

HUGS Program Guidelines

Revised December 2011

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II. HUGS Core Components

A. Statement of Purpose

The purpose of the Help Us Grow Successfully (HUGS) program is to provide home-based intervention services to pregnant/postpartum women, children birth through the age of five (5) years and their primary caregivers. Home visitors form a unique and voluntary relationship with a family with identified needs. Home visitors screen for and identify potential problems, provide education, and connect families with resources in their communities. The HUGS program seeks to prevent or reduce risks as well as promote health and wellness.

B. Program Goals

The goals of the program are:

- To improve pregnancy outcomes
- To improve maternal and child health and wellness
- To improve child development
- To maintain or improve family strengths

C. Governing Legislation/ Program Definitions

1. Definition of Home Visitation: “In-home visitation” means a service delivery strategy that is carried out in homes of families of children from conception to school age that provides culturally sensitive face-to-face visits by nurses, other professionals, or trained and supervised lay workers to promote positive parenting practices, enhance the socio-emotional and cognitive development of children, improve the health of the family, and empower families to be self-sufficient. (TCA-68-1-125).

2. Definition of the Home Visitor: The Home Visitor is a specially trained health care provider, employed by the local health department and/or non-profit organization, providing services in the home setting.

3. Tennessee law requires all persons to make a report when they suspect abuse, neglect or exploitation of children (TCA 37-1-403 and TCA 37-1-605).

a. **The Home Visitor must contact 911 if the situation is a life-threatening emergency.**

b. Home visitors should contact the Tennessee Central Intake Child Abuse Hotline at 1-877-237-0004 or 1-877-54ABUSE (1-877-542-2873) for the following situations:

- Any knowledge or suspicion of child abuse or neglect, emergency and non-emergency situations.
- The home visitor wishes to remain anonymous
- The home visitor has insufficient data to complete the required information on the report
- The suspected abuse/neglect you are reporting occurred outside the state of Tennessee and you do not know how to contact the state where it occurred
- The home visitor is unsure if the child is imminent risk of harm
- Supervisor should be made aware of all DCS reports in a timely manner. Whenever possible, report should be discussed with supervisor in advance.

D. Target Population

1. Program Populations

The HUGS program provides services to all women, infants/ children, and family members in the following populations:

- **Prenatal** - Any pregnant woman with an identified need may benefit from care coordination services and is thus eligible for services.
- **Postpartum** - a new mother (with an infant from birth until one year of age)
- **Infant** - a child from birth to one year of age.

- **Child** - a young person between ages one through the age of five years.
- **Parent/Guardian** - anyone who lives with and cares for the pregnant/postpartum woman and/or an infant or child enrolled in the program or a woman who has lost a child less than 1 year of age.

2. Priority Populations

- Pregnant and parenting adolescents (less than 18 years of age)
- First time parents
- High risk pregnancies - defined as any of the following:
 - History of a chronic disease
 - History of pregnancy related complications
 - History of poor pregnancy outcomes
 - Late entry to prenatal care or no prenatal care
- Families that have experienced the death of an infant

3. Concept of Core Family

- Once a person is referred and accepts HUGS services, all members of their core family receive HUGS services. The rationale is that if any person in the family has a problem that merits home visiting services, then all people in the family are at risk.

The core family is:

- **One adult - Mother or father or primary guardian**
- **All children in the household under 6 years of age**
- **Any additional adult caregivers (Optional)**

The option exists to add additional adult caregivers that have a direct impact on child's life only if they will be participating in home visits.

- A family member may be a core family member but designated as inactive for the following reasons that that would cause their absence from home visits:

- Refused further services
- Moved from state
- Living with relative

- Child turned 6
- Child is enrolled in full time kindergarten, Head Start or daycare program
- Placed in foster care
- Death
- Unable to Locate
- Client schedule unable to accommodate HUGS
- Incarcerated
- Long-term hospitalization
- Separation from family and/or home
- Family closed

E. Eligibility

- i. There are no financial eligibility criteria for the HUGS Program.
- ii. HUGS services are voluntary.
- iii. Services are offered to all referred families based on staff capacity. If staff resources are limited, referrals for families in the priority populations or those with greater needs (based on referral reasons) should be given preference.

F. Service Requirements

- i. The home visitor is to:
 - **Assess** – evaluate and determine the needs of the family using observation/interaction, program assessment tools, and formal assessment tools
 - **Educate** – provide adult family members/caregivers with evidence based information about the Seven Domains of Wellness (Environment/ Safety, Physical Health, Mental Health/ Development, Nutrition, Family Planning, Substance Use, Family Strengths) and using the Partners For a Healthy

Baby Curriculum. Education also includes coaching and modeling of appropriate parenting skills/ interaction with children.

- **Assist** – connect the family with the appropriate resources and services based on need and availability and provide appropriate follow-up, as well as be an advocate for the family.
- ii HUGS services are delivered primarily in the home setting. Telephone contacts with family members are an integral part of care coordination services. However, they do not substitute for a home visit.
 - iii Group education classes may supplement the home visits but do not substitute for a home visit.
 - iv **Visitors are expected to visit families a minimum of once every 30 days.** Family circumstances may indicate more frequent visits and this should be determined by the judgment of the visitor on a case-by-case basis.
 - v The size of the caseload per each full time equivalent (FTE) home visitor is dependent on the experience of the visitor and the needs of the families served. As a general rule, a full caseload for a full time HUGS visitor consists of 25 - 40 active families. Each visitor is expected to work with their supervisor to establish a caseload that allows for maximum benefit to the families served and avoid overstressing the visitor's capabilities. The visitor should be allowed adequate time for travel, preparation, documentation, and continuing education/ training without negatively impacting families. If the caseload for a particular worker seems to be over or under this guideline, then the regional coordinator/supervisor and home visitor should develop an agreed upon plan of action. For planning purposes, a full time home visitor should conduct 4 visits/attempts a day or 20 visits/attempts a week.

III. Interventions

A. Approved Program Educational Materials

The *Partners for a Healthy Baby Curriculum* (developed by Florida State University Center for Prevention and Early Intervention Policy) and *The Creative Curriculum Learning Games, The Abecedarian Curriculum* (developed by Joseph Sparling, Ph.D. and Isabelle Lewis) are the required educational curricula for the HUGS program. Home visitors are expected to utilize the curricula through teaching and interaction at all monthly visits for prenatal women and children for all applicable months.

The following educational materials are acceptable for use as supplemental materials:

- San Angelo Curriculum
- Tennessee's Agriculture Extension Materials
- Planning a Healthy Pregnancy, by Channing Bete - Prenatal
- Caring for Your Baby and Young Child – Birth to Age 5
- Healthy Children Ready to Learn
- Dear Mommy, Dear Daddy - Marie Foss Hafen
- Smart from the Start
- First 12 Months of Life
- Second 12 Months of Life
- Brain Games for Babies
- Keys to Care giving – A Parent's Guide to Learning How Babies Behave

IV. Referral, Enrollment, and Closure Protocols

A. Referring Agencies

Incoming referrals are accepted from

- Local Health Departments (WIC, Primary Care, Family planning/ pregnancy testing)
- Hospitals

- Department of Children’s Services
- Community clinics/physicians/ providers/pediatricians
- Self referrals
- Any community provider who may have knowledge of family that would benefit from home visiting services
- Schools

Note: HUGS services are strictly voluntary. A family may be referred by the justice system, but may *not* be mandated to participate as part of a court sentence.

B. Referral Protocol

- i. Incoming referrals should use the Incoming Referral Form (PH- 3825) (See Appendix 1: Forms)

- ii. Incoming referrals should be contacted within 15 business days of receipt of the referral.

- iii. The HUGS program will attempt to contact a new referral with a minimum of one phone call, one letter, and one attempt at a face-to-face meeting. If no contact has been made after three attempts and 30 business days from the date referral was received, the referral should be closed with the appropriate closure code. (See Section VI: Coding)

- iv. Once contact is established, the HUGS staff member should introduce themselves, introduce the program (benefits, what the program does and does not do, what the basic expectations are of the family) and ask the family if they would like to participate.
 - a. If the referred person refuses, the referral should be closed with the appropriate closure code. (See Section VI: Coding)

- b. If the referred person accepts services, a home visit should be scheduled within 15 business days of contact. (If family is in crisis, every effort should be made to visit as soon as possible).
- v. Once the referred person accepts services, then the HUGS visitor is required to perform the Initial Assessment within 60 business days from the date the referral was received, unless client has deferred visit or been out of service area for an extended time, which must be documented. (See Section V: Assessments).

C. Enrollment

- i. A family is defined as “enrolled” once the referred person has completed the Initial Assessment.

D. Closure Protocol

- i. Case closure may occur at any time and must be documented electronically and in the paper chart.

- ii. Case closure may occur for six reasons:

- a. Case Closure – Family reaches stability and wellness **(1516)**

- The visitor and the family agree that the family no longer requires services.
- Requires verbal discussion
- Family is stable
- Family has resources to meet future challenges
- A *positive* parting of ways

- b. Client Chooses to Terminate Services **(1516C)**

- When a client chooses to end services *before the visitor thinks the family is ready*.
- Requires verbal discussion (visit or phone)
- Family may not be stable but no longer wants services
- The visitor should attempt to understand if there are underlying issues contributing to the family terminating services. If possible, attempt to help and offer resources.
- Let the family know that services are still available to them should circumstances change.

c. Client Moves Out of Visitor Service Area **(1516M)**

- Verbalized by client (visit or phone) to HUGS staff
- If the Primary Client moves but the rest of the family remains, HUGS service may continue if the family desires and remains eligible.
- If the family is moving out of state, close the family.
- If the client is moving within the state of Tennessee, the home visitor should ask client if they would like to continue services, if so the visitor is responsible for referring the family to the HUGS worker who covers the new residential area. This entails at minimum a phone call and written communication to the new HUGS office that the case is being transferred. A copy of client's chart should be forwarded to the new visitor.
 - If the move is outside the PTBMIS service area (metropolitan or rural region) then close the family.

- If the move is within a PTBMIS service area (metropolitan or rural region) then the family should remain open and active but the provider number should be changed to reflect the transfer.
 - Once the move has occurred, the new HUGS visitor should try to contact the family a minimum of three times (phone call, letter, and home visit attempt). If no contact is established within 30 business days of receiving a call or written communication to transfer client, then the family should be closed because they are Unable to be Located.

d. Unable to Locate **(1516U)**

- When the visitor is unable to locate an ENROLLED client after minimum 3 tries (phone call, letter, attempted visit) and 30 business days

e. Client Refuses Services **(1516R)**

- When an UNENROLLED (Primary Client has not completed Initial Assessment) person refuses HUGS services.
- Requires a face-to-face visit and verbalization of refusal of HUGS services.

f. Closure Not Enrolled **(1516NE)**

- Used to close an UNENROLLED client
- Has received a billable service (home visit attempt) but has not verbalized refusal of services.

iii. Please refer to Section VI: Coding for additional information on Closure Codes

V. Assessments

The home visitor is responsible for assessing the family's needs using observation/ interaction, program assessment tools, and formal assessment tools.

A. Initial and Continuous Questionnaire Assessments

Formal program assessments are required on all active core family members.

The home visitor should make every effort to administer the program Assessments in a conversational manner while maintaining the integrity of the Assessment form. Questions should be asked in a standardized manner according to the wording indicated in the Interpretive Guidelines. Refer to Appendix 1: Forms.

1. Initial Assessment

i. The Initial Assessment Form is required:

- On all active core family members within 60 business days of the date the referral was received
- When a Pregnant woman gives birth and becomes Postpartum
- When an Infant is born
- When a woman becomes Pregnant

An Initial Assessment is *not* required at the following population changes:

- When a Postpartum woman becomes a Parent/ Guardian (one year after birth)
- When an Infant becomes a Child (turns one year old)

2. Continuous Questionnaire Assessment

i. The Continuous Questionnaire Assessment Form should be completed for all active core family members every 6 months.

B. Development (Ages and Stages Questionnaire - ASQ)

- i. The Ages and Stages Assessment Tool is a flexible and culturally sensitive screening tool available to screen the development of children 4 months to 5 years of age.

- ii. The ASQ Assessment Tool is required on all active family members under the age of 6 years.

- iii. The HUGS program requires the ASQ to be performed at:
 - 4, 8, 12, 18, 24, 30, 36, and 48 months
 - Within 2 months of enrollment (excluding infants less than 3 months)

- iv. Additionally, the ASQ should be administered *any time* the home visitor or the primary caregiver of the child has a concern about the development of the child.

- v. If the questionnaire indicates a need, the home visitor should make the appropriate referral.

- vi. If a profoundly delayed child is receiving documented services from Tennessee Early Intervention Services (TEIS), the home visitor may use their own judgment about performing the screening at the required intervals on that client. The home visitor may screen to possibly identify other delays.

C. Medical Verification

The role of the home visitor is not to provide medical care, but to encourage and verify that families are getting the recommended medical and preventive care.

1. Children

a. HUGS advocates the preventive care periodicity schedule promoted by the American Academy of Pediatrics (AAP).

b. Key components include:

- Well child Check-ups/ Early Periodic Screening Diagnosis & Treatment (EPSD&T) Exams with all seven required components:
 - Health History
 - Complete Physical Exam
 - Lab Tests (as needed)
 - Immunizations
 - Vision/ Hearing Screening
 - Developmental/ Behavior Screening
 - Advice/ Anticipatory Guidance
- Dental care

Reference: TENNderCare brochure

<http://www.tn.gov/tenncare/tenndercare/brochure.pdf>

Reference: TENNderCare Oral Health

<http://www.tn.gov/tenncare/tenndercare/healthygums.pdf>

c. Medical Verification for Infants/ Children is required within 2 months of enrollment, and at 7, 13, 24, 36, and 48, and 60 months.

- d. To verify medical care, the home visitor must determine the primary care provider for the child, have the provider complete and return the HUGS Medical Verification Form, and place returned form and copy of immunization record in the child's paper chart.
- e. The home visitor should attempt to contact the primary care provider a minimum of three times to verify care. If after three attempts the provider does not comply, the visitor should document the attempts in the child's chart that medical care was unable to be verified.

2. Prenatal/ Postpartum Women

- a. HUGS advocates the preventive care periodicity schedule promoted by the American College of Obstetricians and Gynecologists (ACOG).
- b. Medical Verification for Prenatal/ Postpartum women is required within 2 months of enrollment, each prenatal trimester, and the 6 week postpartum check.
- c. To verify medical care, the home visitor must determine the primary care provider for the woman, have the provider complete and return the HUGS Medical Verification Form, and place returned form in the woman's paper chart.
- d. The home visitor should attempt to contact the primary care provider a minimum of three times to verify care. If after three attempts the provider does not comply, the visitor should document the attempts in the woman's chart that medical care was unable to be verified.

D. Nutrition

- i. Within 2 months of enrollment the home visitor must document at least ONE of the following:
 - a. Food security (on Initial Assessment Form)
 - b. Currently receiving WIC services (in Progress Notes, on Initial Assessment Form, or on HUGS Documentation Record)
 - c. Referral to food services - WIC, TANF, CSFP, Food bank, etc. (in Referral Tracker)
- ii. All eligible women and children should be referred to the Supplemental Food Program for Women, Infants, and Children (WIC) or the Commodity Supplemental Food Program (CSFP).
- iii. Any women or children who may not be eligible for WIC should follow the nutritional guidelines at www.ChooseMyPlate.gov

VI. Coding

Please refer to the PTBMIS Codes Manual for current HUGS Codes and definitions.

A. Definitions Pertaining to Codes

- i. **Billable Service** = a home visit, a home visit attempt, group class, or face-to-face visit in a setting other than home (phone calls and letters are *not* billable services)

- ii. **Primary Client** = the person referred to the program

- iii. **Enrolled** = Initial Assessment has been completed for the primary client

B. Diagnosis Codes

- i. The diagnosis code for a HUGS encounter is the word “HUGS” followed by number of core family members seen at the visit.
Example: Mother and new infant both seen. Diagnosis: HUGS2

- ii. If no person is seen for a face-to-face visit, then the diagnosis code is HUGS0. This would occur for a home visit attempt or an encounter documenting closure only.

C. Incoming Referral

- i. Please refer to Appendix 2: Incoming Referral Flowchart for guidance regarding the process and coding for an incoming referral.

D. Visits

1. Three Step Process

- i. HUGS procedure codes reflect the intensity of the visit performed.

ii. Determining what procedure code to use for each face-to-face home visit is a three step process. The steps are listed below and then discussed in greater detail.

Step 1: Determine if the family is new or established

Step 2: Determine the level of complexity of the visit.

Step 3: Determine the amount of time for the visit.

iii. Please refer to Appendix 3: Codes Diagram Flowchart for guidance on selecting the appropriate visit code.

2. Step 1: New or Established Family

i. A new family is defined as having been receiving services for 2 (two) calendar months from the date of enrollment (the date the Initial Assessment was completed) by the HUGS program.

ii. An established family has been enrolled for more than two calendar months from the date of enrollment (the date the Initial Assessment was completed) by the HUGS program.

3. Step 2: Level of Complexity

i. To determine the level of complexity, count the significant issues that were addressed at the visit for all enrolled core members. A significant issue is any problem or domain that a visitor either assesses, educates on, or assists with (counseling or referral). The count used for coding should be the sum total for all family members seen at this visit.

- 1 Significant Issue = **Low Complexity**
- 2 Significant Issues = **Medium Complexity**
- 3 - 4 Significant Issues = **High Complexity**

- 5+ Significant Issues = **Highest Complexity**

ii. When completing program Assessment Forms, count the number of domains that were assessed at the visit.

iii. The following populations are automatic highest complexity codes, regardless of how many significant issues are addressed at the visit:

- Mothers less than 18 years of age
- Children with special health needs (Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. The condition may be developmental or acquired and may cause limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.)
- Homeless/ transient families

4. Step 3: Time

i. Determine the amount of time the visit took.

ii. If the visit lasted longer than the suggested time for that level of complexity, the visitor may use the next most intense code.

ii. Generally, visits should not last longer than one hour, though special circumstances may arise.

E. Codes for Attempted Visits

99348A	Home Visit Attempt (ENROLLED, SCHEDULED): This code is used to document the home visitor's unsuccessful home visit attempt to an ENROLLED client. The home visitor HAD A SCHEDULED VISIT, traveled to the patient's residence, but was unable to complete the home visit. This code can only be used one time per household each day, even if the worker stops by
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	more than once in a day.
99348B	Home Visit Attempt (ENROLLED, NOT SCHEDULED): This code is used to document the home visitor's unsuccessful home visit attempt to an ENROLLED client. The home visitor DID NOT HAVE A SCHEDULED VISIT, traveled to the patient's residence, but was unable to complete the home visit. This code can only be used one time per household each day, even if the worker stops by more than once in a day.
99348C	Home Visit Attempt (NOT ENROLLED): This code is used to document the home visitor's unsuccessful home visit attempt to a REFERRED client. The home visitor traveled to the patient's residence, but was unable to complete the home visit. This code can only be used one time per household each day, even if the worker stops by more than once in a day.

i. It is permissible by the program to code for an attempted visit and a face-to-face visit on the same day.

ii. It is not permissible to code for an attempted visit and a face-to-face visit in the same encounter.

F. Interpreter Codes

i. Interpreter codes are used to indicate that a visit took more time due to translation into another language. Visitors should estimate the amount of time the visit would have taken had the visit been conducted in one language, then estimate the amount of *extra* time it took to translate the visit. This *extra* time is what is indicated by the following interpreter codes:

INT1	15 minutes
INT2	30 minutes
INT3	45 minutes
INT4	60 minutes

ii. The visitor may use an interpreter code if the translation was performed by an official interpreter/ language line or an unofficial translator such as a family member or friend.

iii. If the visitor is conducting the visit in a language they are fluent in, it is *not* appropriate to use the interpreter codes.

G. Group Education Code

i. Group education classes can be a way to promote learning and socialization amongst HUGS clients, however group education sessions **do not take the place of one-on-one interaction in the home and may not be substituted for the minimum home visit every 30 days.**

ii. Use code **99412** for each family attending the group session

H. Closure Codes

i. When families are closed out of HUGS services, there are 6 codes to indicate the reason for closure

1516	Case Closure
1516C	Client Chooses to Close
1516M	Client Moved
1516R	Client Refused Services
1516U	Unable to Locate
1516NE	Closure – Not Enrolled

ii. See Section IV.D : Closure Protocol

VII. Documentation

A. Introduction

i. The following section is adapted from the Public Health Nurse (PHN) Orientation and Practice Manual (2005 version).

ii. Documentation of patient care in a medical record, including electronic medical record (PTBMIS), is necessary to communicate accurate and complete

information about the patient and the care provided. Documentation is the objective recording of observations, findings, actions, and interactions. Information is recorded according to established standards of practice.

B. Principles of Documentation¹

- Unique patient identification must be assured within and across paper-based and electronic healthcare documentation systems.
- Documentation systems must assure the security and confidentiality of patient information.
- Documentation must be accurate and consistent
- Documentation must be clear, concise, and complete reflecting patient response and outcome related to nursing care received
- Documentation must be timely and sequential
- Documentation must be retrievable on a permanent basis in a nursing-specific manner (SOAP Format)
- Documentation must be able to be audited
- Documentation must meet existing standards such as those promulgated by state and federal regulatory agencies (to include HIPAA as enforced through the Department of Justice, the Centers for Medicare and Medicaid Services, and though accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance.
- Entries into the medical record (including orders) must be legible, complete, and authenticated and dated by the person

¹ Taken from Principles for Documentation, American Nurses Association, January 2003
PHN Orientation and Practice Manual January 2005 II-15

responsible for ordering, providing, or evaluating the care provided.

- Abbreviations, acronyms, and symbols utilized in documentation must be standardized.
- The home visitor must be familiar with regional organization policies and/or procedures related to documentation.

C. The Medical Record

The medical record is a tool used to chart client care in order to assure that appropriate care is provided and also to provide a mechanism to audit both the care and the performance of the health care providers. It should provide a complete written account of the visit history of the client. It is a legal document and is strictly confidential.

The courts have recognized two types of ownership of medical records - the actual record remains the property of the health care agency but the information contained in the record is the property of the patient.

i. Purpose:

- To communicate patient findings to other care providers.
- To provide a legal and permanent record of the care given.
- To provide data for monitoring quality care.

ii. Initiation:

The Department of Health policy (policy 5.1.a) for initiating medical records is as follows:

“A medical record must be prepared for every patient who receives health services of any kind, including immunizations, from health department personnel, under the auspices of the health department, whether done in the health department, the home, or other settings.”

iii. Chart order is determined by regional policy, with the exception of the primary care regions where the chart order is determined by the established primary care standards. The medical record includes:

- Patient identification
- Date of service
- Location where service is provided
- Service provided
- Signature of provider
- All services must be documented on the patient encounter or through PTBMIS.

D. Charting Guidelines

- It is the provider's responsibility to capture required data for tracking and billing purposes that accurately matches services provided.
- Code services rendered on appropriate PTBMIS encounter form.
- Document all information directly into the patient's record immediately following the given care.
- Record facts, not opinions.
- Make all entries in chronological order. Never insert notes between lines or leave space for someone to insert a note. If it should be necessary to record out of time sequence, the entry should be marked "late note", dated and signed, and any unused spaces filled in with lines.
- Correct all charting errors according to policy. The policy for correcting charting documentation is as follows:
 - Draw a line through the entry needing correction

- Write CID (Correction in documentation) immediately above the entry
- Initial Date (if different from date of original entry)
- Never obliterate entries or use “white out”.
- Write with blue or black ink.
- Use only standard abbreviations approved by the Nursing Practice Committee (See PHN Protocol Manual) or Region-specific approved abbreviations
- Date and sign every entry according to specific medical record instructions.
- Use proper signature on medical record - first initial, last name, and provider status (e.g., J. Doe, R.N.; if initials are used (medical record, logs, equipment maintenance) full signature must be on file.
- Do not chart for anyone else or allow others to chart for you.
- Always record return visits, telephone conversations, and follow-up instructions.
- Telephone calls may be documented in patient’s record by indenting date (regional option) and a brief narrative note summarizing telephone call (SOAP format is not required).
- Make all charts legible.
- If you are documenting subjective information, identify the informant.
- If an interpreter is used, document full name.
- Simplify charting as much as possible.
- Use correct grammar and spelling.

E. SOAP format

To assure an orderly and coherent narrative of the home visiting process, as well as to facilitate data retrieval, information in the client record should be organized

in a consistent pattern. The S.O.A.P. format is recommended, i.e., SUBJECTIVE, OBJECTIVE, ASSESSMENT, and PLAN.

1. Subjective (S):

Subjective data is information about the client, based on personal experience or the reporting of someone close to the patient. This includes client history, including pertinent physical, social, emotional, mental, spiritual, and economic information. May also include subjective feelings, symptoms, and perceptions reported by the patient.

2. Objective (O):

Objective data is describable, measurable, observable, and verifiable. Information is obtained through observation. It is something you can see, hear, feel, smell, quantify, etc.

3. Assessment (A):

Assessment is an analysis or interpretation of the patient's status and need for help, based on subjective and objective data. It is a statement of conclusion – an assessment of a problem and/or need.

4. Plan (P):

This is a written plan of management for each client problem. The plan indicates intervention that will take place to alleviate or solve the problem. The plan must be related to the problems/needs and include a written action for each problem or need identified. The plan may include the following:

- The need for more information to accurately diagnose problem or need
- The need for treatment, care coordination, follow-up, referral, or management
- The need for patient and/or family teaching/education

5. Abbreviations

See Model PHN Protocol manual for list of accepted standard abbreviations that can be used for documentation in the medical record. New requests for abbreviations to be added to the list should be submitted to the State Public Health Nurse Practice Committee for their review and approval. The use of abbreviations in standard program manuals are allowed

For additional abbreviations, also refer to current PTBMIS/RVU Codes Manual and WIC Manual. If regional specific abbreviations are used, they must be approved by the regional medical director and/or regional nursing director and added as an appendix to the standard abbreviations in the state Model PHN Protocol Manual.

6. Records Management

a. **Central Patient Filing:** See Section 5.1.a, HSA Policies and Procedures Manual. All client records (paper/or electronic) should be filed according to Central Patient Filing System. In local health departments, the Clerical Consultant is responsible for the maintenance of medical records in a safe and organized manner to insure confidentiality of content/ready accessibility to medical providers.

b. **Transfer of Medical Record:** See Confidentiality, 5.1.b, 5.1.c, 5.2, HSA Policies and Procedures Manual.

c. **Closing Records:** See Retention and Destruction of Records, Section 5.3, HSA Policies and Procedures Manual.

d. **Release of Information:** See HSA Policies and Procedures Manual, sections HSA 5.1.b, 5.1.c, and 5.2

e. **STD Contact Records:** See Confidentiality, Section 5.2, HSA Policies and Procedures Manual.

f. **Subpoena of Medical Records:** See Section 3.1, HSA Policies and Procedures Manual.

g. **Forms Processing and Printing:** See Section 5.4.a, HSA Policies and Procedures Manual.

F. Electronic Data Collection System

1. Background

- i. Beginning July 1, 2009 the HUGS program began to utilize a specially designed HUGS module for the statewide Patient Tracking, Billing, and Management Information System (PTBMIS) for electronic data collection for evaluation. This system is integrated with other Health Department functions and allows for timely data extraction and analysis.
- ii. Please reference Appendix 5: Electronic Data Capture System for complete technical assistance on utilizing the electronic data capture system.

2. Encounters

- i. The HUGS module in PTBMIS has distinct and separate HUGS-specific encounters for data collection.
- ii. Please reference Appendix 5: Electronic Data Capture System for complete technical assistance on utilizing the electronic data capture system.

3. Attempts

- i. A HUGS encounter that documents an attempted home visit (See Section VI: Coding for Attempted Home Visit Codes) may suffice for the only documentation for that encounter (no paper documentation is needed).

4. Assessments

- i. The HUGS module in PTBMIS records HUGS assessment data.
- ii. All assessment data must be entered electronically within 3 days of assessment visit.

ii. Please reference Appendix 5: Electronic Data Capture System for complete technical assistance on utilizing the electronic data capture system.

5. Outside Agency Referral Tracker

- i. Based on formal and informal assessments, the home visitor may identify needs or problems that require an outside service or agency. The Outside Agency Referral Tracker serves as a family-centric record of referrals made as well as a data collection tool regarding referrals and referral outcomes.
- ii. Only the electronic version of the Outside Agency Referral Tracker is mandatory. A paper version is available if the visitor prefers to keep a paper record of referrals in addition to the electronic version. Please reference Appendix 4: Outside Agency Referral Tracker for the paper version of the Outside Agency Referral Tracker, a complete list of the abbreviations used in the electronic Outside Agency Referral Tracker, and a complete list of Available Referral Agencies.
- iii. Once a problem has been identified on the Referral Tracker (either manually or automatically from an assessment) a referral must be made and documented within 7 or fewer business days.
- iv. Please reference Appendix 5: Electronic Data Capture System for complete technical assistance on utilizing the electronic Outside Agency Referral Tracker.

VIII. Staff

A. General Policies for Staff

The following are some general policies for staff. Regions/ Metros are required to develop policies around these topics more fully and with specifics to their own sites and communities.

1. Scheduled Work Hours

Family support programming requires flexibility. Each site determines its normal hours of operation. Note that programs may adopt flexible schedules, e.g.,

evenings and weekends in order to meet the needs of families with work or school conflicts.

Any changes in scheduled appointments, or calling in sick, are communicated to the immediate supervisor. Supervisors need to know where and when home visitors are conducting visits each day. It is recommended that staff who are in the field call the office to speak with their supervisor and check on messages. If a visitor starts their day before coming to the office or ends their day without coming to the office, it is recommended that they call the office and check in with a supervisor.

2. Punctuality

Staff members are expected to schedule visits in a timely manner and to be on time for scheduled visits. If home visitor is delayed or must change time or date of home visit due to unforeseen circumstances, client should be notified of change in a timely manner.

3. Staff Safety

Safety of staff members is a program priority. Each program site must have established a policy on safety to guide staff in their work in the office, families' homes and the community. This includes protocols around signing-in and out, calling in throughout the day, and assuring supervisors know staff's schedules. Home visitors and supervisors share responsibility for maximizing safety of staff members. Staff members should never attempt to intervene in a domestic dispute. Program staff should leave if their safety is threatened for any reason and immediately contact a supervisor or manager.

4. Mobile Phones

Staff should not use personal mobile phones to contact clients.

5. Boundaries

Program staff receives initial orientation before their first home visit alone, and on-going support and training on maintaining effective boundaries between the personal and the professional. Feelings such as excessive worrying, ‘rescuing,” and over-identification should all be recognized by staff as issues where support is needed and should be brought to the attention of the supervisor.

6. Accepting Gifts or Favors

Staff should report to their supervisor any gifts given by clients and should not accept a gift of anything of significant value. Staff is encouraged to explain to the family that this is an agency policy.

7. Transportation Guidelines

State of Tennessee travel guidelines and policies should be followed at all times. Refer to the State Department of Finance and Administration Comprehensive Travel Regulation listed under personally owned automobile. <http://www.tn.gov/finance/act/documents/policy8.pdf>

For Staff Utilizing Automobiles: A copy of staff’s valid driver’s license and registration and insurance cards of the vehicle used for work must be on file. Mileage sheets are to be turned in to supervisors on a monthly basis. Mileage forms are completed as the local county requires.

B. Orientation

The guidelines for Orientation are currently under development.

C. Professional Development/ Training

The guidelines for Training are currently under development.

D. Supervision

The guidelines for the Protocol for Supervision are currently under development.

IX. Quality Monitoring

A. Audit Tool

The audit tool is utilized by program staff to ensure that basic program guidelines are adhered to and the program is implemented in a standard way.

B. Program Measures

The guidelines for Program Management are currently under development.

X. Regional/ Metropolitan Health Department Responsibilities

A. Annual Plan

1. Each Regional/Metro Health Department must develop and submit an annual plan to the Central Office Program Director of HUGS by July 1.

2. The plan should include, but not be limited to:
 - A description of target population along with a projected number of clients and families to be served annually
 - Plan to reach the identified target population
 - Number of FTE/ Average caseload per FTE
 - Referral sources
 - A description of supplemental client education classes, if any
 - The regional training schedule for periodic updates of skills and review of topics important to home visiting services
 - Any approved deviation from program guidelines (additional forms/ protocols/ etc.)

B. Regional/ Metropolitan Target Population

1. The decision regarding which population of prenatal/postpartum women and/or children, birth through the age of 5 years that are enrolled should be made at the Regional/ Metropolitan Office level by the regional program supervisor. Decisions should be based on the degree of need identified in these populations in their respective service areas and the capacity to provide such services.