FY 2013 GA SHINES PBC REPORTING GUIDE

Division of Family and Children Services
Office of Provider Management

DHS
Georgia Department of Human Services

FY 2013 GA SHINES PBC Reporting Guide

This instruction guide covers how to report applicable Performance Based Contract (PBC) measures via the GA SHINES Portal. RBWO Providers only have access to create contact documentation in GA SHINES. Therefore with the exception of selecting the correct "purpose type" and "narrative type" the instructions are the same for each applicable measure. The general instructions below apply to making all contact documentation in SHINES.

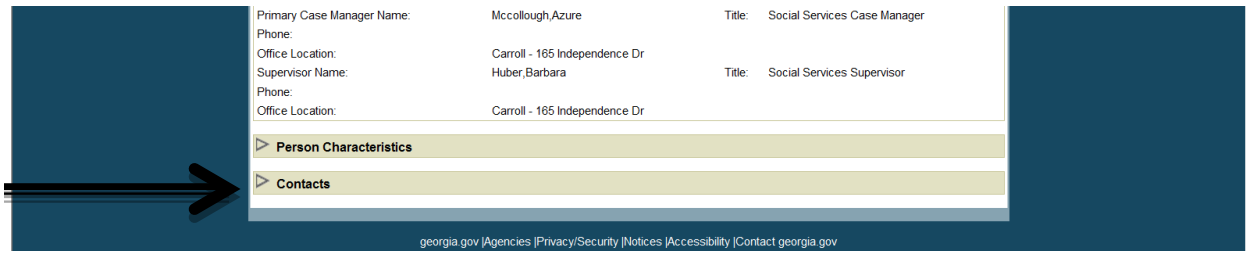
General Instructions

Step One: Log onto the GA SHINES portal via https://shines.dhr.state.ga.us:8443/login/Login/

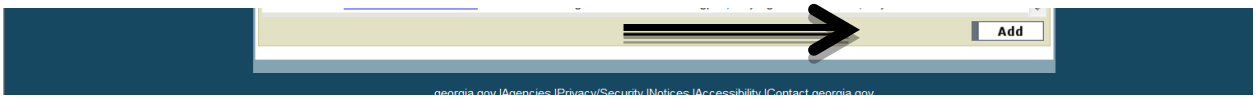
Administrative questions regarding SHINES passwords should be directed to Brenda Jones at bjjones1@dhr.state.ga.us .

Step Two: Once you are logged in , the landing page will show your site's child roster. Select **the child's hyperlink** that you wish to add documentation on. This will lead you to the Child's **Portal Detail Page**.

Step Three: At the bottom of the Portal Detail Page is the Contacts section. Click on Contacts arrow.



Step Four: Click the Add button to begin adding your contact narrative.

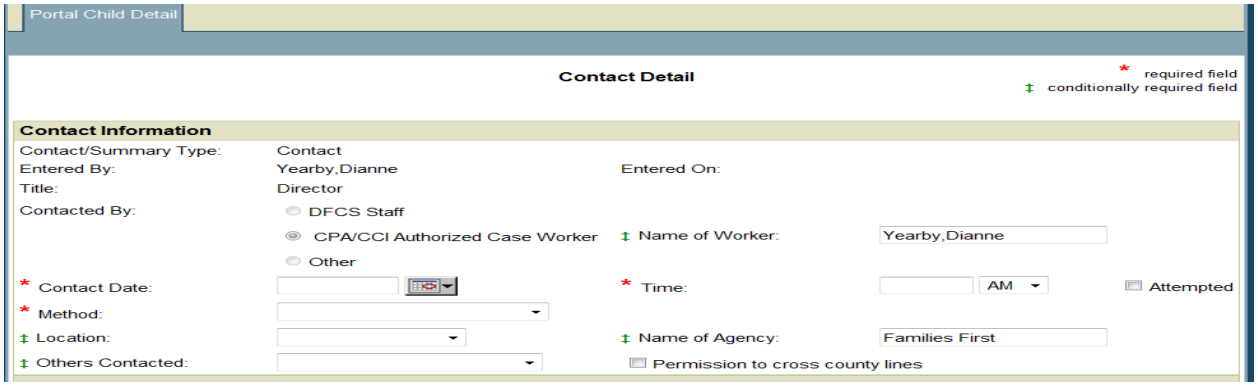


Step Five: Once you click Add, the **Contact Detail Page** will open. This is the page where the specificity of each PBC measure becomes very important. Selecting the correct purpose type and narrative type will ensure that you receive proper PBC credit.

