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# Lessons from the Field: A Systems Thinking Approach for Case Management Documentation

Graham F. Watts Sr  
[grahamfwatts@yahoo.com](mailto:grahamfwatts@yahoo.com)


Angela E. Prince  
*UF Health Jacksonville*, [aeprince01@gmail.com](mailto:aeprince01@gmail.com)

Heather Vaughan  
*Lutheran Social Services of NE Florida*, [heather.vaughan@lss.org](mailto:heather.vaughan@lss.org)

Porschia McCray Watts  
[msp.lyn@gmail.com](mailto:msp.lyn@gmail.com)

Beth Parker  
*Northeast Florida AIDS Network*, [bparker@nfanjax.org](mailto:bparker@nfanjax.org)

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# Lessons from the Field: A Systems Thinking Approach for Case Management Documentation

Graham F Watts, Sr, PhD; Angela E Prince, MSN, RN, ACM; Heather Vaughan, MS, CRC; Porschia McCray Watts, LPN, BSM; Beth Parker, BA

## ABSTRACT

*Case management is a core HIV health service that focuses on service coordination—the seamless access to an array of integrated services. Integration aims to reduce barriers to medical care. In the busy HIV health services environment, inadequate documentation of case management activities limits the capacity of stakeholders to know what happens during care encounters. This study used theory and qualitative inquiry to uncover best practices that support optimal case management documentation. Two research questions guided the inquiry: What principles should arise in higher order cognitive functioning among case managers during client encounters? What characteristics of a system level approach to care encounter documentation reinforces case management critical thinking skills? The study settings included two, Northeast Florida, Ryan White funded organizations. Findings indicated that the confluence of intrapersonal, interpersonal, organizational, community, and policy factors support more rather than less robust case management documentation. A multi-tired approach to documentation of services rendered is no panacea. However, it offers a useful framework for defining stakeholders' roles and expectations and monitoring the performance of activities. Disseminating these findings in the local Ryan White network and the public domain may trigger dialog and more research about the preservation and effective use of documentation skills.*

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## BACKGROUND

The human immunodeficiency virus, (HIV), (<https://www.mayoclinic.org/diseases-conditions/hiv-aids/symptoms-causes/syc-20373524>), affects the health of many people. Case management is often used to help people with HIV (Lo, MacGovern, & Bradford, 2002). In 2017, the Jacksonville Transitional Grant Area, (JTGA), Services Utilization Report had the highest number of billed service units for case management. Case management is care coordination. The aim of care coordination is to give clients more seamless access to an array of integrated services to help them effectively manage chronic, and potentially disabling conditions (Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). People Living with HIV or Acquired Immunodeficiency Syndrome, (AIDS), (PLWHAs), rely on case management as a gateway to other Ryan White funded services that reduce barriers to treatment adherence and care involvement. The JTGA embraces an idealized conception of case management. Stakeholders see case management as a collection of activities that includes client assessment, care plan development,

services matching, case-conferencing, linkage to other services, client follow-ups, client-education, service effectiveness monitoring, and efficacy evaluations. A clear understanding of case management at multiple levels of service delivery has a justifiable role in the delivery of HIV health services.

Timely and accurate documentation of case management services is imperative. Blair and Smith, (2012) states that both the lawful and real-world implications of documentation warrant communication of "... observations, decisions, actions, and outcomes related to [client] issues and care" (p. 161). Case Management Society of America, (CMSA), Standards of Practice for Case Management, Revised 2010, calls upon case managers to "employ ongoing assessments and documentation to measure the client's response to the plan of care" [Standards of Practice for Case Management, p. 17] (<https://www.abqaurp.org/DOCS/2010%20CM%20standards%20of%20practice.pdf>). The National Association of Social Workers, (NASW), Standards for Social Work Case Management manual, page 44, is explicit about documentation

(<https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0>).

Clear, concise, and ongoing documentation of social work practice facilitates clear communication with other service providers and organizations, thereby promoting continuity of services...; serves as a foundation for service planning, practice, and program evaluation, [and]...is often needed for reimbursement, for utilization review, and to promote organizational accountability to payers or funding sources.

