

Case Notes Guidance: Best Practices

Case notes should provide an image of the client's current status of care and document the quality provision of contracted services

- **Address the important questions:**
 - **WHO:** The name, qualifications, and/or title of staff involved
 - **WHAT:** What conversations took place and what actions were taken by or on behalf of the client
 - **WHERE:** The physical or digital location in which services were rendered
 - **WHEN:** Date and time of day of relevant actions
 - **HOW:** Measurable and concrete description of interventions implemented/action taken
 - **WHY:** The intended outcome related to the intervention/action

- **DAP Standardized Format:**
 - **Data:** What occurred & who was present, when & where did it happen
 - **Assessment:** Why & how an action/behavior happened, why & how an outcome was either achieved or missed
 - **Plan:** Proposed resolutions, assignment of tasks, follow-up

- **After writing, ask yourself, “Does my note...”**
 - ✓ Indicate client needs?
 - ✓ Indicate any changes since last encounter?
 - ✓ Address client's current disease status?
 - ✓ Clearly assign tasks for follow-up?
 - ✓ Identify client strengths and achievements?
 - ✓ Address who, what, when, where, how, and why?
 - ✓ Support appropriate provision of services?

- **DO:**
 - Refer back to plan of care
 - Include only relevant details
 - Be specific when necessary
(e.g., appointment details, contact information)
 - Avoid slang and overuse of abbreviations
 - Use professional language and grammar

- **DON'T:**
 - Include irrelevant personal details
 - Take shortcuts at the cost of clarity
 - Use medical diagnoses unless verified by an appropriate provider (e.g., “client has been depressed” vs. “client says he is in a depressed mood”)
 - Allow personal biases to be reflected

Case Notes Guidance: Acceptable Abbreviations

Remember: excessive use of abbreviations compromises the readability of case notes.

- **ADAP:** AIDS Drug Assistance Program
- **ART:** antiretroviral therapy
- **BWCA:** Burnham, Woods, Champa & Associates
- **CHC:** Comprehensive Health Care
- **CLT:** client
- **CW6:** CAREWare 6
- **EIS:** early intervention specialist/services
- **F2F:** face-to-face
- **FDOH:** Florida Department of Health (Osceola/Brevard)
- **FPL:** federal poverty level
- **H&H:** Hope & Help Center of Central Florida, Inc.
- **HOPWA:** Housing Opportunities for People with AIDS
- **MCM:** medical case manager/management
- **MMSC:** male-to-male sexual contact
- **MOL:** Miracle of Love, Inc.
- **NMCM:** nonmedical case manager/management
- **NOE/NOI:** notice of eligibility/ineligibility
- **PAP:** patient assistance program
- **PCCER:** Patient Care Core Eligibility Recertification
- **PCP:** primary care provider
- **PO:** purchase order
- **PR:** Project Response
- **PT:** patient
- **PWID:** person/people who injects drugs
- **RDA:** referral determination assessment
- **ROI:** release of information
- **RS:** referral specialist
- **RWHAP:** Ryan White HIV/AIDS Program
- **RX:** medication
- **SNAP/EBT:** Supplemental Nutrition Assistance Program/Electronic Benefits Transfer
- **SS(A):** Social Security (Administration)
- **STD/STI:** sexually transmitted disease/infection
- **VL:** viral load

HEART OF FLORIDA UNITED WAY – RWHAP PART B
Case Notes Guidance: DAP Examples

EXAMPLE 1B – REFERRAL SPECIALIST

D. RS met with client for redetermination at main office. Client provided utility bill and two recent paystubs. Client now qualifies for health insurance at work due to increasing hours and is fully enrolled with Insurance Company (card uploaded to CW6). RS completed RDA and client scored a level 1.

After redetermination, client requested assistance with SNAP recertification (\$94 monthly) due to vision issues and low computer literacy (username/password). RS provided client with ACCESS Florida phone number to check on status. Client recently completed labs with his PCP and has a lab review via telehealth on 01-28-2022 at 3:15 PM. Client reports no additional diagnoses, symptoms, housing, or emotional concerns.

