Documentation Best Practices Overview

- June 29th, 2023

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Your Facilitators

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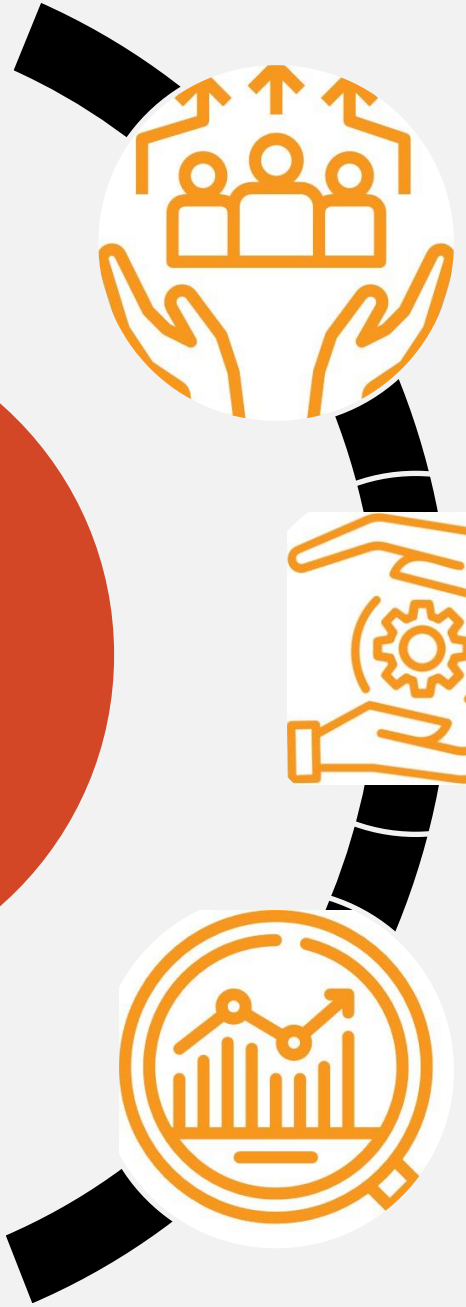
Why