From the perspectives of health services research and community health, documentation has implications for understanding how services coordination contribute to timely utilization of HIV primary medical care and other core services. Devolution of these noble aims sometimes fail to reach the documenting fingertips of a few earnest case managers. The service environment of case managers includes large caseloads, clients with multiple comorbidities, many interactions with staff and clients, planned meetings, and ad hoc workplace responsibilities. If relaxed supervision, reliance on written policies, agency level credentials, and staff certification combine with the busy environment of case management, a culture develops that fails to systematically and periodically check the status of key case management indicators.

Valid documentation preserves a history of what happens in the HIV health services context. The introduction of health information systems has produced "...a high demand for the documentation and communication of patient-related data" (Ammenwerth & Spötl, 2009, p. 84) because HIV care requires the highest quality, multidisciplinary care that is available to clients (Wilson et al., 2006). The Ryan White community has available documentation guidelines. Exhibit 1 is available online at the Target Center, Tools for the Ryan White Community, website. The City of Jacksonville Ryan White Part-A program office also has a Medical Case Management Curriculum binder. Provider contracts include language about documentation requirements. CAREWare, the jurisdiction's electronic health record, has built-in functionalities for facilitating timely and accurate documentation. Despite these available resources, including discussions at Ryan White Part A provider meetings and private consultations with agency personnel, documentation missteps persist among a few case managers.

Documentation missteps are not a novelty issue! Lauder Milch, Schiff, Nathens, and Rosengart, (2010), discussed the lack of adequate emergency medical services, (EMS), documentation. Documentation wanes in other contexts suggesting that the Ryan White community is not alone in missed documentation opportunities. However, setting

context aside, whatever documentation omits remains unknown. The inability to know about what happened during the care or service encounter interferes with evaluation of evidence-based decision-making and appropriate service provision; therefore, it follows that the inference of poor-quality care is reasonable where poor documentation exists (Wenger et al., 2003). Rather than assume or make accusations about the counterfactual, i.e., what has not happened, it is more productive to investigate success stories, i.e., instances of acceptable documentation, to learn how to disseminate documentation effectiveness best practices. Reliance on this positive approach holds promise to ensure that all jurisdictional case managers are comprehensive in their job-related functions.

In Northeast Florida, differential documentation exists among funded Ryan White Part-A providers. Broadly speaking, five functions comprise case management. These functions include "assessing patients' needs, developing service plans, linking patients to services, monitoring provision of services, and evaluating patients' progress" (Goering, Wasylenki, Farkas, Lancee & Ballantyne, 1988). If the Case Notes, which operationalizes the plan of care, do not reflect fulfillment of at least some of the case management functions, multiple stakeholders may have questions. For example, third-party reviewers like the billing departments at the Ryan White Administrative Agency will question and possibly deny payment for services. The chart reviewer at the annual site visit will score the record poorly. The medical case management supervisor auditing the chart will place a flag on the record for follow-up consultation with the case manager. Health services researchers implementing retrospective quality assurance projects will question both the system and quality of care provided to clients. A pause, at all the levels of review discussed, is helpful because when case management documentation fails to capture key service components, it points to the absence of distributive justice—equitable distribution of scarce resources in HIV health services. To summarize, where no accurate record in the client chart substantiates execution of any of the five case management functions, it is challenging to make any case that client services have been delivered in a way that contribute to client or treatment cascade outcomes, (Ziegler-Brown, Brown, Chen, & Blackburn, 2007). Previously, a local, unpublished study by Wilson and Carter, (2015), drew attention to case management deficits in the JTGA—a report that was largely overlooked by some stakeholders.