A. It appears client remains at acuity level 1. It appears client has increased self-advocacy by enrolling in his own insurance.

P. RS will request copy of labs from PCP. Client will keep upcoming appointment.

EXAMPLE 2B – Medical Case Management

D. Medical case manager (MCM) received a voicemail from client that their ART prescription was not available at their pharmacy (Pharmacy Information) even though client had left a voicemail for their provider (Provider Information). MCM reached out to provider's office and confirmed prescription would be sent this morning. Client has upcoming appointment on 02-07-2022 at 8:40 AM. MCM called client, provided medication update, and reminded client of appointment. Client said they had set up a new calendar in their kitchen. MCM suggested getting a planner as well, as client prefers physical reminders to using their phone.

A. It appears client is intending to stay adherent to medication and compliant with appointments.

P. Client will pick up medication and attend upcoming appointment.

EXAMPLE 3B – Early Intervention Services

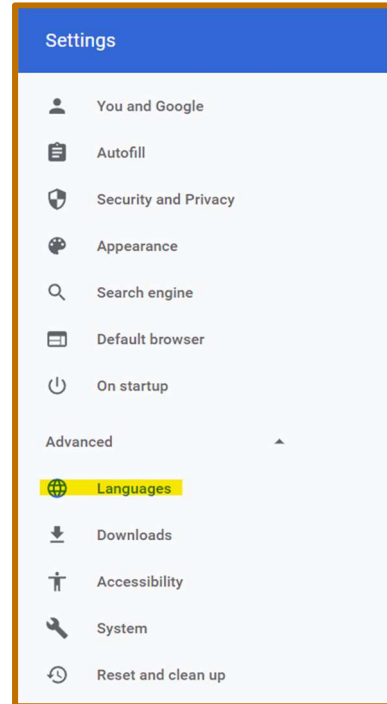
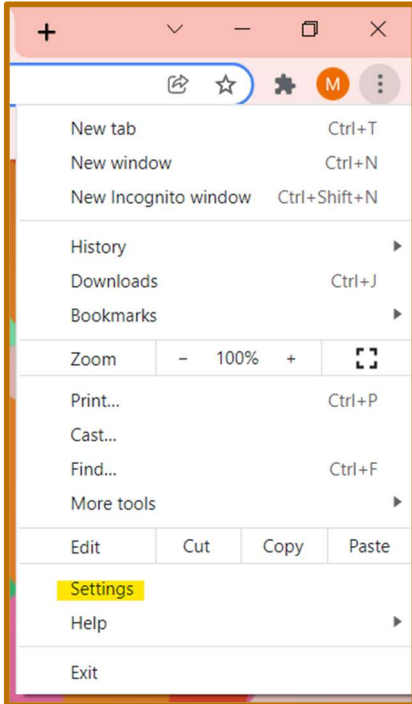
D. EIS received referral from Agency, last Agency contact with client was on 11-02-2021. EIS called client, but no answer. EIS used data research software to find a new phone number (999-999-9999), and established contact. Client said their mother had died recently, they were feeling depressed, and had not picked up their medication since 10-2021. Client reported slight fever and skin rashes. EIS set redetermination appointment and provided information on gathering required documents. Client agreed to call provider to request prescription and appointment.