To honor and provide our best care to clients

To support staff and organizational needs

To better tell our story with more data

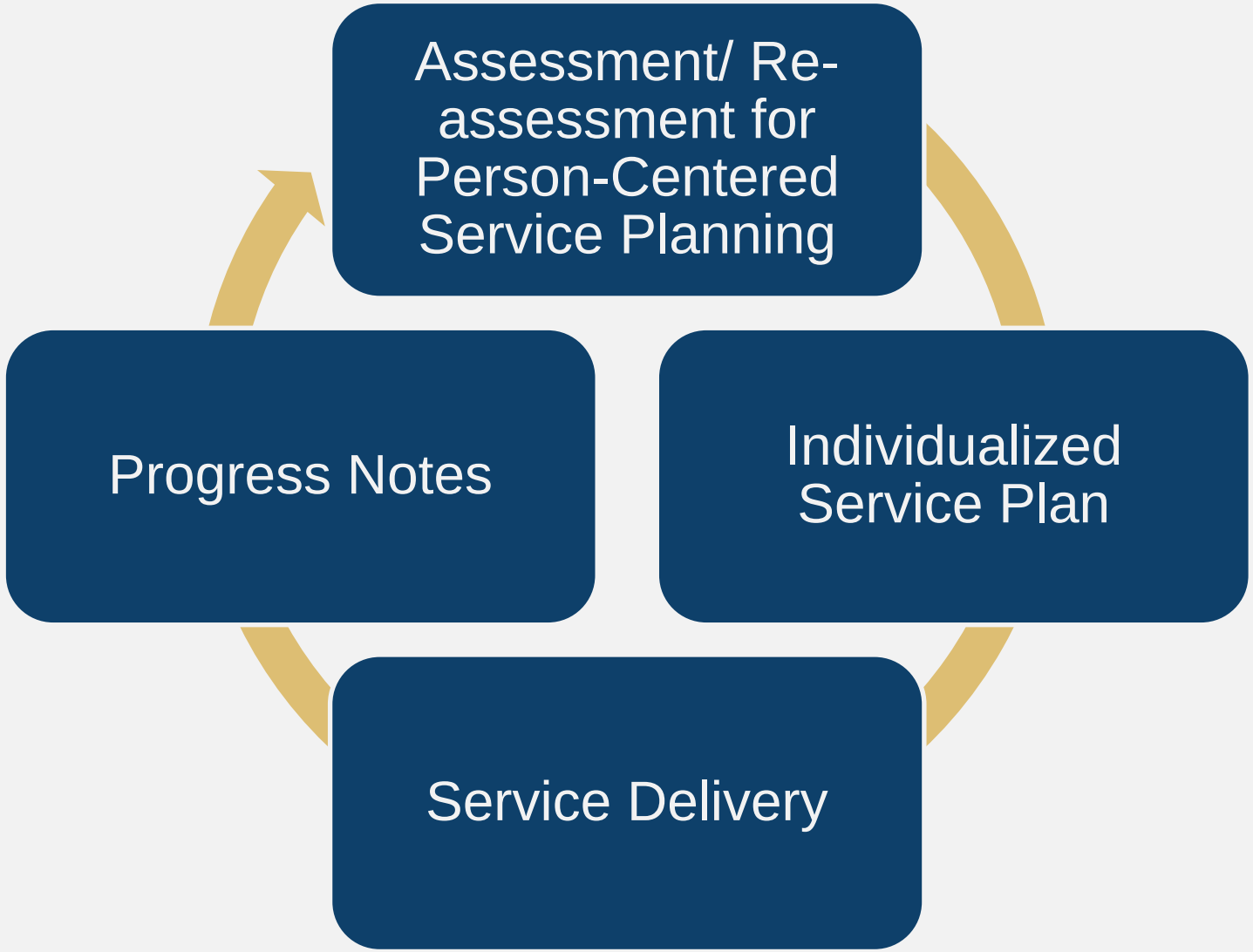
The Golden Thread

What is the “Golden Thread?”

- **"An idea or feature that is present in all parts of something, holds it together, gives it value" Oxford Dictionary**

- In Healthcare, it is defined as a way to consistently present relevant information throughout all documentation for a client, *tying together* a narrative of a client’s experience as evidence of medical necessity

Housing Community Supports- Documentation Thread

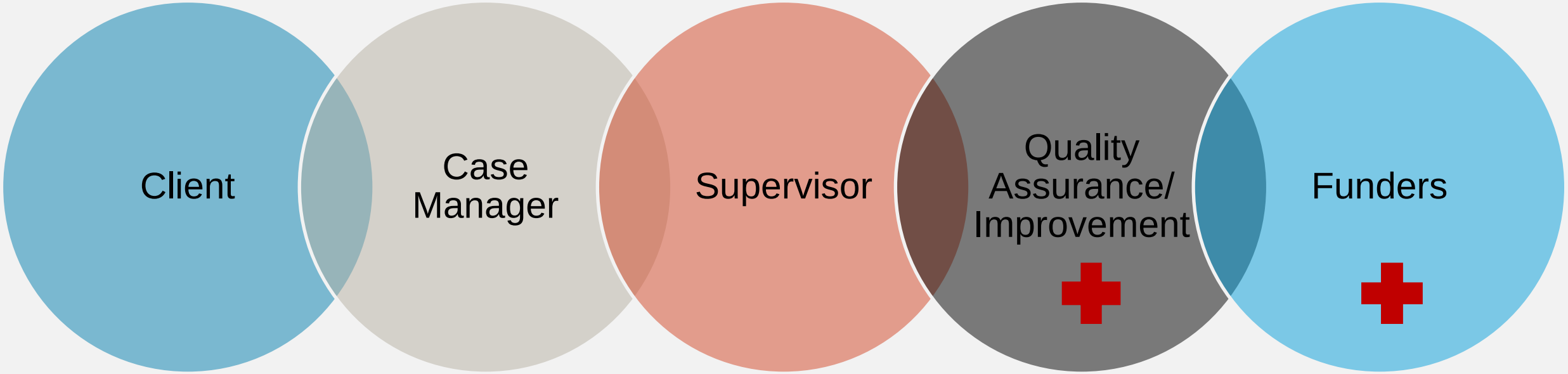


Golden Thread

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

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

Who is involved in the documentation process?



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Documentation Requirements Review

1915(i) Required Medical Record Information

- Individual's name and date of birth
- **Date, begin time, and end time of service (for services billed per 15-minute unit)**
- **Name and title of individual providing (rendering) the service**
- Person-Centered Plan of Care
- **Signature and date by the person providing the service**
- Service authorization number
- Claims, billings and records of Medicaid payments and amounts received from other payers for services provided to members
- Any other related medical or financial data that may include appointment schedules, account receivable ledgers and other financial information.

1915(i) Medical Records Policy

Technical Elements of a Billable Progress Note

Green=not required but best practice

May be electronic or paper

- Date of entry
- Date the service was provided
- Start and End Times with am and pm designation
- Length of service in minutes (required if reimbursement is a unit rate)

Location/type of contact

Client Name and ID#

Service name and description

- Client response, progress, changes
- Service is linked back to goals in service plan
- Next steps/appointment date and time

Authentication

- Name of provider, signature and title of service provider

Medicaid Documentation for Medical Professionals (cms.gov)

Medical Records Signature Policy

- Signed (written or electronic) by the individual enrolled provider
- CMS requires all medical record entries must be
  - ✓legible
  - ✓promptly completed
  - ✓dated and timed
  - ✓authenticated in written or electronic form by the individual provider providing the service

CMS policy on signature requirements

Justifying Time Spent

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

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

*Use caution to not pressure staff for “productivity” that could lead to fraudulent note stretching (i.e. making a 2-minute call last 15 minutes in order to bill, even though extra time was not medically necessary).

Remote Service Delivery

- Cannot be more than 25% of services provided in a calendar month
  - ✓Includes telephone and secure video conferencing
  - ✓Must be elected by the individual receiving services, and
  - ✓Must not prohibit needed in-person services for the member
- NO remote option for Respite or Non-Medical Transportation
- Documentation must include:
  - ✓Remote delivery was elected by the member, and
  - ✓Did not block the member's access to the community, and
  - ✓Did not prohibit needed in-person services for the member, and
  - ✓Utilized a HIPAA-compliant platform, and
  - ✓Prioritized the integration of the individual into the community
- Best practice is to provide services directly to the extent possible

*this guidance is noted in the separate policies for *each* service on the 1915(i) website

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Staff Training Recommendations

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

Best Practices

Documentation: Connect back to goals established on Person-Centered Plan of Care

Person-Centered Service Planning Best Practices

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

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Assessment Elements – Best Practice

- Diagnosis/functional criteria*
- Needs to be addressed
- Goals developed based on needs and desires
- Measurable and clear goals that represent what the client wants/needs
- Smaller objectives to reach goal
- Strengths of client linked to the goal
- Timelines
- Roles and responsibilities
- Service type, amount and duration
- Progress and update

Plan of Care Elements – Best Practice

- Diagnosis/functional criteria
- Needs to be addressed
- Goals developed based on needs and desires
- Measurable and clear goals that represent what the client wants/needs
- Smaller objectives to reach goal
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- Timelines
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- Service type, amount and duration
- Progress and update

