High Risk Documentation – Module 3

Introduction

This on-demand training module is provided by the MN Department of Health WIC Program. It provides an overview of High Risk Care in the Minnesota WIC Program.

High Risk Documentation

Objectives

The objectives of the Module are to:

- Learn how to develop and document High Risk Care Plans and the Follow-up contacts
- Identify the components of a SOAP note

There are numerous links to webpages in this module. If you would like to check out any of the webpages, pause the module and select the link. When you are ready to continue viewing the module, select play.

Documentation of High Risk Care

The previous modules discussed "how to provide High Risk Care" Now let's talk about documentation.

- Ultimately, the purpose of documentation is to provide continuity of care. That means that your documentation assures the high risk condition, the nutrition intervention and the planned follow-up are clear to others who open that record.
- Documentation of the care plan in a HuBERT SOAP note is a common method. The SOAP template populates some of the participant's data, reducing data input from the CPA. Another documentation method may be used if it is approved in the agency's Nutrition Education Plan.

HuBERT SOAP Template

There are numerous ways to access the SOAP template:

- In the CGS – select the SOAP link
- In the participant folder – Select Participant Activities in the menu and then Manage notes or simply click on the Notes Icon

SOAP Note Template

The SOAP Note Template autopopulates the following information from the most recent certification:

- Height and weight measurements
- The ht/age and wt/age percentiles
- Bloodwork values
- Risk Factors

- Referrals

SOAP Example

Let's write a SOAP note for a 4 year old boy Lucas who is underweight.

The Risk Factors Tab shows that the child has been assigned 103 for Underweight. The * by 103 means the child is flagged as High Risk. BMI-for age is $\leq 5^{th}$ percentile on the CDC Growth Grid so Lucas meets the criteria for High Risk.

S is for Subjective

S in SOAP stands for subjective and may include:

- Information collected from talking with an individual
- An individual's thoughts or feelings
- An individual's description of his or her problems
- Dietary intake or reported food habits

S Example

Here is the Subjective part of the high risk care plan for Lucas:

S Mom reports Lucas eats small amounts of a few select foods. Doesn't offer Lucas any snacks. He usually will not eat breakfast, TV distracts him. Runs out of SNAP benefits before end of month. Pediatrician is monitoring his weight, next appointment is in one month. Will also see dietitian for initial appointment.

O is for Objective

O in SOAP stands for Objective and includes:

- Facts you collect, tangible findings and your clinical observations
- Physical findings
- Factual information regarding background, history

O Example

On the screen you will see the Objective part of the High Risk Care plan for Lucas

- HuBERT auto populates some participant data into the template for "O". This includes anthropometric data, bloodwork and risk factors.
- CPAs can add other objective information as needed.

A is for Assessment

A in SOAP stands for Assessment and includes:

- Your assessment or impression of the individual's overall situation.
- Summary and evaluation of diet and nutritional status
- Meaning of the information collected
- Problem definition or interpretation

Identify the High Risk Condition or conditions in your assessment to promote continuity of care. This is particularly critical for a participant with a risk code that can be assigned for a variety of high risk conditions. For example: Risk Code 349, Genetic and Congenital Disorders is assigned

for multiple conditions including cleft palate, Down Syndrome, and Sickle Cell Anemia. The high risk care is quite different for each of these conditions.

P is for Plan

P in SOAP stands for Plan and includes:

- Specific nutrition education, goals and recommendations regarding the high risk condition(s)
- Any additional information that is needed and plan to obtain that information
- Referrals that were made
- Recommendations and plans for follow-up visits
- Educational materials used and given to the individual

Strive for continuity of care. Write the plan so your colleague knows how to follow-up on this participant's high-risk needs.

P Example

Here is a Plan for Lucas:

P

- Encouraged to increase frequency that food is offered, try for 3 meals and 2 snacks every day.
- Goal is to keep TV off during breakfast so he will eat better.
- Gave list of food shelves to help supplement SNAP benefit.
- Follow-up in in 3 months - Check wt and ht, what were results/recommendations from scheduled November appointment with pediatrician and RD?