A. It appears client has been experiencing difficulties with grief but is willing to re-engage in care.

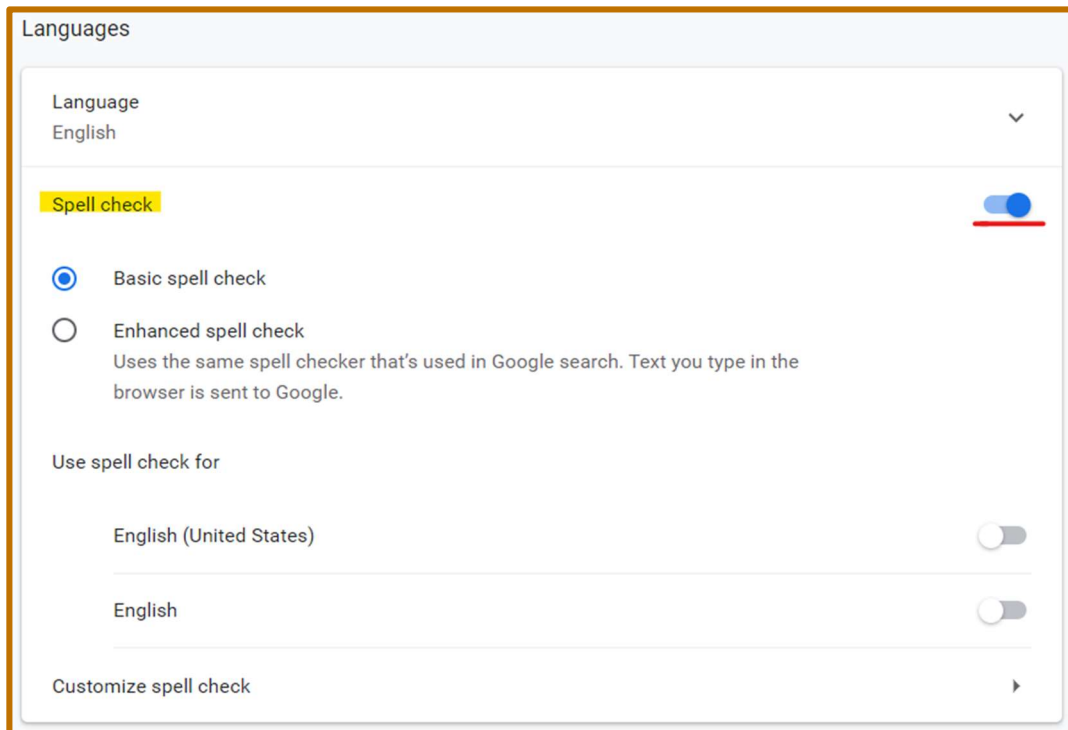
P. EIS will meet client at main office on 01-28-2022 at 9:00 AM.

Case Notes Guidance: Spell-Check in Chrome

1. Open Google Chrome and open the **Settings** tab by clicking on the three dots in the upper right-hand corner of the screen.
2. Navigate to the left-hand side of the screen. Click **Advanced**, and select **Languages**.

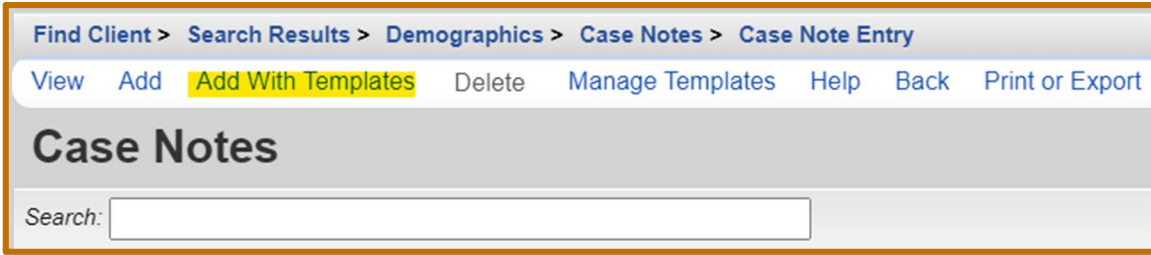


3. Navigate to **Spell Check** and turn the slider on (color will change from gray to blue). Select “Basic spell check” *not* “Enhanced spell check.”



