



Documentation and Quality Assurance

May 10, 2018



Today's Presenter

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- Health Home Training and Quality Assurance Program Manager
 - Department of Social and Health Services
 - Aging and Long Term Support Administration (AL TSA)

• Kathryn Pittelkau

- Contracts Manager
 - Health Care Authority
 - Medicaid Program Design and Implementation

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- Health Home Quality Assurance and Outreach Specialist
 - Department of Social and Health Services
 - Aging and Long Term Support Administration (AL TSA)

Training Objectives

- Present the Documentation Guide updated in November 2017
- Provide guidance on documenting Health Home (HH) activities
- Share key elements for quality assurance
- Provide program updates and resources

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Documentation

Health Home Documentation Guide

General Principles

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Documentation Guide

 Health Home Care Coordination Documentation Guide		
Health Home Activities	Activities	Documentation
General guidelines	<ul style="list-style-type: none"> Documents all activities related to the provision of Health Home services 	<ul style="list-style-type: none"> Document in the client's record periodic contacts: <ul style="list-style-type: none"> The type of contact: telephone call, secure email message, written correspondence, face-to-face visits, multidisciplinary care team meetings, and attendance at appointments or other meetings Attempted or completed contacts Names and relationships of those contacted if not the client Highlights from the conversation Objective observations Outcome of the contact Other important information Location of the visit and names and relationship of collateral (e.g. family members, guardians, agency staff, caregivers, or others) present Name of staff person completing the activity (include the writer's title for the first entry)
Outreach and Engagement	<ul style="list-style-type: none"> Completes required activities for due diligence: <ul style="list-style-type: none"> Telephone contacts Letters 	<ul style="list-style-type: none"> Document in the client's record: <ul style="list-style-type: none"> Date and type of letters or program information mailed Alternate addresses used for clients that are homeless Date letter mailed to the client if a new address is known or to a collateral who may be able to deliver the letter to the client Date telephone contact initiated and outcome of the call Date telephone contact attempted and outcome (e.g., phone disconnected, wrong number, etc.)

This document serves as a guide for documentation of Health Home activities by Care Coordinators and allied staff. Allied staff means Community Health Workers, peer counselors, wellness or health coaches or other non-clinical personnel who provide supportive services, outreach, and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Please contact your Lead Organization for additional documentation requirements. Consult your supervisor for documentation requirements established within your agency.

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Documentation Guide (cont.)

- Organized by topics:
 - General suggestions for effective documentation
 - The six core services
 - The Health Action Plan (HAP)
 - Transition planning when a client is leaving the program or transferring to another Care Coordination Organization or Lead Organization
 - The Advanced Home Care Aide Specialist Pilot
 - The Community Integration Program for Adult Family Home residents

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Where to start

- Professional requirements for your licensure or credential

Nursing Standards:

<https://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission/Laws>

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Where to start (cont.)

- National Association of Social Workers (NASW) Code of Ethics
<https://www.socialworkers.org/Practice/Practice-Standards-Guidelines>

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Where to start (cont.)

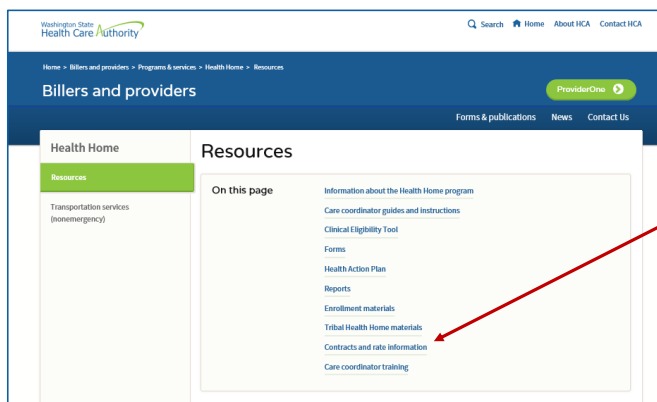
- Your agency's requirements and standards
 - Supervisor and management expectations
- Your Lead's requirements
 - Contract
 - File checklist
 - Technical assistance
- HCA and DSHS expectations



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Health Home Contract Templates

Visit the Health Care Authority's website for Exhibit C for the MCOs and the Managed Fee-for-Service contract information



<https://www.hca.wa.gov/billers-providers/programs-and-services/resources-0>

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Why document?