Does this SOAP Note meet documentation requirements?

- Does this SOAP note provide continuity of care? YES
  - The CPA providing the next contact has a good snapshot of the high risk condition and planned follow-up
- Does it provide an assessment of the individual's situation? YES
  - Child is underweight. Poor dietary intake, irregular meal/snack pattern
- Does it review health services provided for the HR condition? YES
  - Child is being followed by pediatrician, will see clinical RD next month.

Does this SOAP Note meet documentation requirements? Slide 2

- Does the SOAP note identify specific goals/recommendations regarding the HR condition? YES
  - Set regular meal/snack pattern
  - Avoid TV at meal time
- Are referrals to health care provider and other services provided as needed? YES
  - Food Shelf
- Are plans for the follow-up visits apparent? YES
  - Check weight and height in 3 months

- Follow up on physician/dietitian feeding recommendations

Follow-up

Now that we have determined our plan for follow-up for Lucas, let's talk about High Risk Follow-up:

- **Tailor the high risk care follow-up to the needs of the participant.** Just like the high risk care provided at certification appointments, the follow-up appointment should be tailored to the needs of the participant. There is not a one-size fits all approach.
- **The high risk follow-up needs to be specific to the high risk condition.** It provides an opportunity to examine progress towards established goals; provide positive support; identify barriers that may be hindering participant's progress; and assess and refine future nutrition education needs.
- High risk Follow-up for a participant may include some of the following:
  - Dietary assessment.
  - Monitoring anthropometric measurements and discussion of growth and weight gain/loss.
  - Monitoring hemoglobin and discussion of blood work results.
  - Discussion of participant's/caregiver's nutrition or health-related concerns.

Follow-up (continued)

  - Discussion or reinforcement of instructions given by other health care providers.
  - Assessment of food package needs and/or revision of food package prescription.
  - Individualized nutrition education.
  - Monitoring participants with complex medical problems or serious risks to assure they are receiving adequate care from appropriate health/nutrition professionals.
  - Referral to other programs and services, as needed.
  - Follow-up on referral to other programs.
  - Monitoring/modifying realistic goals established with participant/caregiver.
- Remember these are just examples and you will tailor your follow-up to the needs of the participant.

Follow-up Example

What would you follow-up on the next time you saw Lucas? Here are some possible follow-up activities for Lucas, 4 year old child who is underweight:

- Check height and weight
- How is his appetite?
- Meal/snack pattern? What kinds of snacks?
- What is TV viewing like at breakfast?
- What medical intervention/recommendations were received from Pediatrician or clinical RD

- Family was referred to the food shelf?

Follow-up Example

Documentation of the follow-up contact for Lucas:

Per today's measurements, growth remains slow but steady. Mom reports he is still not eating much at a time. Offering 3 meals and 2 snacks every day, has been eating breakfast better since dad eats with him and no TV! Pediatrician and clinical RD appts went well, nothing new. Used the food shelf last 2 months. Drinking juice out of sippy cup frequently during day. Goal is to give water between meals in place of juice. Will follow up at Midcertification in 3 months.

Follow-up Expectations

What are the expectations for high-risk follow-up:

- Follow-up addressing the status of the high-risk condition must be provided at least quarterly until the high-risk condition is resolved or stable.

Discontinuing High Risk Care

- The high risk care can be discontinued when:
  - CPA determines the High Risk condition is resolved or stable
  - CPA determines participant has adequate HR care and follow-up from the health care provider (see MOM Section 6.6 for specific requirements)
- Use the Resolve System-Assigned High Risk Checkbox in the participant folder, as we discussed in Module 1.
- When resolving high risk status, CPA must use professional discretion and justify the reason in the participant's record.

Congratulations!

Congratulations! You have completed the third and final High-Risk Module. Thank you for your care of the Women, Infants and Children of Minnesota!

End

End Slide

We appreciate you taking the time to review this on-demand training module presented by the MN Department of Health WIC Program.