The development of documentation thinking skills is critical for creating a reliable history of the care provided to people living with HIV and AIDS, (PLWHAs). In part, the dearth of documentation thinking skills has led a medical informatics

evaluation research study to show that the “use of the electronic health records has not been associated with improved ambulatory care quality” (Schnipper et al., 2008). Publicity about the potential benefits of electronic health record, (EHRs), created expectations about the role of centralized documentation in making available a rich reservoir of information for evaluating clinical practice. Those expectations rested on the idea that “Healthcare information technology, (HIT), holds great promise for improved patient outcomes, increase cost-effectiveness, and better patient and staff satisfaction” (Rogers, Sockolow, Bowles, Hand & George, 2013, p. 1069). However, as is sometimes the case, documentation, even in medical settings, falls short of offering clear and easy to follow data that provides compelling information about clinical decisions and interventions that aimed to achieve outcome goals. It is our contention that where these incomplete records exist, they show a lack of reciprocal critical thinking defined here as making objective analysis for clinical judgment explicit and verifiable. The absence of such documentation leads to questions about the processes of care (Blair & Smith, 2012). Anecdotal evidence by one local provider referred to this lack of explicit and verifiable clinical judgment as lazy documentation. In 2018, at least in the Northeast, Florida HIV health services context, “documentation of the treatment process” (Franklin, Solovitz, Mason, Clemons & Miller, 1987) remains an opportunity for continuous improvement and an essential component of HIV health services delivery.

The research questions, with programmatic implications that guided this qualitative inquiry, asked,

1. What principles should arise in higher order cognitive functioning among medical case managers during client encounters?
2. What characteristics of a system level approach to care encounter documentation reinforces case management critical thinking skills?

Strong Structuration Theory, (SST), provided the top-level framework for pursuit of the research questions. SST posits a triadic and dynamic interaction between the structures that underlie the social environment, the sense of agency, (SA, a.k.a., sense of control), which inspires human behavior, and actions mediated by technology that holds promise to change society (Shaw et al., 2018). What does that mean? The effect that individuals, such as health services leaders and managers, have on the care or service environment comes from the crossing point of social processes, (i.e., actions arising from exchanges between people), their sense of control over events in the environment, and the effects of their actions in specific contexts and intervals (Jack, 2017). SST alone, while it pointed the

research in a strategic direction, provided little guidance on how to capture the crossing point. Thus, we drew upon the social-ecological framework, which offers a pathway for understanding how a social system and the interconnections, or lack thereof, among agents in the system, defines behavior at the crossing point.

### Purpose

The purpose of this study is to advance emerging ideas about a comprehensive framework for supporting an environment that can serve as host for accurate and timely case management documentation. This work should stimulate on-going discourse, and even debate, in the public’s sphere about how to institutionalize productive and accurate documentation of client care and services in high caseload situations that includes brief, episodic client contacts.

### METHODS

Qualitative mixed methods provided data for analysis. A review of multiple client records, using CAREWare, raised flags during invoice processing at the Ryan White Administrative Agency. The subsequent, annual site visit at the same provider in the same service category offered confirmatory evidence for questions about the quality of service delivered by a specific case manager. A subsequent fact-finding in-depth interview applying the ecological framework described elsewhere (Bronfenbrenner, 1986; Mcleroy, Bibeau, Steckler & Glanz, 1988), and shown in Figure 1, asked five questions of one funded agency leader where stellar documentation occurs. The questions asked:

1. What intrapersonal factors help case managers accurately document client encounters?
2. What interpersonal factors help case managers accurately document client encounters?
3. What organizational factors help case managers accurately document client encounters?
4. What community factors help case managers accurately document client encounters?
5. What policy factors help case managers accurately document client encounters?

Administrative agency staff summarized the face-to-face interview and developed an initial version of Table 1, which summarizes principles for generating input for documenting case management encounters. Subsequent distribution of Table 1 to a second Ryan White Part A funded agency and two nursing professionals garnered additional feedback and culminated in the final version of Table 1.

## RESULTS

Table 1 identifies principles for generating input for documenting provision of case management services. These principles include:

1. A priori chart review, (based on the daily appointment schedule);
2. Clarify the purpose of the case management encounter;
3. Conduct a rapid gap analysis;
4. Engage in client empowerment activities;
5. Check-in with the client to ensure client owns the solutions to problems to be solved;
6. Conduct a qualitative care experience assessment;
7. Focus on client-physician healthcare communication.

These principles are neither exhaustive nor completely mutually exclusive. The order from one to seven does not imply linearity or unidirectionality. Emphasis on few points offer a beginning for thinking about the case management encounter and laying a foundation for skills acquisition and attitude valence—development of a positive approach toward the encounter.