- Serves as a record of your work
- Provides a record for others to access
 - Colleagues and other team members
 - Supervisors: coverage in your absence
 - Lead organizations
 - Quality assurance reviews by the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS)
- Improved client service
- Liability and risk management

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General Format for Documentation

- Name and title of writer
- Date
- Type of contact
- Core service provided
- Highlights from the conversation: quotes
- Objective observations
- Use person first language
- Plan for next steps or conclusion
 - Specify due dates and who is responsible

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Timely and Legible

- Chart in the moment
- Carve out time to document
- Reduce typos and errors
 - Use spell check feature
 - Cut and paste from a document
 - Use with caution

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Acronyms: explain and limit

- **HCA**...Home Care Aide vs Home Care Agency
- **ADA**...Americans with Disabilities Act vs American Dental Association vs American Diabetes Association
- **MI**...Mental Illness vs Myocardial Infarction
- **CP**- Cerebral Palsy vs Care Plan

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Professional and Ethical

- Don't alter a record: add another note amending the narrative containing the error
- Releasing information:
 - Ensure written consent has been provided

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Sharing Information

- Do you have the proper permissions?
 - Client
 - Adolescent (age 13 and older)
 - Family/parent
 - Guardian or legal representative

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Washington State Health Care Authority **Health Home Participation Authorization and Information Sharing Consent** Washington State Department of Social & Health Services

Participation Authorization

I, agree to participate in the Health Home program with

Print name of beneficiary Print name of health home Lead

Signature of beneficiary or beneficiary's legal representative Date

Information Sharing Consent
 your health information is private and cannot be given to other people unless you agree or applicable Washington State or federal laws allow the information to be shared. The providers/partners that can get and see your health information must obey all these laws. This is true if your health information is on a computer system or on paper. In addition to laws that apply to all types of health information, specific laws provide greater protection of information related to sexually transmitted diseases, mental health treatment, and substance use disorder.

I agree that my health home can obtain all of my health information from the providers/partners listed on this form to coordinate my care. I also agree that the health home and the providers/partners listed on this form may share my health information with each other, and other providers/partners involved in managing my care. I understand this form takes the place of any other health home participation authorization and information sharing consent forms I may have signed before. I can change my mind and take back my consent at any time by signing a [Health Home Participation - Opt-Out/Decline Services](#) form and giving it to my Health Home.

PLEASE NOTE: If your health records include any of the following information, you must also complete this section to include these records:

I give my permission to disclose information about (please put initials next to all that apply):
 mental health HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate [Release of Information form for Substance Use Disorder \(SUD\) Services](#) form.

Please initial the appropriate choice below.
 This consent is valid: as long as my health home needs my records for this program; or
 until
date or event

I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
 A copy of this form provides my permission to share records.

Print name of beneficiary Beneficiary's date of birth

Signature of beneficiary or beneficiary's legal representative Date

Print name of legal representative (if applicable) Relationship of legal representative to beneficiary

List your providers/partners on page two.

HCA 22-602 (12/17) page 1 of 3

Participant ideas



What strategies or time management practices do you use to manage your workload and ensure that your documentation is completed in a timely manner?

Please enter your response in the Question Pane

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Quality Assurance

Annual reviews by HCA and DSHS

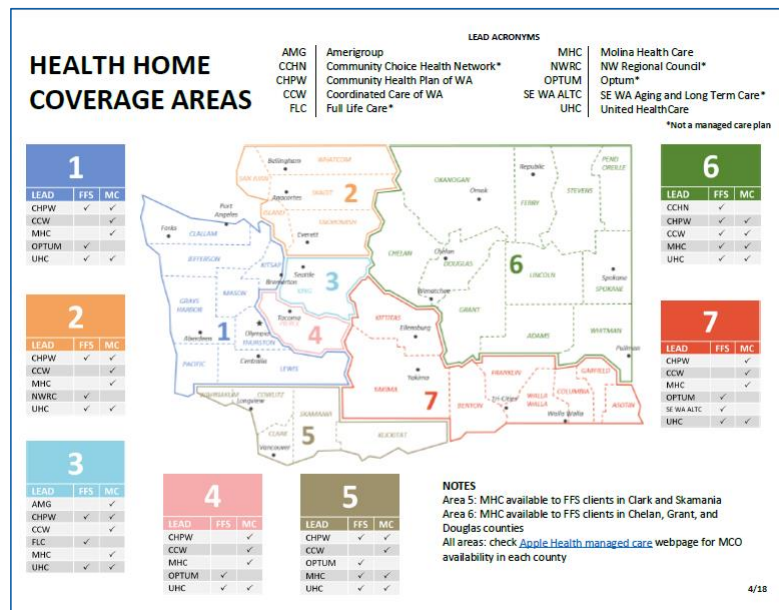
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Two Processes

- TEAMonitor is completed by the HCA for the Apple Health Contract for managed care organizations
 - UnitedHealthcare, Amerigroup, Coordinated Care of Washington, Community Health Plan of Washington, and Molina
 - DSHS also participates for Health Home Services
- Fee-for-Service (FFS) monitoring is completed by HCA and DSHS
 - Community Choice, Northwest Regional Council, SE WA Aging and Long Term Care, Optum, Full Life Care, Molina, and UnitedHealthcare

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Do You Know Who Your Leads Are?



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Quality Assurance (QA)

- Leads complete their review of client records
 - Ask for their case file checklist
- HCA together with DSHS
 - Reviews 10-15 files each year
 - Proficiency rate is usually 90%
 - Nine out of ten records reviewed meet the requirement
- Leads often use the results of their internal quality reviews from HCA to develop training and provide technical assistance

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Performance Periods for Reviews

- TEAMonitor: previous calendar year starting January 1 through December 31st
- MFFS: previous year starting July 1st through June 30th
 - For example: 2018 review will look at client files beginning July 1, 2017 to June 30, 2018

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What Are Reviewers Looking for in a Client File?

Note: requirements change with each update of the Lead's contract/s. QA elements and focus may change.

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Core Services

- Does the case narrative indicate core service/s provided during the month?
 - If a core service was provided by another entity note this and describe how the Care Coordinator is coordinating services with other providers
 - Care Coordinators do not duplicate services
 - Indicate services provided by allied staff
 - Allied staff may document their activities in the case narrative or provide information for the Care Coordinator to document services rendered., i.e. mailed health promotion materials

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Completion of Forms

- Was the *Participation Authorization and Information Sharing Consent Form* completed, signed, and dated?
 - If not is there a note in the case narrative citing the reason the form was not completed and signed by the client, parent, or guardian?
 - Were additions and deletions dated and initialed by the client, parent, or client representative (POA, guardian)?
- Was the *Health Home Participation Opt-Out/Decline Service Form* completed, signed, and dated?
 - If the client does not complete the form is there a narrative documenting the client's verbal request to opt-out?
 - Was there a note that a copy of the completed form was mailed to the client or representative?

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Required and Optional Screenings

- Document the date required screenings were completed and the score (and level for the Patient Activation Measures®)
 - If the client, parent, or guardian decline to complete a screening document the date it was offered. Also include the reason if known
 - For example, a parent declined the PPAM® because the child was ill and needed the parent's care
 - If the client, parent, or guardian decline to complete the optional screening document the date it was offered and the reason if known
 - Optional screenings are required when applicable to the client's health needs
 - Example: client reports a recent fall so My Falls-Free Plan assessment should be offered
 - Example: a client creates a long term goal to improve management of pain so a pain assessment should be offered

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The Health Action Plan (HAP)

- Were all fields completed?
 - If not, is there an explanation?
- Were **person-centered short and long term goals** created?
- **Action steps** to achieve the client's prioritized short term goal and who is responsible to complete each step
- Was HAP information shared with the client, parent, family member, or guardian?
 - Formats vary depending on the Lead

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The Health Action Plan (HAP) (cont.)

- Review and updates to the HAP:
 - At a minimum every four month activity period
 - Complete new required screening scores, reassess client's **progress** toward meeting goals, **addition** of new goals, and **changes** in current goals
 - Whenever there is a change in **health status** or **needs**
 - Example: Client transitions from inpatient status to home or other location
 - With client's permission, information may be **shared** with other individuals

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Key Considerations to Document

- **Periodic** in-person and telephonic interactions with the client
- Initial and subsequent **scores and levels** for PAM[®], CAM[®], or PPAM[®] as appropriate
- **Required screenings** for the BMI, Katz ADL, PHQ-9 or PSC-17 scores or a reason the client declined the assessment or screening tool

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Key Considerations to Document (cont.)

- **In-person visit** with the client to develop and finalize the HAP
- Completion of the HAP within **90 days** of enrollment with the Care Coordination Organization
- Case narrative supports the Tier that was billed
 - Documentation of work the Care Coordinator did to help meet client goals
 - Such as: arranging for Durable Medical Equipment delivery; arranging for Specialty Care or Behavioral Health; arranging for home improvements, etc.

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Key Considerations to Document (cont.)

- Management of **barriers** to achieving goals
- **Progress** in meeting goals
- **Opportunities** to prevent avoidable emergency department, inpatient hospital, and institutional use
- Use of **self-management, recovery, and resiliency** principles that employ person-identified supports (such as family and caregivers)

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Key Considerations to Document (cont.)

- Changes in the client's **circumstances or conditions** in a timely manner
- Inclusion of **paid and unpaid caregivers** in supporting the client to achieve health action goals and access to health care services – with permission
- **Coordination, collaboration, and communication** with health care, behavioral health, Home and Community Services, Area Agencies on Aging, and other supports

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Key Considerations to Document (cont.)

- Provision of services in a **culturally competent** manner with equal access for clients with language and communication barriers
- Provision of interventions and services tailored to special needs such as **functional impairment or environmental factors**

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Key Consideration to Document (cont.)

- Provide or oversee Health Home Services with **cultural humility** that addresses **health disparities by:**
 - Interacting directly with the client or their family in their **primary language** recognizing **cultural differences** when developing the HAP
 - Recognizing obstacles faced by persons with a **developmental disabilities**
 - Recognizing the **dynamics of substance use**

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Key Consideration to Document (cont.)

- Development and/or coordination of **multidisciplinary teams** to provide assistance as needed
 - May include local community providers, primary care providers, mental health professionals, chemical dependency treatment providers, Home and Community Services staff, Area Agency on Aging case managers and nurses, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, home health providers, family members, and housing and employment specialists.
 - This aids in documenting that Health Home services are not duplicative
 - It demonstrates **cross-system** care coordination

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Key Consideration to Document (cont.)

- Opportunities to **mentor** and **model communication** with providers
- Participation in **joint** office visits
- Efforts to ensure client is **accompanied** to critical health and social service appointments
- **Coordination** and **mobilization** of providers
 - Reduce confusion and duplication
 - Reinforce support of health action goals

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Key Considerations to Document (cont.)

- Foster **communication and coordination** between the client and their providers, and other support systems to address barriers and achieve health action goals
- Provision of **individual and family support** through care coordination and **care transition** activities
- Facilitate and enable access to **transportation** and **interpreter** services

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Key Considerations to Document (cont.)

- Individual and family support:
 - **To improve access** to peer supports, support groups, and self-management programs to increase adherence to prescribed treatment
 - **Recognize the role** of family, informal supports, and paid caregivers including help provided to client
 - **Educate and support** the client, family, and caregivers to support health action goals
 - **Provide support** that considers language, activation level, literacy, and cultural preferences

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Key Considerations to Document (cont.)

- Referral to community and social support services:
 - **Identification** of resources
 - **Assistance** to obtain and maintain eligibility
 - **Coordination** of services between programs and providers
 - Governmental and community-based organizations
- Services may include:
 - Health care
 - Disability benefits
 - Housing
 - Employment
 - Personal needs
 - Legal services
 - tenant support
 - Social and recreational activities

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Key Considerations to Document (cont.)

- Use of **appropriate** coaching methodology to develop a teaching and support plan that includes:
 - Provision of **wellness** and **prevention education**
 - Assessment of needs and facilitation of routine preventive care
 - Provision of **educational materials** that:
 - promote improved clinical outcomes
 - increase self-management skills and participation in their care
 - promote continuity of care
 - are appropriate to the level of activation
 - are customized to reflect progress in self-management

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Key Considerations to Document (cont.)

- Connects to **resources** that support a health promoting lifestyle
 - Smoking prevention and cessation, nutritional counseling, or disease specific or chronic care management self-help resources
- Use of **peer supports** to increase the client's knowledge about their health conditions and adherence to treatment
- Use of community health workers and non-clinical staff to **assist** in the delivery of HH services

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Key Considerations to Document (cont.)

- Discussion about **advance care planning** with the client, parent, or collateral
 - Within the first year that the client agrees to participate in the Health Home Program
 - If this was not completed by a previous Care Coordinator then document that a discussion was offered to the client, parent, family member, or guardian

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Key Considerations to Document (cont.)

- Process for notification of the client's **admission to or discharge from** an emergency department or an inpatient setting
 - Because health home services do not duplicate services provided by another agency, such as the MCO providing care transitions, note this is the case narrative

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Key Considerations to Document (cont.)

- Provision of care transition to **prevent** avoidable readmissions after discharge from an inpatient facility and ensure proper and **timely follow-up care**
- Participation by the Care Coordinator in all *appropriate* phases of **care transition** to include:
 - Discharge planning, hospital or nursing facility visits, home visits and telephone calls
 - Transition planning detailing medication reconciliation, timely follow-up care, and monitoring
 - Client education that supports discharge care needs

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Key Considerations to Document (cont.)

- **Gaps** in care:
 - Client's **perception** of gaps in care
 - **Interventions** in the HAP or progress notes
 - Client's **response** to interventions
 - **Follow-up** actions and who is responsible
- **Support of goals** to attain recovery, improve functional or health status, or prevent or slow declines in functioning

“Gaps in care” means: The identification, coordination, and processing of needed referrals to meet a client’s medical, behavioral health, and social service needs.

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Participant ideas: Let's See What You Offered



What strategies or time management practices do you use to manage your workload and ensure that your documentation is completed in a timely manner?

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Program Updates

Participation Authorization and Information Sharing Consent form

Care Transitions

Advanced Home Care Aide Specialist Pilot

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Consent form was revised

- Health Home Participation Authorization and Information Sharing Consent form
- Form #: HCA 22-852 (12/17)
 - https://www.hca.wa.gov/billers-providers/forms-and-publications?combine=Information+Sharing+Consent+Form&field_topic_tid=All&field_billers_document_type_value_1=All&sort=filename+ASC

Washington State Health Care Authority

Health Home Participation Authorization and Information Sharing Consent

Participation Authorization

I, , agree to participate in the Health Home program with .
Print name of beneficiary Print name of Health Home Lead

Signature of beneficiary or beneficiary's legal representative Date

Information Sharing Consent

Your health information is private and cannot be given to other people unless you agree or applicable Washington State or federal laws allow the information to be shared. The providers/partners that can get and see your health information must obey all these laws. This is true if your health information is on a computer system or on paper. In addition to laws that apply to all types of health information, specific laws provide greater protection of information related to sexually transmitted diseases, mental health treatment, and substance use disorder.

I agree that my health home can obtain all of my health information from the provider(s)/partner(s) listed on this form to coordinate my care. I also agree that the health home and the provider(s)/partner(s) listed on this form may share my health information with each other, and other provider(s)/partner(s) involved in managing my care. I understand this form takes the place of any other Health Home Participation Authorization and Information Sharing Consent forms I may have signed before. I can change my mind and take back my consent at any time by signing a [Health Home Participation - Opt-Out/Revoke Services](#) form and giving it to my health home.

PLEASE NOTE: If your health records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose information about (please put initials next to all that apply):
 Mental health HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate [Release of Information form for Substance Use Disorder Services](#) form.

Please initial the appropriate choice below.
 This consent is valid: as long as my Health Home needs my records for this program; or
 until date or event

I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
 A copy of this form provides my permission to share records.

Print name of beneficiary Beneficiary's date of birth
 Signature of beneficiary or beneficiary's legal representative Date
 Print name of legal representative (if applicable) Relationship of legal representative to beneficiary

Use your providers/partners on page two.

HCA 22-852 (12/17) page 1 of 3

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Consent form was revised (cont.)