Case Notes Guidance: Template in CAREWare 6

1. On the Case Note Entry page, select **Add With Templates**.



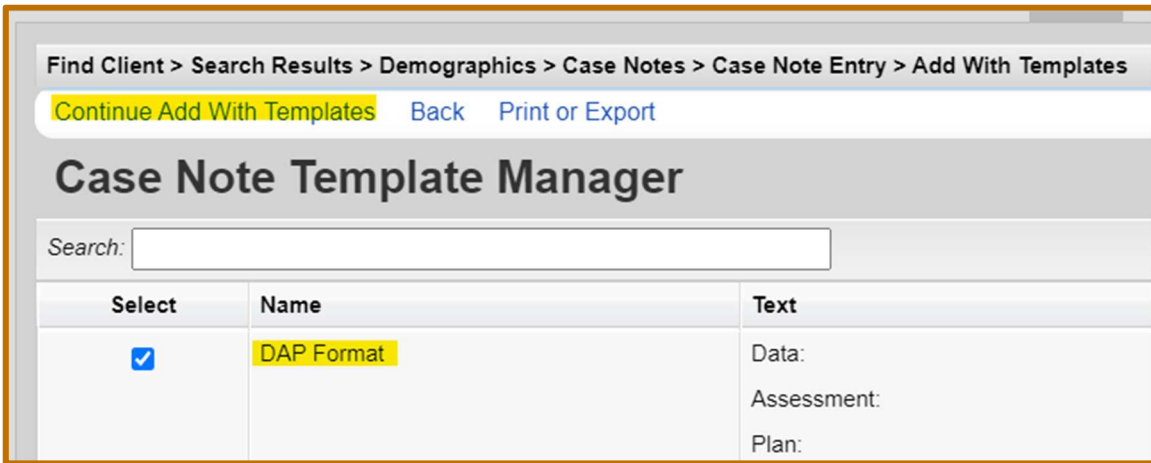
Find Client > Search Results > Demographics > Case Notes > Case Note Entry

View Add **Add With Templates** Delete Manage Templates Help Back Print or Export

Case Notes

Search:

2. From the Case Note Template Manager, check the box for **DAP Format** then select **Continue Add With Template**.



Find Client > Search Results > Demographics > Case Notes > Case Note Entry > Add With Templates

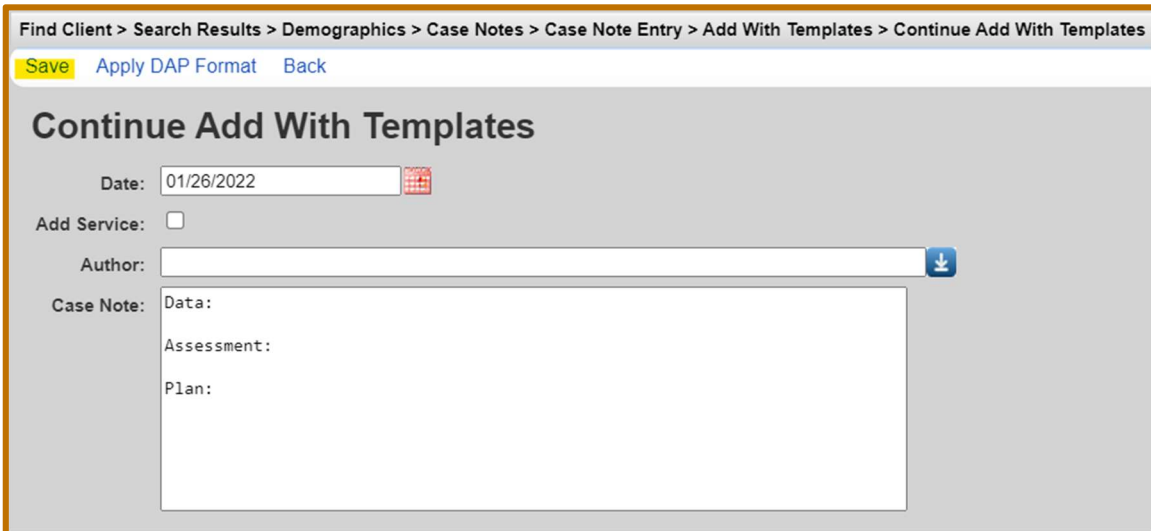
Continue Add With Templates Back Print or Export

Case Note Template Manager

Search:

Select	Name	Text
<input checked="" type="checkbox"/>	DAP Format	Data: Assessment: Plan:

3. Write your case note using the DAP format and select **Save**.



Find Client > Search Results > Demographics > Case Notes > Case Note Entry > Add With Templates > Continue Add With Templates

Save Apply DAP Format Back

Continue Add With Templates

Date:

Add Service:

Author:

Case Note:

Data:
Assessment:
Plan: