Part 2: Best Practices in HCS Documentation: Supervisor's Guide

About YOU

Which agency are you joining us from? Do you currently supervise staff who are providing direct services in PSH?

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About CSH

CSH collaborates to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities.

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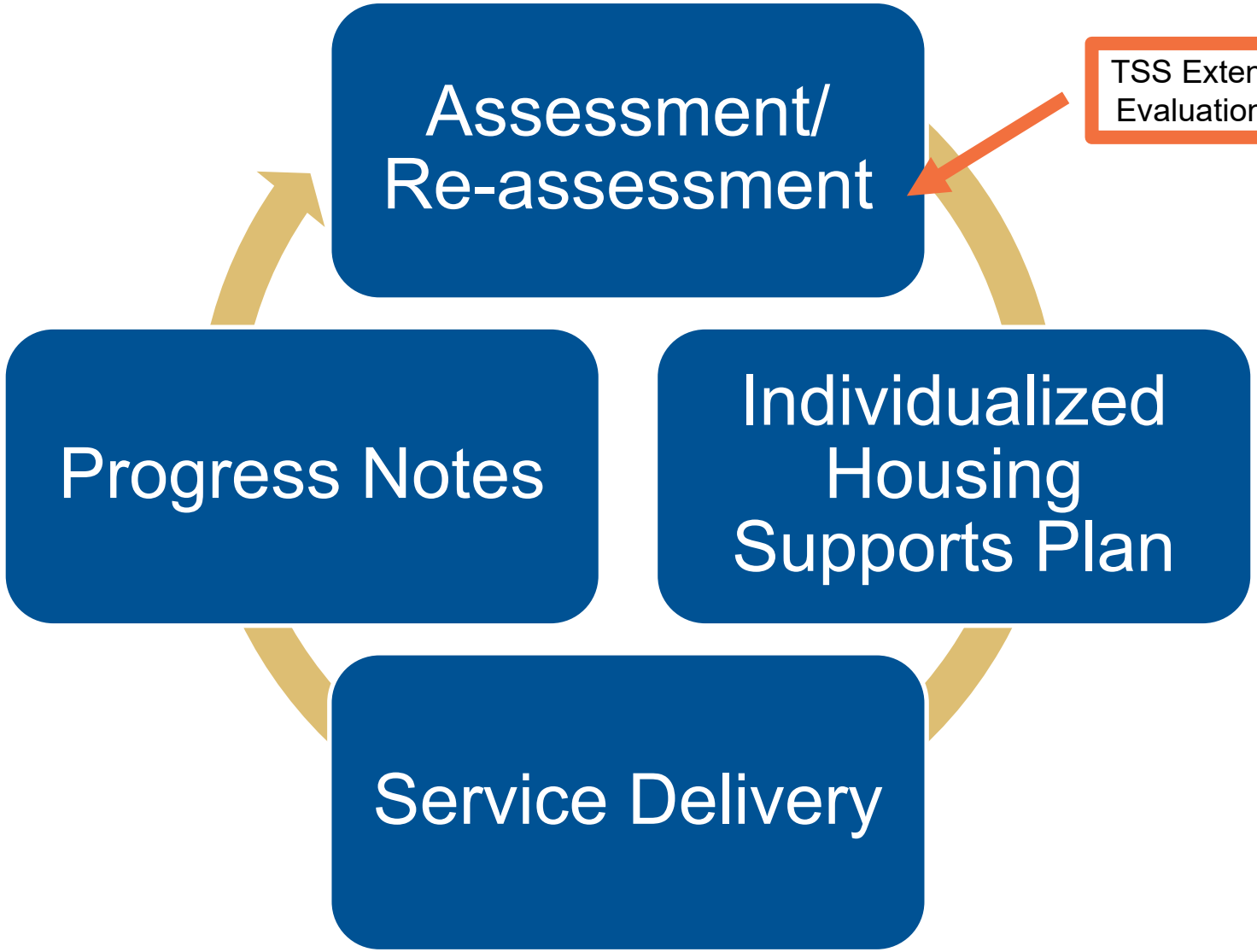
Learning Objectives for Today

- Understanding key elements for documentation thread
- Supervisor's role in strengthening documentation quality
- Common challenges in documentation
- Best practices in internal quality review
- Agency roles for supporting documentation compliance

Key Elements in Health Care Documentation Thread

Housing Community Supports- Documentation Thread



✚ *Golden Thread*

An external reviewer must be able to clearly track the need for the services on the evaluation for services into the recommendations from the evaluation, then understand how these are translated into goals and proposed activities for the service staff with the tenant on the housing supports plan and then the proposed activities are turned into actions, tracked in progress notes.

