

# Documentation Best Practices

Fall Learning Session

September 23, 2021

Medical Assistance recipient who is 18 years old or older

Disability or  
disabling  
condition



Housing  
instability



Need for services  
due to limitations  
caused by the  
individual's  
disability

Eligibility for Housing Stabilization Services

# ELIGIBLE SERVICES

- Housing Consultation

- Housing Transition

- Applying for benefits
- Housing search activities
- Understanding the lease and negotiating with landlords
- Developing a budget
- Ensure safety of new house
- Remote support

[DHS on Services](#)

- Housing Stabilization

- Housing support and crisis plan
- Prevention/early identification of behaviors that could jeopardize housing
- Rights/responsibilities of a tenant
- Advocacy activities
- Applying for/maintaining benefits/maintain income
- Assistance in building natural supports/community resources
- Remote support

# Service Plan Quality – Best Practice

- Housing stability and eviction prevention included in goals
- Services are coordinated with other providers to avoid duplication and re-traumatization
- Service plan goals are a living breathing used document that sets the framework for services
- Service plans are strengths-based
- Client's voice is reflected in their service plan
- Goals are created *with* client and reflect client's own recovery goals
- Goals are reviewed with progress and barriers noted and new goals established

# Service Plan Elements – Best Practice

Diagnosis/functional  
criteria

Problem to be  
addressed

Goals formed from  
assessment, needs  
and problems

Goals are measurable  
and clear and  
represent what the  
client wants

Smaller objectives to  
reach goal

Strengths of client  
linked to the goal

Timelines

Roles and  
responsibilities

Service type /  
intervention

Progress and update

# Documentation: connect back to eligibility and needs/person centered plan

Eligibility and needs through person centered plan

Individualized service plan goals

Progress notes

# Technical Elements of a Billable Progress Note

**\*red: not required but  
best practice**

*May be electronic or paper*

- Date of entry
- Date the service was provided
- Start and End Times with am and pm designation/**length of service in minutes**
- Location/type of contact
- Client Name and ID#
- Service name and description
  - **Client response, progress, changes**
  - **Next steps/appointment date and time**
- Name, signature and title of service provider
- **Service is linked back to goals in service plan**

# Writing the Progress Note Narrative

Focus on the service related to the housing instability

Relate service to needs assessed and service plan goals

Include direct client quotes but avoid unnecessary “he said” “she said”

Focus on the facts of what happened, avoid being too subjective or opinionated

Demonstrate “sufficient duration to accomplish the intent/goal”

Include client’s response, progress and plan for next steps



# Justifying time spent

Demonstrate “sufficient duration to accomplish the intent and goal.”

- Consider issues and challenges present at time of service
- Document best practice approaches used
- Note any functioning limitations that would cause session to be longer
- Document impact service had on client

\*Use caution to not pressure staff for “productivity” that could lead to fraudulent note stretching (i.e. making a 2-minute call last 8 minutes in order to bill, even though extra time not medically necessary).

# Staff Training considerations

- Housing First
- Harm Reduction
- Cultural competency, humility, anti-racism
- Trauma-informed care and organizational practices used throughout
- Assertive engagement
- Motivational Interviewing
- Technical training around compliance
- Mandatory annual training

# EXAMPLES

## Subjective

“The apartment was a mess.”

“”Client was out of control and kicked out of the store.”

Client is doing much better living indoors.

## Objective

Writer observed food, garbage, clothing and papers blocking walkways and vents.

“Client was experiencing active paranoia and persecutory thoughts. Client began to scream at other shoppers. Security was called and escorted client out.

“Client appeared calm, confident and in good health. Client showed writer how she stores her meds in her weekly pillbox. When asked how she is liking her new unit, client reported “I like this place, I mean I can’t stop smiling. I love it. Especially the A/C unit.”

# Objective writing

Focus on the facts of what happened, avoid being too subjective or opinionated. Write notes knowing that these are the legal medical record or your client.

# Connecting the note to the goals

## Assessment

- Included diabetes

## Service Plan

- Included goal of improving health, specifically diabetes A1c.

“Observed client had no food when conducting a home visit. Client stated that he was asking neighbors for food which resulted in complaints to property management. Accompanied client to grocery store. During the trip, discussed several important items with client. First, the importance of buying healthy food to help with diabetes. Second, discussed how to alert the housing case manager if he needs food instead of asking neighbors. Third, provided resources for healthy meals and diabetes information.”