Participation Authorization portion of the form must be signed

Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

Health Home Participation Authorization and Information Sharing Consent

Participation Authorization

I, _____, agree to participate in the Health Home program with _____

Print name of beneficiary Print name of Health Home Lead

Signature of beneficiary or beneficiary's legal representative Date

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Consent form was revised (cont.)

Information Sharing Consent portion of the form must be signed in order to release information

Information Sharing Consent

Your health information is private and cannot be given to other people unless you agree or applicable Washington State or federal laws allow the information to be shared. The providers/partners that can get and see your health information must obey all these laws. This is true if your health information is on a computer system or on paper. In addition to laws that apply to all types of health information, specific laws provide greater protection of information related to sexually transmitted diseases, mental health treatment, and substance use disorder.

I agree that my Health Home can obtain all of my health information from the providers/partners listed on this form to coordinate my care. I also agree that the Health home and the providers/partners listed on this form may share my health information with each other, and other providers/partners involved in managing my care. I understand this form takes the place of any other Health Home Participation Authorization and Information Sharing Consent forms I may have signed before. I can change my mind and take back my consent at any time by signing a [Health Home Participation - Opt-Out/Decline Services](#) form and giving it to my Health Home.

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I give my permission to disclose information about (please put initials next to all that apply):

_____ Mental health _____ HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate [Release of Information \(ROI\) for Substance Use Disorder \(SUD\) Services](#) form.

Please initial the appropriate choice below.
This consent is valid: _____ as long as my Health Home needs my records for this program; or
_____ until _____
date or event

I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared. A copy of this form provides my permission to share records.

Print name of beneficiary Beneficiary's date of birth

Signature of beneficiary or beneficiary's legal representative Date

Print name of legal representative (if applicable) Relationship of legal representative to beneficiary

List your providers/partners on page two.

HCA 22-852 (12/17) page 1 of 3

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Consent form was revised (cont.)

Added information to identify the form as a release for the Health Home Program

Print name of Health Home beneficiary: _____

List the name of participating providers/partners	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials
Fast Care Coordination Org (CCO)/Lead _____	_____	_____	_____	_____
Fast CCO/Lead _____	_____	_____	_____	_____
_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____

This release of information should include page 1 of the Health Home Participation Authorization and Information Sharing Consent form in order to provide the legal authority to release information for the beneficiary listed above.

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Care Transitions

- Former guideline in the two-day training to complete medication reconciliation within five days of discharge has been discontinued
- Timeframe has been removed
 - Consult with your Lead on your contract requirements
 - Use your professional judgment
 - Example: client leave facility against medical advice cannot be given prescribed medications when they leave the facility

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Resources: contracts


Websites:

- Apple Health Contract:
 - https://www.hca.wa.gov/assets/billers-and-providers/model_contract_ahmc.pdf
- MCO Health Home Exhibit C
 - https://www.hca.wa.gov/assets/billers-and-providers/MC_ContractTemplate_ExhibitC.PDF
- MFFS Contract
 - <https://www.hca.wa.gov/assets/billers-and-providers/FFScontract.pdf>

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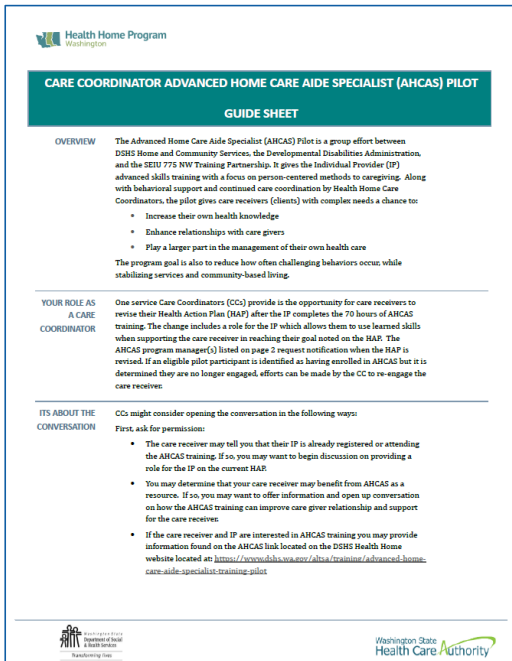
Alphabet Soup