One size does not fit all. Client needs are person-centric and highly individualized. Therefore, as case managers grow in competence and in understanding their caseloads, defining and identifying encounter principles and the extent of exercise of each principle commensurate with the client's acuity level has several advantages. For example, case managers become efficient at quickly connecting with clients of diverse backgrounds. Moving beyond establishing rapport, the case manager acquires skills in easily transitioning to working productively and collaboratively with clients to address their HIV health service needs. The case management skills associated with rapport development and working collaboratively with clients lay a foundation for documenting the encounter in a way that supports invoicing for CM services.

JTGA has reimbursable, invoicing case management components. In other words, there are specific activities that a case manager must demonstrate to get paid for services rendered. The seven principles that follow establishes payment justification:

1. Healthcare communications;
2. Case conferencing;
3. Chart/Case review;
4. Care coordination, inclusive of service linkages and referrals;

5. Reduce barriers of access to care engagement;
6. Transitional care planning, inclusive of modality of case management as acuity declines;
7. Treatment adherence and counseling.

There is nothing magical about the tally of seven components. Others may legitimately argue and demonstrate that case managers do more than the seven conceptual tasks listed above. The field of HIV health services values the work of case managers, as an integral part of the HIV health services team. If the list of conceptual tasks is incomplete, the jurisdiction should prioritize time and resources to update it. However, the current reimbursement schedule for case managers in the JTGA calls for invoicing and case management Case Notes that evidence two or more of the seven components. The service delivery modality can be one face-to-face encounter per client, per month, or multiple non-face-to-face encounters per month. The seven principles of Table 1 align with the seven reimbursable invoicing components to demonstrate that case management, as applied in practice, fulfills the aims described by local policy and nationally recognized standards.

## DISCUSSION

This study used the unevenness of documentation quality among JTGA Part-A Ryan White providers as an opportunity to learn from high-performing funded organizations. The researchers did not explore organizational leadership styles to uncover behavior patterns of leaders and managers that support accurate and consistent documentation (Eagly & Johannesen-Schmidt, 2001). Future research should explore whether organizational leadership styles are factors in establishing an ecological context for successful documentation. Despite the limitation, the study has merits because it used a natural setting and a theoretical framework to explore the conditions of documentation success, ex-post facto. Using theory to guide the research questions offers a useful starting point for performance improvement. First, it allows for reframing medical case management documentation, or the lack thereof, as a conditional behavior that is amenable to change. Second, it offers the opportunity to interpret the findings reported here, in the context of antecedent processes that contribute to the desired behavior. Finally, and perhaps more importantly, it swings the locus of change from what individuals do to what the system in which they function permits.

<b>Principles for Documenting Case Notes</b>	<b>Activity Intensity Varies by Acuity Level</b>			
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1. <u>Chart Review</u>: Review client's plan of care, (POC), before the encounter</b>	<b>Cursory</b>			<b>In-depth</b>
<b>2. <u>Encounter Purpose</u>: Evaluate purpose of the encounter against POC objectives</b>	<b>Simple</b>			<b>Complex</b>
<b>3. <u>Gap Analysis</u>: Identify gap/s that the encounter seeks to fill in relationship to the POC objectives</b>	<b>Global</b>			<b>Specific</b>
<b>4. <u>Empowerment</u>: Offer client-centered psycho-education to support client's POC objectives</b>	<b>Generic</b>			<b>Tailored</b>
<b>5. <u>Checking-In with Client</u>: Discuss or review client's medication adherence experience</b>	<b>Basic</b>			<b>Intricate</b>
<b>6. <u>Care Experience Assessment</u>: Review client's perceptions and/or experience of the last documented HIV and related medical visits</b>	<b>Standard</b>			<b>Advanced</b>
<b>7. <u>Healthcare Communication</u>: Ask client to recap medical engagement with infectious disease doctor to identify opportunities, if available, to strengthen client-physician communication</b>	<b>Reinforcing</b>			<b>Teaching</b>



Exhibit 1: Documentation Requirements of Units Billed

## VI. DOCUMENTATION REQUIREMENTS

For agencies receiving funding awards, documentation requirements for all service categories must be completed prior to submission for a reimbursement request. Documentation should occur at the completion of each contact resulting in a reimbursable unit of service. Documentation should include the following elements for *all service categories* unless noted below:

1. **WHO RECEIVED** - Who received the service? Client's name or identifying number should be on all backup documentation. Not required for Outreach-Street.
2. **WHO PROVIDED** - Who provided the service? For every unit of service for which reimbursement is requested, someone at the agency level had to interface with the client – the backup documentation for every encounter should include their name, signature, and credentials if appropriate. Not required for Insurance Assistance and Drug Reimbursement.
3. **WHAT** - What service was provided? All documentation should indicate what service was being provided: medical case management, transportation, food pantry, etc.
4. **WHEN** - Date and time of service provided; the duration of time on that date or start and stop times.

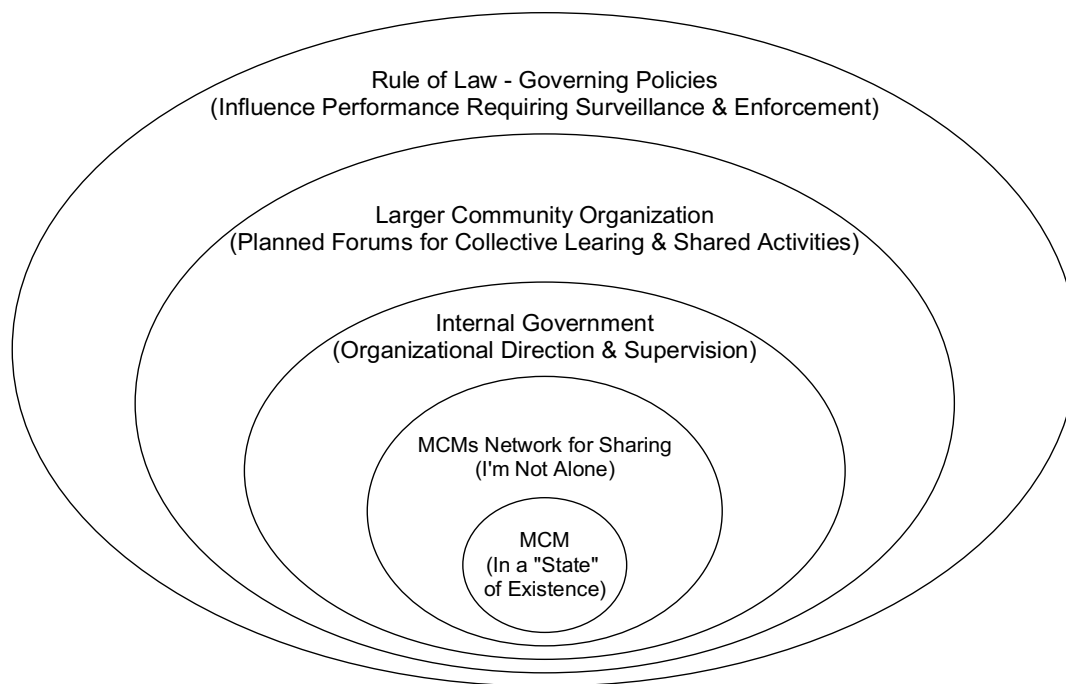
1 unit	2 units	3 units	4 units
1-29 minutes	30-44 minutes	45-59 minutes	60 minutes

5. **HOW MUCH** – How many units of the service were provided? Each unit of service billed to DCHHS should match the number of units documented. This documentation of units should follow the guidelines in the *Continuum of Care* for each service category.
6. **WHERE** - Where was the service provided? Specify the location: clinic, street corner, client’s home, van, health fair, etc. Not required for Insurance Assistance and Drug Reimbursement.
7. **WHY** - What was the purpose or intent of the service encounter? Documentation should always reflect what needs, goals or objectives have been identified in the client’s care plan. Not required for Outreach-Street.
8. **STATUS** - Progress or lack of progress in achieving goals outlined in the care plan. Not required for Insurance Assistance, Drug Reimbursement, Outreach-Street, and Interpretation/ Translation.

Agencies may develop documentation formats to meet their own needs while incorporating these required elements. Most of these elements can be documented in checkboxes and tables. Sample documentation forms for each service category may be obtained from a DCHHS program monitor.

Data Source: [https://careacttarget.org/sites/default/files/file-upload/resources/2010\\_COC\\_Final.pdf](https://careacttarget.org/sites/default/files/file-upload/resources/2010_COC_Final.pdf)

Figure 1: Application of the Ecological Model to Community HIV Health Services Documentation in Ambulatory Settings



Therefore, examining system level influences on individual level behavior offer more advantage than blaming the underperformer (Watts, Donahue, Eddy, & Wallace, 2001). Hence, the interpretation of an ecological approach to client care documentation follows.

The intrapersonal level of documentation requires command of an explicit cognitive framework. That framework consists of both knowledge and understanding of the Constructive Client-Centered Helping Process, (CCCHP). Case managers employing the CCCHP do the following:

1. Listen to clients' subjective statement of needs
2. Gather objective data from diverse sources using dialog, screening, assessment, and observation
3. Process information to make meaning of the data collection process
4. Evaluate care gaps in the client's plan of care in relationship to legitimate and validated unmet needs
5. Check in with the client and other members of the client's healthcare team to ensure a prepared solution addresses an upstream problem rather than symptoms of a problem
6. Settle on a decision solution that helps the client advance the aims of HIV plan of care

7. Review and communicating information with the clients to foster understanding and valuation of the clinical encounter experience, and
8. Appropriate dedicated time, before memory erosion, to prepare case notes that capture the diverse facets of the case management encounter.

The interpersonal level of documentation requires social influence. Connecting case managers in networks such as groups of two or more may comprise a social node. Node formation may be voluntary or strategically involuntary. Irrespective of the approach used, the social influence of nodes has the following potential advantages:

1. Peer review of each other's plans of care and associated case notes documentation
2. Asking peer's questions about their documentation work that triggers reflection and insight for self-identification of alternative ways of representing historical activities in a new and or more meaningful way
3. Sharing, if safe to do so, alternative conceptualizations of the same data that may help a peer to examine client care encounters through new cognitive lenses or vantage points, and



4. Professional relationship building for mutual support through informal coaching.

This reciprocal process may serve as both a learning and teaching opportunity, which are essential components of professional development. Offering some guidelines for nodal activities may include suggesting activities such as time sensitive cross-chart reviews and feedback, dual staffing of complex cases and adoption of nodal-partner caseload during temporary absences such as sick leave.

The organizational level of documentation requires context sensitive activities. These activities include, but are not limited to:

1. Individual level trainings;
2. Group level trainings;
3. Round-table discussions;
4. Lunch-and-learn sessions;
5. Periodic review and update of the jurisdictional MCM Curriculum;
6. Distribution of a cues-to-action documentation prompt and/or a “Did You Do This” checklist;
7. Systematic sampling and evaluation of Case Managers charts by the agency Quality Assurance Team

This work holds promise to identify best practices and pitfalls that can serve as teachable moments in appropriate individualized and small group contexts. As conceived here, these organizational activities may provide opportunities for empowering intrapersonal and interpersonal change in the direction of the positive documentation culture created and reinforced at the organizational level.

The community level of documentation requires strategic uses of organized public forums. One example is the bimonthly medical case management meeting. Features of this forum can include:

1. A carefully crafted agenda that advances a health services improvement philosophy;
2. Substantive dialog about lessons learned in fostering excellence in documentation;
3. Identification of best practices that support accurate and timely documentation;
4. Develop standardized referral forms for information interchange;
5. Identify protocols and timelines for sharing client referral information in a timely manner;
6. Disclose strategies or best practices that make organizational level activities effective

These features can offer new insights by stimulating thoughts, offering directions for the future, and propagating positive change among the community of funded providers. For example, the network can reduce the time lost in calls to clarify ambiguous information exchanged and reduce errors in

information capture during case management documentation. This community level of influence process holds currency if the HIV care network assembles the right people in the appropriate meetings so that planned, (i.e., non-crisis), regular meetings has the communal impetus for sustainable change.