✚ Notes health care practices that may be new to some homeless service providers new to health sector funding

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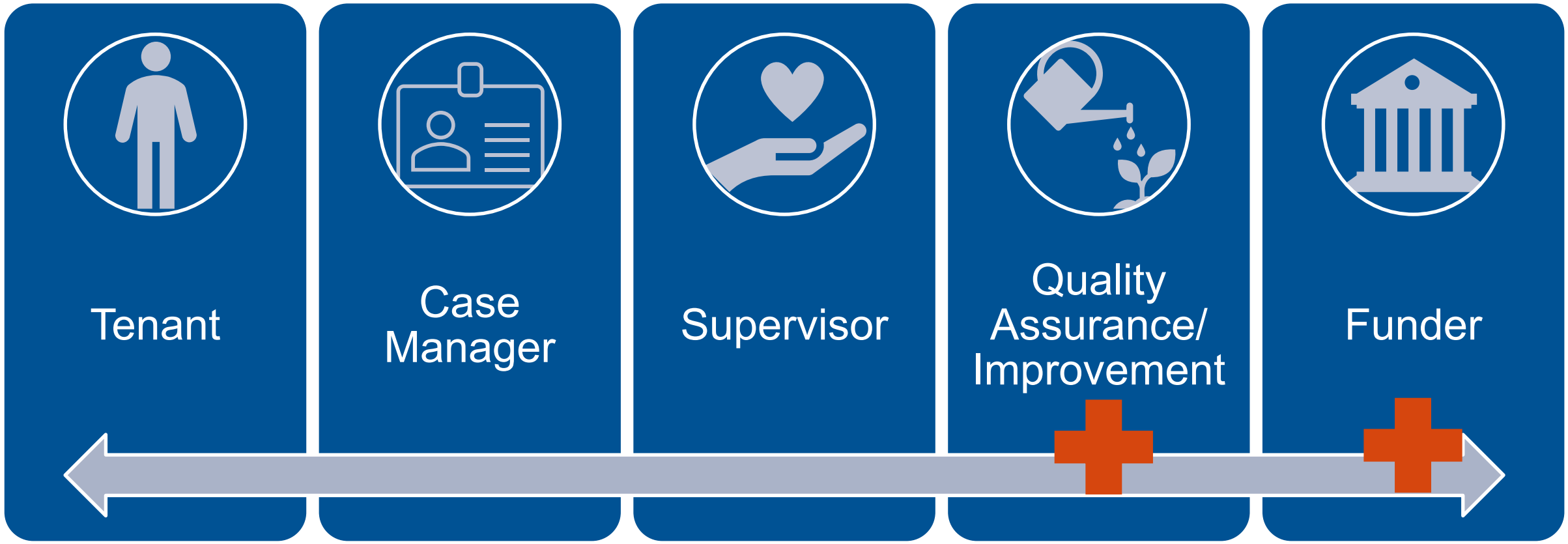
Who is involved in the documentation process?



Why TSS Evaluations Matter

Continuing authorizations and reimbursement of services, for **all who need them.**

To reauthorize a tenant for services, they must have a **demonstrated need for services- an evaluation is required**

Many PSH tenants need **ongoing, long-term supports, and needs change over time.**

We know that housing stability, trusting community networks and **recovery take time.**

Documenting Need for Services (Medical Necessity)

