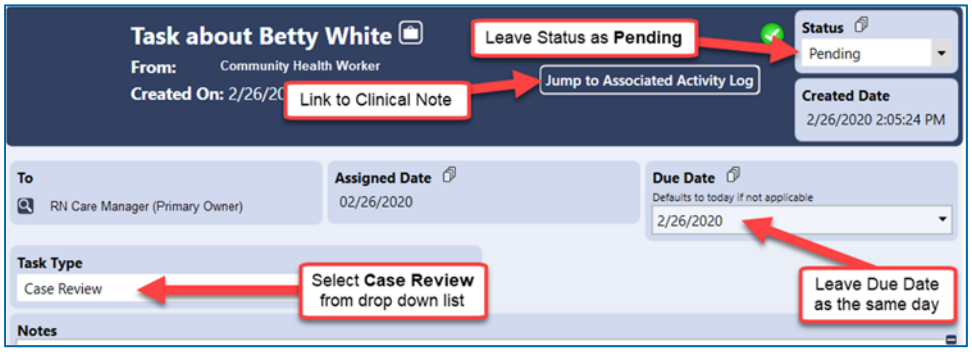
Once you are finished, complete your Clinical Note and Task the SCO Clinical Consultant:

1. In the upper right hand corner, change the Status to **Complete** using the drop down.



2. Click the in the upper right hand corner of the Activity Log. This will open a Task with a link directly back to your Clinical Note.

3. Send the Task to the SCO Clinical Consultant, using Task Type **Case Review**. Leave the Status as **Pending** and the Due Date with the same date the Task is being sent.



4. In the Notes section, call out any areas of concern, member requests or questions (refer to icons in Clinical Note Template). Otherwise, document "**Member assessment completed. Please review Assessment and Clinical Note.**"