Finally, the policy level of documentation is the deliberate system of principles for guiding decisions and practices. Key components include:

1. Systematically engage all agency case managers in the development and updating of agency level case management standards and guideline;
2. Administrative Agency review of case management standards and guidelines;
3. Provider, Administrative Agency, and Planning Council conjoint review of case management standards and guidelines.

The convergence of work at all five levels holds promise to establish clarity about what constitutes a case management encounter and appropriate documentation of the encounter. Clarity and transparency regarding components of a case management encounter and how to document it can maximize retention of a set of case management principles, which aim to guide decision-making and behaviors of case managers. This multiple level view proposed here can create a perimeter that not only defines case management encounters but also supports retention of case management knowledge, skills, and abilities for understanding how to maintain service excellence. In the absence of a comprehensive, proactive engagement process, policies created to guide current and future practices can become relics—permanent fixtures on bookshelves and only revisited in crises. In contrast, key stakeholders should sequester staff time for systematic review of case management roles, responsibilities, knowledge, skills, and attitudes germane to performance of the job. Systematic refresher opportunities communicate a culture of both public and private accountability toward the profession and clients served. Furthermore, it minimizes the potential for cognitive lapses that may occur in busy client and patient care environments.

The science of behavior change offers a variety of tools to support robust case management documentation. This article identified how the social-ecological framework provided guidance at two local Ryan White providers to support and reinforce reciprocal critical thinking for documentation, which involves the analysis and evaluation of facts, synthesis of new knowledge in the form of clinical judgment, and application of clinical judgment to address needs, (Bissell & Lemons, 2006). The formation of new knowledge for problem solving through data

collection, analysis, and clinical judgment are rudimentary skills that underlie meaningful and sustainable change in documentation content and practice. As the case manager acquires increasing levels of competence, other cognitive factors that emerge include, but are not limited to, factors such as the following:

1. Attitude, (standpoint, style—empower vs. depower), toward the encounter participant;
2. Attitude valence, (strength of attraction or repulsion), toward the service encounter;
3. Valuation of the client as a resource person with capacities for self-paced development,
4. Identifying gaps in care and services through a collaborative process with clients and other members of the health services team;
5. Well-developed rationale for selection of service deliverables to meet the client's immediate needs and advance progress along the HIV Continuum of Care;
6. Sequestration of brief, quiet time, post-encounter, for timely and accurate recording of data before new client interactions lead to either loss or blurring of information from previous clinical encounters.

Behind the cognitive wall lies, a plethora of mind freeing or freezing strategies, that one way or another, either liberates or bewilders the case manager. Cognitive liberation is the desired endpoint because documentation is the last line of defense in the demonstration of accountable provision of HIV health services. After assessment, diagnosis, and treatment, how would other stakeholders know about the processes of care? How would a service provider address specific questions regarding service delivery in the aftermath of service provision? The maxim, “If it's not documented it did not happen,” is well known, yet poor documentation persists. Knowing the proverb is necessary for influencing documentation, but not sufficient for changing the unwanted effects that stem from erosion of system level influences that culminate in recurrent patterns of poor documentation quality.

### Conclusion

The knowledge generation process has just begun. Existing theories suggest key exploratory elements that may be integral to successful and sustainable case management documentation in HIV health services. More research is needed to advance knowledge about practical approaches for improvement in documenting care. Gathering testable, theory driven empirical observations lies at the heart of science-based best practices in health care. Employing the methodological rigor of randomized controlled studies is a useful hypothesis testing tool for knowing whether

a theoretical model of case management documentation is equivalent to an intuitive approach. This next step is key to moving the science of documenting the complexity of client care beyond the infancy stage and has implications for informing the development of training curricula for future social work and behavioral science practitioners in public health and health services.