Client needs the service based on assessment

Clear connection of service plan goals to the assessment

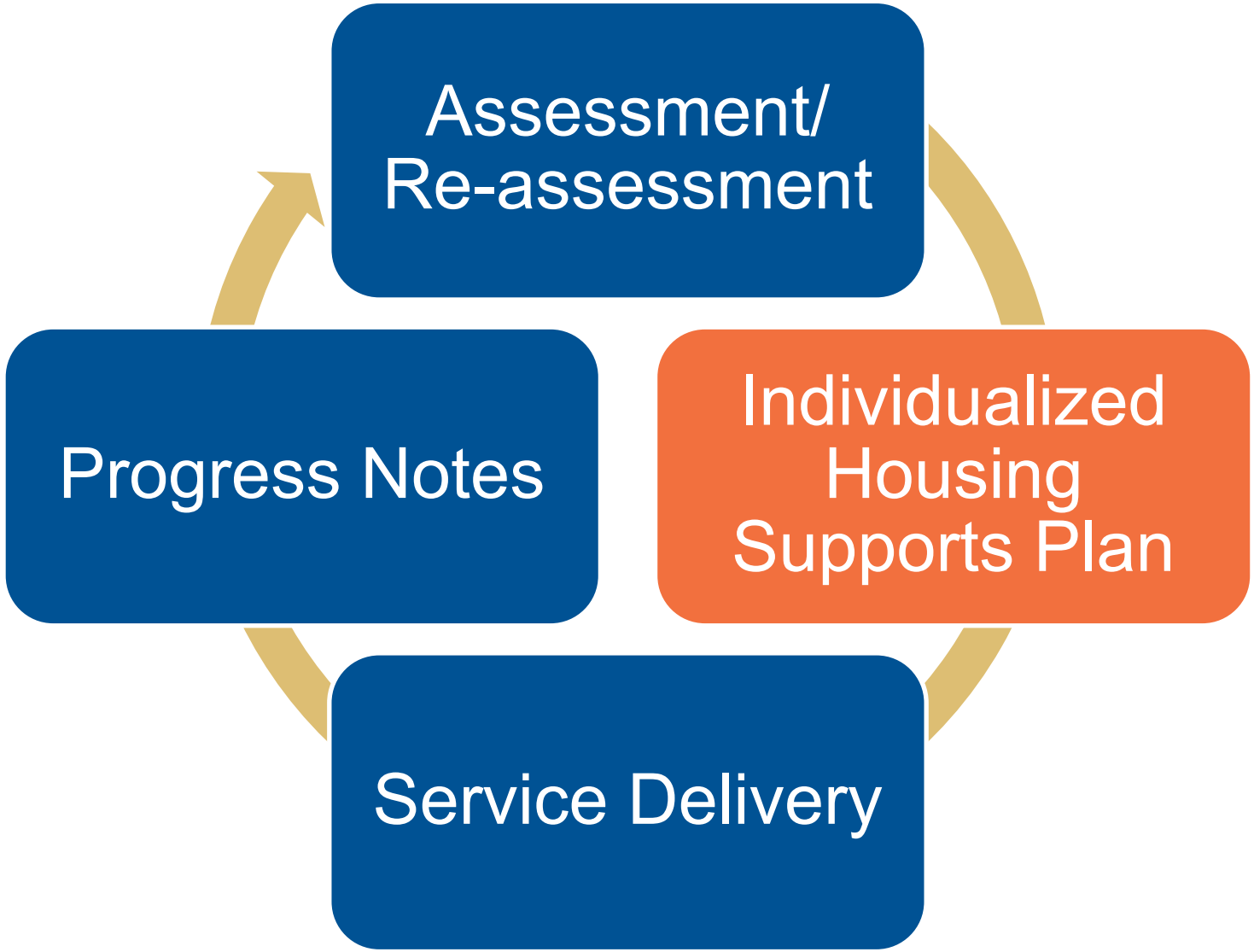
Writer must explain the rationale and “tell the story” of why writer’s assistance will be of help

Reader must understand the service rationale

Progress notes are tied to service plan goals

Type and frequency of services is appropriate to interventions and goals

Housing Community Supports- Documentation Thread



✚ *Golden Thread*

Individualized, detailed HSP, revised at least every 180 days

✚ Notes health care practices that may be new to some homeless service providers new to health sector funding