Acronyms, Abbreviations, and Terminology: just a start on an exhaustive list of possibilities

 ACRONYMS, ABBREVIATIONS, and TERMINOLOGY	
ACRONYM/TERMINOLOGY	DEFINITION/MEANING
5/50	Refers to 5% of the population that utilizes 50% of the resources
504 Plan	Plan to meet needs of students with disabilities in schools
A/R	Applicant/Recipient
A&O	Alert and Oriented (x3 = person, place, time; x4 = person, place, time and situation/event)
b/c	Before meals
AAA	Area Agencies on Aging
AAARP	American Association of Retired Persons
ABD	Abdominal
ABD	Aged, Blind & Disabled
ABO	Antibiotic
ABP	Alternate Benefit Plan
ABX	Antibiotic Treatment
ACA	Affordable Care Act
ACES	Automated Client Eligibility System used to capture Medicaid financial eligibility
ACH	Accountable Communities of Health
ACK	Acknowledgement
ACP	Advance Care Planning
AD	Advanced Directive
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit/Hyperactivity Disorder
ADH/ADC	Adult Day Health/Adult Day Care
ADLs	Activities of Daily Living
ADRC	Aging and Disability Resource Center
ADT	Admit/Discharge/Transfer
AFH	Adult Family Home
AHAC	Apple Health Adult Coverage
AHCAS	Advanced Home Care Aide Specialist Pilot
AI/AN	American Indian/Alaska Native
AIRC	American Indian Health Commission
AKA	Above the Knee Amputation
AKA	Also Known As
ALF	Assisted Living Facility/Alternate Living Facility
ALJ	Administrative Law Judge
ALS	Advanced Life Support
ALS	Amyotrophic Lateral Sclerosis
ALTA	Aging and Long-Term Support Administration

Page 1 of 15 Note: these are examples of acronyms and their use is not required by the Health Home Program

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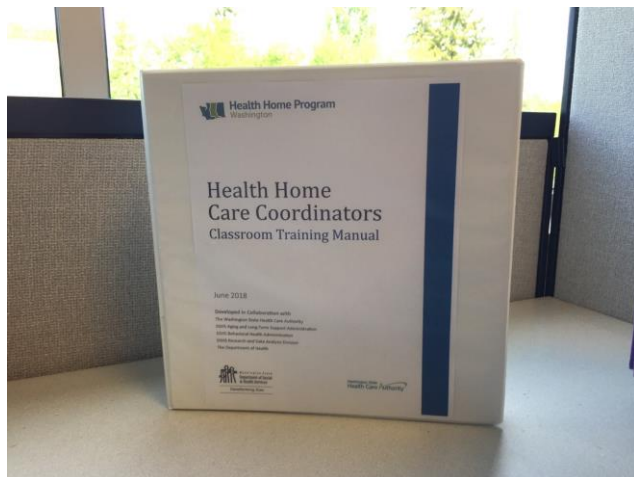


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Updated Advanced Home Care Aide Specialist (AHCAS) Guide Sheet

Where Can I Find the Classroom Training Manual?

DSHS Health Home Website
Core Training:
<https://www.dshs.wa.gov/alt/sa/washington-health-home-program>



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Good news!



Adult clients who have Medicaid Fee-for-Service coverage may be eligible for hearing aids starting January 1, 2019

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Today's Geriatric Medicine

News and Insight for Professionals in Elder Care

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Health Home Program
Washington

Certificate of Completion

Documentation and Quality Assurance

Presented by
Brendy Visintainer and Cathy McAvoy
Department of Social and Health Services—ALISA
and
Kathryn Pitteikau
Washington State Health Care Authority

*Webinar aired on: May 10, 2018 in Lacey, Washington
for Health Home Care Coordinators and Allied Staff*

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Post webinar discussion questions

- What are your Lead Organizations?
- What quality assurance activities have your Leads completed?
 - Do you have a copy of their file checklist?
- How do you balance working with your clients and completing documentation of your activities?
- What time management and tracking strategies do you use to ensure you meet program requirements and complete the HAP and required screenings at least once during each four-month activity period?

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