### Implications for Public Health Practice

In the context of the ecological framework, substandard documentation is an effect, much like a dependent variable. Construed this way, it represents a “double-edged sword.” On the one hand, the multi-level emphases provide an opportunity for maintaining a supportive cultural influence that reinforces expectations and potentially empowers case managers to engage in timely and reliable documentation of client care. On the other hand, any breakdown across the cascading levels of influence results in depletion of the supportive cultural influence. Any collapse in the levels of influence results in loss of positive feedback that supports optimal documentation. The exception would be instances where case managers internalized professional standards rely on internal locus of control to maintain ideal documentation. Either way, the model offers a helpful framework for building accountability in documentation of client care, recognizing the value of tiered influences on individual professional practices, and offers insights on possible next steps to address or reward service delivery documentation. Although the ecological framework is no panacea, it can trigger the dialog about multiple levels of contributions for understanding the processes or lack thereof that influence or fail to influence documentation of client care encounters. From this perspective, if the JTGA achieves a deeper wakefulness of the intricacies that either motivate or demotivate “sloppy” documentation, perhaps, renewed efforts can focus on implementation of a comprehensive suite of behavior modification strategies to raise the standard of medical case management documentation, where indicated.

As a jurisdiction, what are the next steps for improvement of case management documentation? Providers in the JTGA have traditional roles like Executive Directors. Professionals in this role sign off on organizational goals, policies, and benchmarks that guide middle managers at the clinic or agency level. Middle managers translate the noble, high-ceiling aspirations into practical strategies and dashboards to inform the work of front-line supervisors. On the front-line, overseers like case management supervisors, guide the day-to-day activities of staff by coaching, monitoring, counseling, and motivating.

Are these activities sufficient for closing gaps in case management documentation?

The waterfall sequence of cascading responsibilities and accountabilities is a good starting point, but clearly not good enough for supporting timely and accurate client care documentation. Assuming the processes of case management services occurred, the need exists for creation of an HIV health services culture that supplements staff training, certifications, meetings, slogans, webinars, and traditional roles with an innovative and dynamic tension of excellence. What does that mean? A dynamic tension of excellence recognizes the status quo and the gap that spans the desired outcomes, which are the National HIV/AIDS Strategy, (NHAS), Goals 2 and 3, codified in Northeast Florida Integrated HIV Prevention and Patient Care Plan, (IHPPCP), 2017 – 2021. Patterning corrective action as implied by the ecological framework holds promise to begin peeling back the layers of defenses that get in the way of documenting processes of case management services.

The process of removing the layers of defenses aligns with Fernandopulle et al., (2003) idea regarding the generation of new knowledge for bridging the quality chasm. Such new knowledge has implications for reducing HIV-related disparities, health inequities, and improving health outcomes for PLWHAs. Would it not be appropriate to demonstrate through thorough and accurate documentation how providers are achieving the NHAS goals? A possible role for clinical leaders is to jump-start the peeling back process by triggering activation of an innovative and dynamic tension for excellence in client care documentation, starting here in the Jacksonville Transitional Grant Area. If successful, improved case management documentation will capture key service processes that underlie care coordination, which affect treatment cascade outcomes—linked to care, retained in care, on-antiretroviral therapy, and viral suppression.

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Graham F Watts, Sr., PhD. City of Jacksonville, Social Services Division, Consultant. Park, Recreation, & Community Services Department, Jacksonville, FL. Email at: [grahamfwatts@yahoo.com](mailto:grahamfwatts@yahoo.com). Angela E Prince, MSN, RN, ACM, Manager, Case Management, UF Health Jacksonville, Jacksonville, FL. Email at: [aeprince01@gmail.com](mailto:aeprince01@gmail.com). Heather Vaughan, MS, CRC, Lutheran Social Services of NE Florida, Jacksonville, FL. Email at: [heather.vaughan@lss.org](mailto:heather.vaughan@lss.org). Porschia McCray Watts, LPN, BSM, Recovery/Intake Nurse, Digestive Diseases and Endoscopy Center, Silverdale, WA. Email at: [msp.lyn@gmail.com](mailto:msp.lyn@gmail.com). Beth Parker, BA, Director of Administration and Special Programs, Northeast Florida AIDS Network, Jacksonville, FL. Email at: [bparker@nfanjax.org](mailto:bparker@nfanjax.org).  
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