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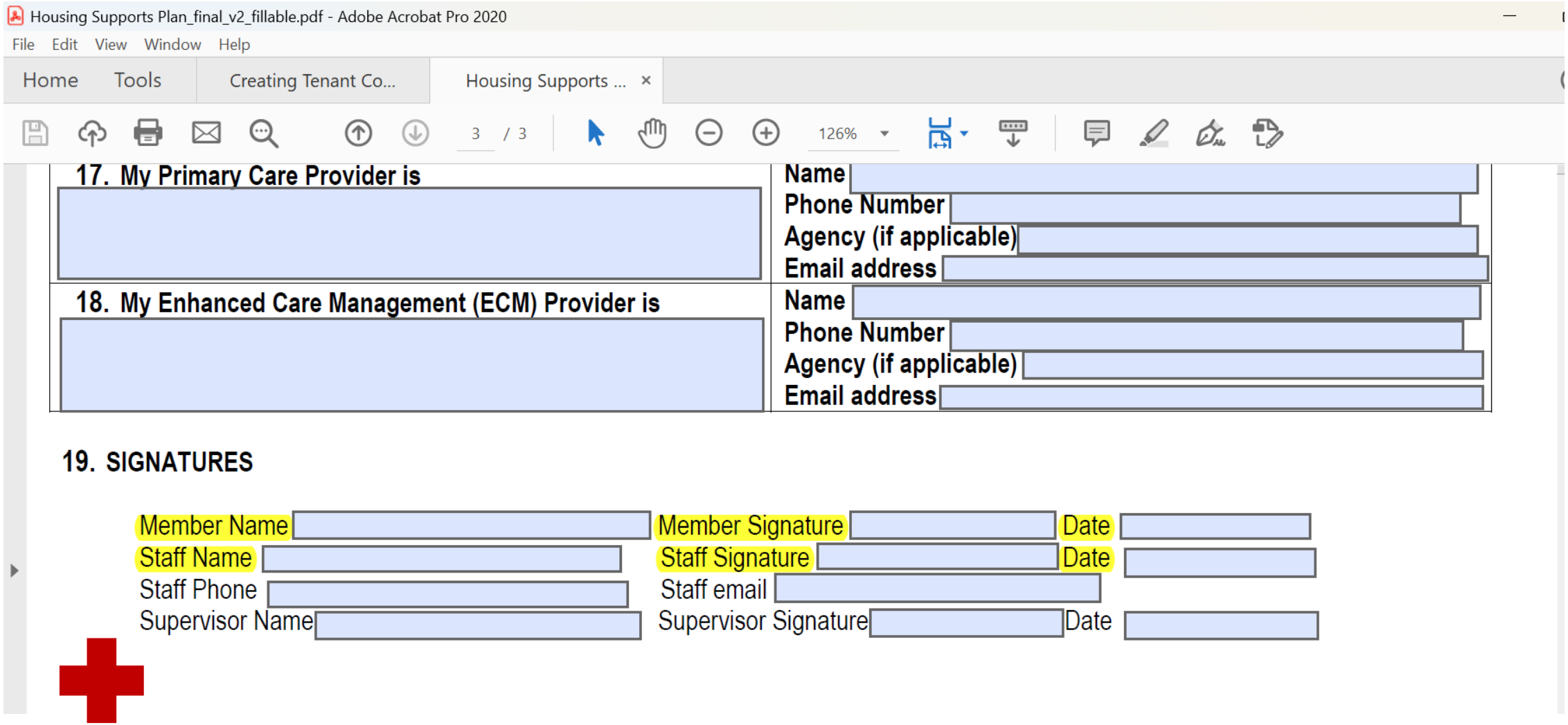
Goals, Actions & Responsibility

10. Activity Number	11. Identified Barriers	12. Goal (short & long term)	13. Action Steps	14. Person(s) Responsible (Member/Staff)
Example: 6.3 *(Assisting in obtaining ID and documentation for SSI)*	*No transportation to SSI office; no phone number to get in touch with client to arrange ride to SSI*	*Short term: get SSI set up for member* *Long term: use ID and SSI for rental applications*		
Example: 7.10 (Continuing assistance with lease compliance, including ongoing support with activities related to household	*I need help remembering to pay my rent on the day that it is due, sometimes I forget what day it is.*	*Short term: set up a calendar to track when rent is due and hang on fridge* *Long term: Pay rent on time each month for 12*	*Case manager to meet with client on the 1st of each month in person to remind and assist in paying rent.*	