Specific PBC Measures Instructions

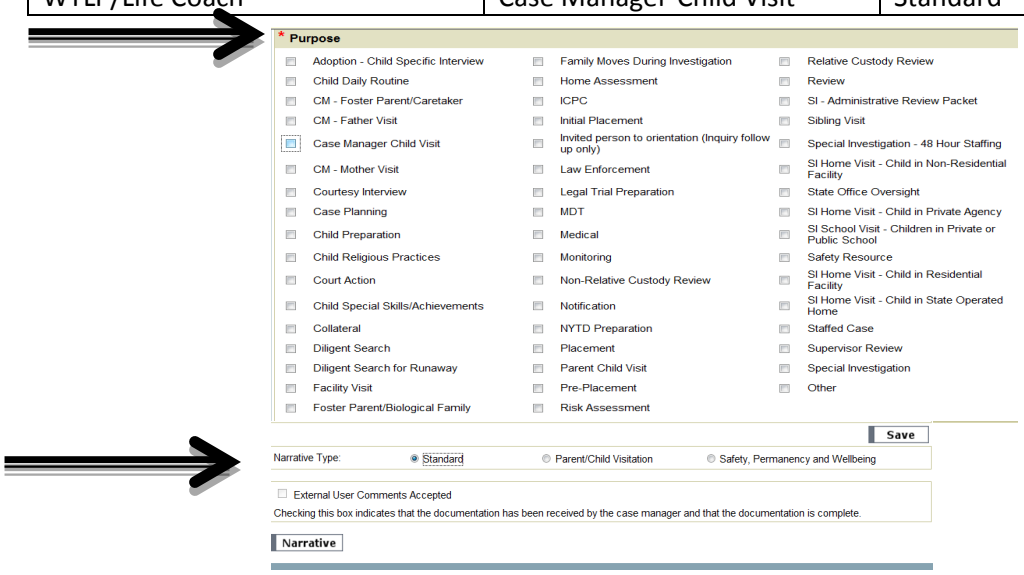
The preceding General Instructions apply to making any contact documentation in GA SHINES. The following specific instructions detail how to make two specific decisions as it relates to your PBC credit: #1) which contact **purpose type** to select and # 2) which contact **narrative type** to select. Making those two decisions correctly will ensure that you are properly credited for your documentation as it relates to PBC scoring.

Step One: Fill in the Contact Information.



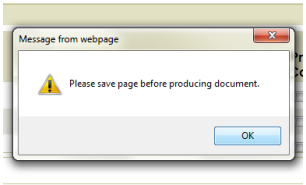
Step Two: Select the Purpose Type and Narrative Type As Indicated for the PBC Measure:

Measure	Purpose Type	Narrative Type
Sibling Contacts	Sibling Visit	Standard
EPSDT Medical	Medical	Standard
EPSDT Dental	Medical	Standard
ECEM	Case Manager-Child Visit	Safety, Permanency and Well-Being
General Contact	Case Manager-Child Visit	Standard
Permanency Contact	Parent-Child Visit	Parent/Child Visitation
IL and TLP Provider's Only		
Independent Living Skills Provision	NYTD Preparation	Standard
WTLP/Life Coach	Case Manager-Child Visit	Standard



Step Three: In between the Purpose and Narrative Type boxes is the Principals/Collaterals Contact. Based on who was a part of the contact that you are documenting, you should select the appropriate names and whether the contact included a private conversation or a discussion in reference to the person's name selected.

Step Four: You must click "Save" before launching the narrative tab otherwise you will receive an error message:



Step Five: Based on the Narrative Type that you selected, once you click the Narrative button, the Standard, Parent/Child Visitation or Safety, Permanency and Well-Being document will open. (See Documentation Notes below for more information on documentation.)

Step Six: Click Save after documenting in the narrative. Be sure that your information saved before exiting.

Documentation Notes

The Standard document is a blank free-form text document. The Parent/Child Visitation includes one question but the rest is a blank free-form text document. The Safety, Permanency and Well-Being type is a guided narrative. Review the ECEM webinar for detailed information on completing it.

Keep in mind that the SHINES case record is the official comprehensive account of activities relating to a child and family. Providers must ensure that documentation is thorough, accurate, timely and detailed enough for another reader to clearly understand. An "Acceptable Abbreviations and Terms to Avoid" document is located on GA SCORE.

There are two primary components of a child and family's official DFCS record:

(1) The case narrative, which is the written documentation of case contacts by case managers, supervisors, RBWO staff and other agency personnel; and

(2) Forms, formal assessments (such as family assessments, psychological test, case plans) and information related to medical, psychological, legal and financial aspects of the case.

The case record serves as an administrative tool used to provide information concerning the case to state and county administrators. It is also a vital resource for the agency in providing continuity of

service to the family and as a resource if the case requires court action. The case record may also be seen by auditors, the legal community and, in some instances, the media. Therefore, accurate, timely documentation significantly impacts the credibility of the worker as a professional and the agency as a responsible institution.

In general, documentation should include the following types of information:

- Facts
- Observations
- Interpretations
- Decisions

A few examples of documentation of facts, observations, interpretations and decisions in case recording follow:

Facts are client activities, agency actions or information from official records or documents. In addition, facts may be straightforward descriptions of circumstances.

Example: Mrs. White called the office today and asked for childcare services for her children while she is in substance abuse treatment.

Observations are recorded notes about the client, condition of the home, physical injury and/or behavior seen by the case manager or seen and reported to the worker by others. When recording observations, the source of the information must be clear.

Example: The case manager observed Mrs. Lee crying and clenching her fist.

Example: Ms. June Allen, aunt, reported seeing Jack playing in the street at 5 P.M.

Interpretations are the case manager's opinions or conclusions, based on facts and observations. When recording an opinion, document clearly that this is an opinion and supply ample evidence to support it.

Example: The client reported she frequently has to leave work to return home to see about her children because her husband leaves them alone. It is the opinion of the case manager that Mrs. Christian needs childcare, as she has no one to care for her children while she is at work.

Decisions in cases are based on program policy and good practice principles. They are supported by documented facts, observations and interpretations. It is also important to document supervisory consultation and approval, staffings, and other consultation received in making a decision. The four-step assessment process of 1) gathering information 2) analyzing information 3) drawing conclusions and 4) making decisions would be applied in this process. These decisions provide the basis for actions in a case.