# Housing Transition Services

## Individualized Service Plan example

*Person Centered plan developed by housing consultation agency*

- I want housing because I don't want to be homeless anymore.

Recommendation: Client needs housing stabilization services - transition services to help find safe, stable and supportive housing

*Individualized Service plan developed by the housing transition services provider*

- I want to find housing that makes me feel safe.
- I want to live in a nice apartment.

# Progress note

- Met with client. Explained different housing options and timelines. This writer acknowledged how important it is to get feedback and information from her on what is important to her in regards to housing. Explained how we will go about helping to locate appropriate housing for her.
- Client was very anxious about housing but agreed to discuss and set goals for herself. We will meet again next Monday 9/27 to review possible housing options. Client felt optimistic and positive about possible housing soon.

# Housing Stabilization Services

## Individualized Service Plan example

### *Person Centered plan developed by housing consultation agency*

- I don't want to be evicted but want to stay in my apartment
- I want to learn how to get along with my neighbors

Recommendation – Client needs housing stabilization services – sustaining services because she is at risk of eviction due to continued negative interactions with neighbors and complaints by neighbors

### *Individualized Service plan developed by the housing stabilization services provider*

- I will engage in anger management interventions to try to learn how to communicate better
- I will find productive things to do so I don't have too much time on my hands with nothing to do.



# Progress Note

- Met with client to discuss her housing issues regarding a potential eviction. This writer offered a non judgmental approach which allowed client to be open and honest. We discussed strategies she could look into utilizing to better resolve conflicts so she doesn't get evicted and possibly become homeless again.
- She agreed to attending anger management sessions to find new ways of resolving conflicts and communicating more positively with neighbors.
- We will meet twice weekly for 3 weeks and then weekly, after things get more stabilized. Client is hopeful about this plan and keeping her housing. This writer offered much support and encouragement to client.

# TEMPLATE EXAMPLES

# Individualized Service Plan

Client Name:				Client #:	
Recommendations from the Person Centered Plan/assessment					
Goal #1					
Desired Results in Client's Words:					
Strengths/Abilities and how they will be used to meet the goal:					
Effective Date:				Review Date:	
Measurable Objectives	Intervention	Service Type	Person Responsible	Frequency	Target Date

# Individualized Service Plan Review

**Client Name:**

**Date:**

**Previous Plan Date:**

**Next Review Date:**

**Goals from previous plan:**

Goals	Measurable Objectives	Original Target Date	Progress/Barriers	New Target Date

# Individualized Service Plan Review

**Client Name:**

**Date:**

**New Goals:**

Desired Results in Client's Words:

Strengths/Abilities and how they will be used to meet the goal:

Measurable Objectives	Intervention	Service Type	Person Responsible	Frequency	Target Date

# Services Review

# Services do not cover

- Deposits
- Food
- Furnishings
- Rent
- Utilities
- Room and board
- Moving expenses
  - Documentation
  - Travel without the client

# Indirect services

- Tasks performed on behalf of a client
- Service categories listed on the [DHS policy site](#) with an asterisk MAY be provided indirectly
- Must be documented in case notes
- Remote support limits do not apply; there are no limits on indirect services, although best practice is to provide services directly to the extent possible



# Indirect v. direct services: Examples

- May be provided indirectly: “Supporting the person to apply for benefits to retain housing”
  - Indirect: You call client’s county financial worker from your office to follow up on a Housing Support application
  - Direct: While at a home visit, you and the client call the client’s county financial worker on speakerphone to follow up on the application
- Cannot be provided indirectly: “Developing, updating and modifying the housing support and crisis/safety plan on a regular basis”
  - Person needs to be involved in developing plan
- What if you are providing an indirect service on behalf of more than one client? e.g., calling a landlord about unit openings
  - Cannot bill the same 15 minute unit to multiple clients
  - Choose one and alternate which person you bill to
  - Must be calling about specific clients; general outreach is not billable

# Remote support

- Services provided while not physically with the client
  - Includes phone, video conferencing and text messaging
  - Does NOT include email or fax or leaving a voicemail
- Current – 50% of total services provided per month
  - Limit waived during COVID
- Document and track in case notes
- [DHS policy on remote support](#)





**QUESTIONS**