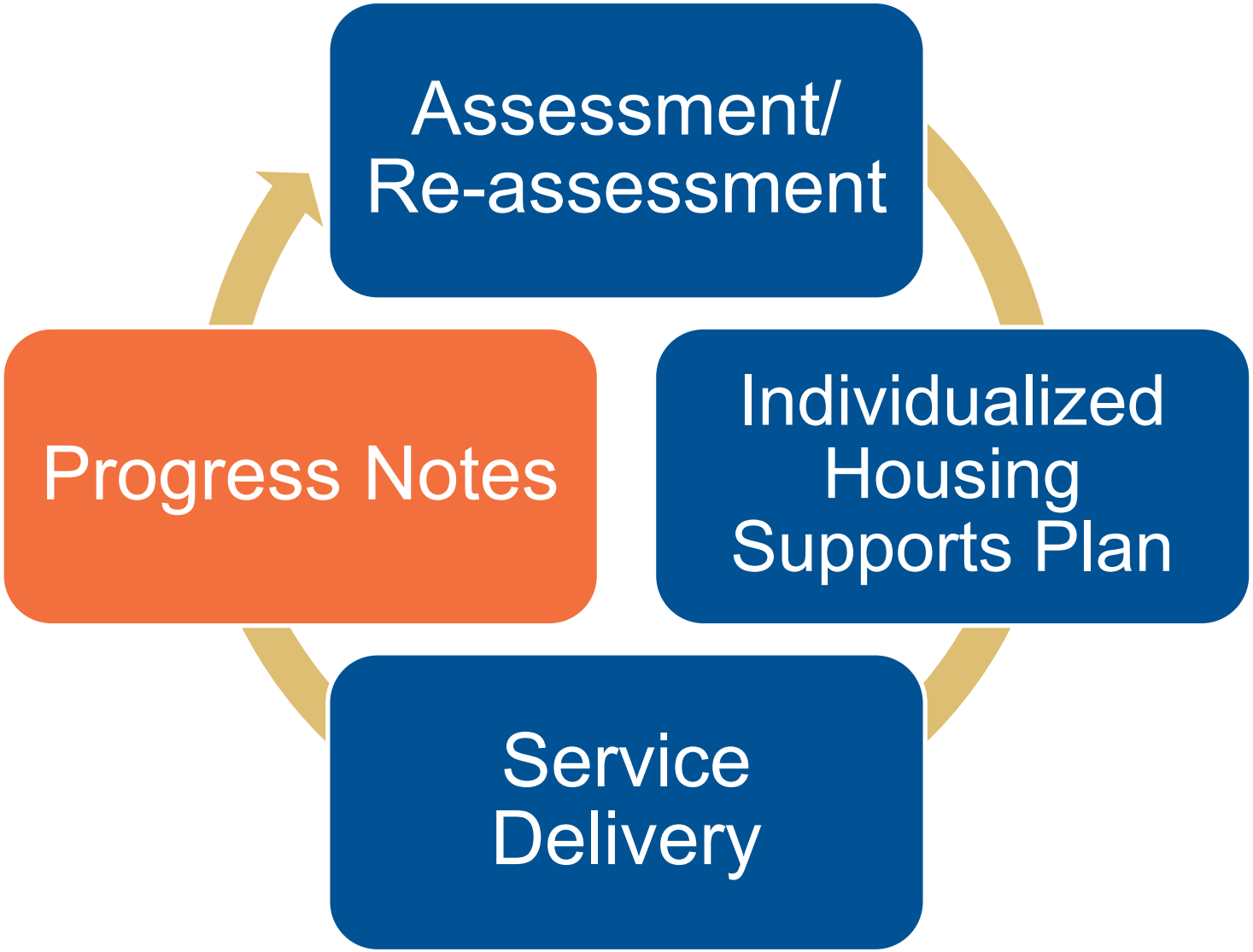
NOTE: Responsibilities and action steps are how your staff show that their services and interventions are needed and how they will can be successful. A funder approving services will wonder why the tenant cannot accomplish these goals independently. **What is the staff member's role? What proposed actions will they take WITH and FOR the client.**

Supervisor Review



Supervisor signature not a current requirement, but a very helpful step to review during supervision and support the staff member in planning interventions and activities that are person-centered and honor client choice. Your signature helps all readers know that you've reviewed and approved.

Housing Community Supports- Documentation Thread



Golden Thread

Written as soon as possible during or after intervention.

Include date of service, client name, case manager name & location of service

Keep details objective- write as if the tenant was there with you, knowing they have a right to access, as it is their legal medical record

Include tenant's voice & quotes

Link to the goal your activities help further

Note progress toward goal

List next step(s) – these next steps should then create a thread to the next progress note.

Notes health care practices that may be new to some homeless service providers new to health sector funding.

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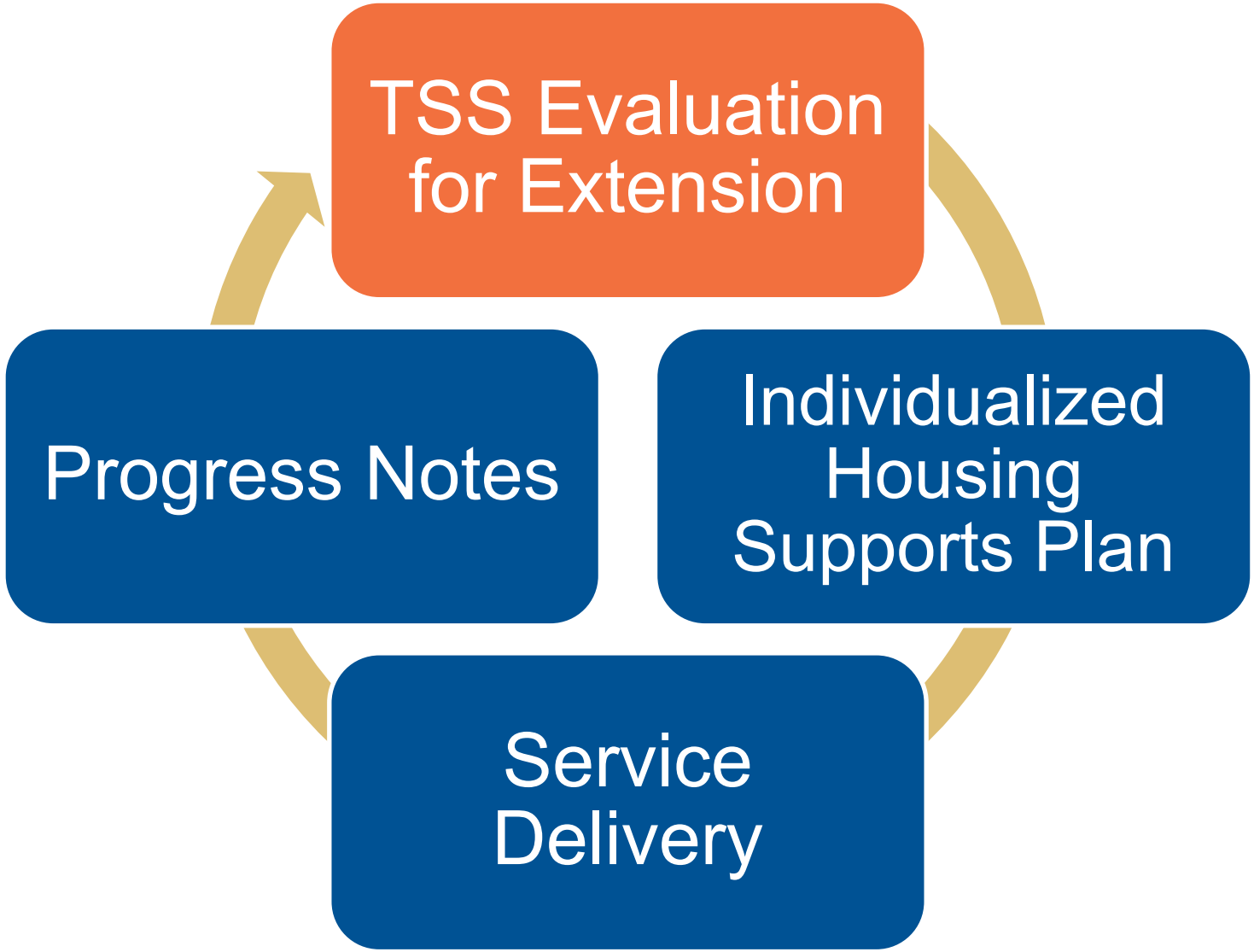
Housing Community Supports- Documentation Thread



Golden Thread

- **All required elements in TSS Evaluation for Extension complete every 180 days**

Notes health care practices that may be new to some homeless service providers new to health sector funding.

TSS Evaluation Checklist

A case manager will be responsible for completing the evaluation, to the best of their ability. The tenant is not required to be present. For any questions the case manager cannot answer, the tenant and other providers should be consulted.

Components of the PDF Evaluation:

- ❑ Names and Identifiers
- ❑ Assessment questions in True/False format of common criteria that support why a tenant may need ongoing service to remain successfully housed
- ❑ Automatically calculates # of True
- ❑ Case manager makes final recommendation
- ❑ A minimum of 3 (Criteria marked False) require a service goal and timeline
- ❑ To be completed every 180 days

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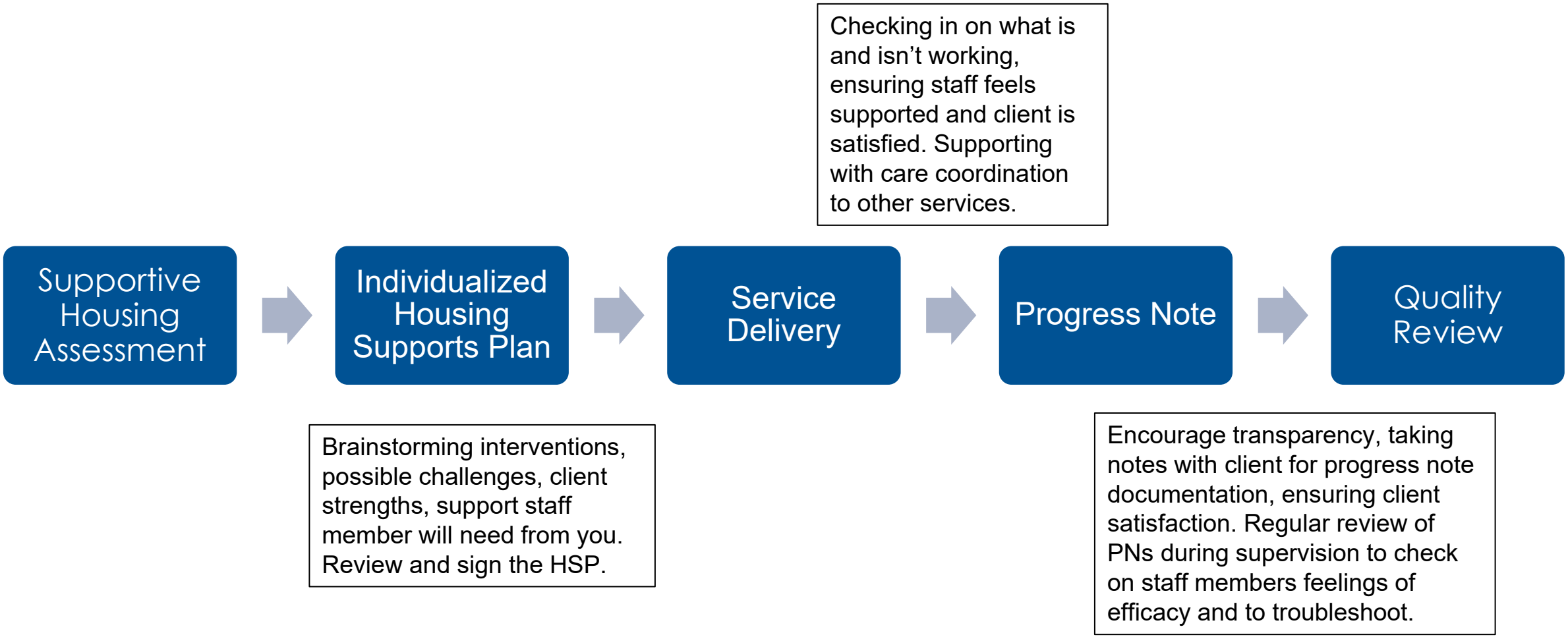
Supporting Documentation

How supervisors can support staff in person centered care while strengthening documentation quality

Supervision Occurs Throughout Documentation Processes



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Good Documentation Supports Continuity of Care

New staff and new supervisors can rely on documentation to understand past work

More Importantly, to understand tenants' needs, preferences, motivation, values when they are stepping in after a case manager leaves

New staff will need extra time & coaching to complete forms and understand expectations for documentation

What do you and your agency currently do to support new staff in the documentation learning curve?

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“Concurrent Documentation” including the client in note writing

- “Today you said you wanted to work on x, y, z… how do you feel about our time together today?”
- “What else would you like us to work on to achieve this goal together?”
- “We’ve been meeting together each week at X time, will this time work for me to come by again next week?”
- “Are there any other goals you’d like us to work on next time?”
- What could I do differently?

Supervision & Support for Success

- Review HSP during case conferencing in supervision
- Prep staff for upcoming TSS Extensions and schedule reviews of TSS Evaluations for extension of services prior to submitting
- Ask staff about and assess the time it takes for completing documentation- is there opportunity for efficiency?
- Staff training in documentation at onboarding and quarterly for those with need for quality improvement
- Staff 1:1 coaching and feedback from staff on how to simplify documentation and clarify what is needed
- Write supervision notes that are shared with staff to access and track development goals.
- When possible, add in **FUN**

Quality and Compliance requires regular review & ongoing learning support

Staff Training & Onboarding

- Documentation Training in 1st two weeks
- Regular documentation coaching
- Clear policies & examples of documentation expectations
- Ramp up period for seeing fewer clients at first to have more time to write notes

Policies can differ but produce same results- individualized and accurate notes

Less risk averse

“Documentation short cuts may create problems with determining:

(1) the individuality of the care rendered,
(2) the medical necessity of the care or service rendered, and
(3) the complexity of the service billed. Use of a boiler plate or pre-prepared text template, requires provider vigilance to ensure that the documentation accurately reflects the services/care provided. Failure to do so may result in errant billed practices and denial or recoupment of claims payments.

Use of cut, copy and paste or cloned functionality not only raises the question of authorship but also whether or not the service actually occurred. Risks of cloned notes include populating records with inaccurate, incomplete, inconsistent, and/or outdated information.

Therefore, providers must review their notes for accuracy and relevance prior to appending either their hardcopy or electronic signatures.”

Johns Hopkins HealthCare Medical Record Documentation Standards

More risk averse

“X agency prohibits the use of documentation “cloning” or copying and pasting text from one medical record to another.

If documentation cloning or copying and pasting from one client record to another is detected, it will result in disciplinary action."

Client & Staff Centered Quality Improvement

Managing risk, ensuring services aren’t disrupted, supporting staff & centering tenants in all

HIPAA Privacy and Security

Privacy around disclosing client information and **security** while maintaining client records

Privacy

Privacy standards apply to all protected health information ...

whether shared in conversation, in writing, or electronically transmitted.

Privacy standards are about WHO has the right to share and receive WHAT protected information and WHEN they have the right do so.

The HIPAA Privacy Rule protects client rights

Clients have the right to:

ask and see a copy of their health records

have corrections added to their health record

and receive a notice explaining how their health information is used and shared

HIPAA Requirements

Clients have the right to decide if they want to give permission before their health information can be used or shared for certain purposes, such as marketing

Clients have a right to get a report on when and why their health information was shared

Clients have a right to know any time their health information privacy was breached. An example of this might be when an unencrypted provider tablet, smartphone or laptop, with unprotected client information is lost or stolen.

Clients have a right to file a complaint with their provider, insurer or the U.S. Government if they believe that their rights have been violated.

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Security Regulations

Client records are legal documents- EHR or EMR (Electronic health or medical record)

Client records include electronic, paper and scanned records

Under HIPAA, “reasonable steps” must be taken to keep records secure

Reasonable Steps

- Automatic log-outs of electronic record and computers when idle
- Password protection
- Unique username and passwords for each staff member
- Screen covers for phones, tablets, laptops if used in public places

Safeguarding Privacy

Use client initials when discussing or writing about client in unprotected or public setting

Avoid using identifiers in non-secure records like email and cloud-based documents

Include a disclosure statement at the bottom of all staff email signatures

Safeguards

Private client information should never be kept in an unlocked drawer, in a vehicle, or anywhere other than a unique file labeled for that client and secured in a locked cabinet, behind a locked door.

Viewing Electronic Information

Screen protectors
Password protection
Take care with fax machines!

Important Documentation Considerations when Starting Internal Audits

- Current state of client charts-
  - Baseline from checklist of required documents
  - Location and security of client charts
  - Business Associate Agreement responsibilities related to HIPAA
- Documentation standards in policy and procedure format with examples
- Current staff training on documentation standards
- Review forms for needed revisions (based on staff and client feedback)
  - Agency intake/assessment
  - Individualized service plans
  - Progress note templates
  - Quality Review forms and tools
- Review job descriptions of service staff, supervisors, Quality Improvement/Assurance and update

Internal Monitoring and Quality Reviews

Conduct reviews of agency charts & quality of care

This is proactive and done regularly

Have a plan for how internal audits are conducted

Include frequency and follow up

Re-evaluate this plan regularly

Identify areas at risk for external audits

Learn from other agencies in your network

When risk areas are found, determine the appropriate corrective action plan- including updating policies, procedures, staff training and supervision

Roles in QI: Who takes the first step?

Designate a staff person

Process of communication

Program goals and outcomes

Assign Role

Schedule

Plan

Schedule client chart reviews

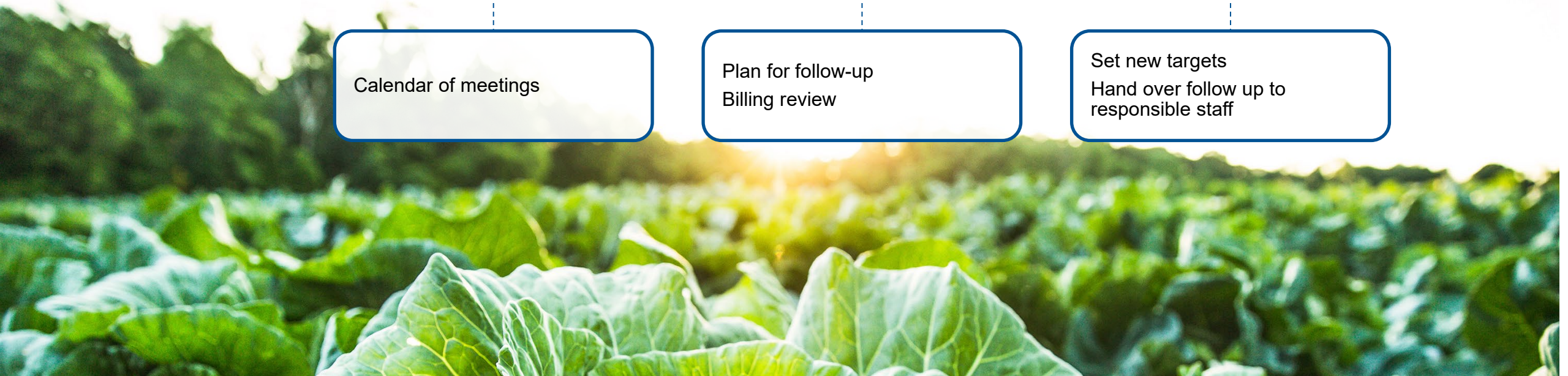
Review

Closing the Loop

Calendar of meetings

Plan for follow-up
Billing review

Set new targets
Hand over follow up to responsible staff



Questions Related to Today's Topics

Thank you!

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