Writing the Progress Note Narrative

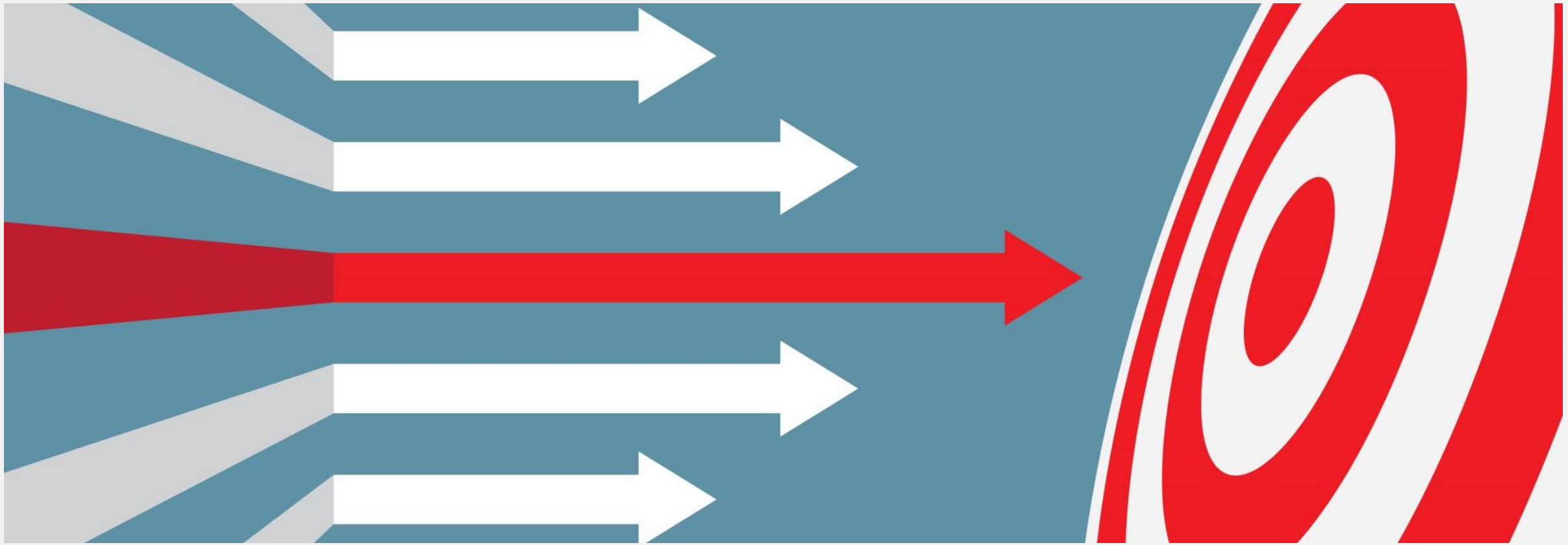
- Focus on the service related to the goals
- Relate service to needs assessed and Person-Centered Plan of Care goals
- Include direct quotes by the individual, but avoid unnecessary “he said” “she said”
- Focus on the facts of what happened, avoid being too subjective or opinionated
- Demonstrate “sufficient duration to accomplish the intent/goal”
- Include client’s response, progress and plan for next steps

“Concurrent Documentation” including the client in note writing

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

Goal and Intervention

- What is your role in helping the client to hit the target? How are you coaching?



Key words in Goal Setting

INCREASE

IMPROVE

DECREASE

REDUCE

BUILD

GROW

MINIMIZE

ACHIEVE

REMAIN

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Actions = Interventions

Key words for Interventions

PROVIDE EDUCATION	MODEL BEHAVIOR	ASSESS FOR RISKS	IDENTIFY STRENGTHS	REFER FOR SERVICES	COMPLETE
DESIGNATE	SHARE	HELP TENANT…	NORMALIZE	EXPRESS…	DIRECT/REDIRECT
REDEFINE	UTILIZE MOTIVATIONAL INTERVIEWING TO ENGAGE TENANT IN DISCOVERING…	IDENTIFY THEMES/TRIGGERS	DEMONSTRATE	EVALUATE	DEVELOP
FACILITATE	TEACH	ROLE PLAY	ADVOCATE FOR	ASSIST WITH	

Good Documentation Supports Continuity of Care

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

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

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

Subjective	Objective
“The apartment was a mess.”	“Writer observed food, garbage, clothing and papers blocking walkways and vents.”
““Client was out of control and kicked out of the store.”	“Client was experiencing active paranoia and persecutory thoughts. Client began to scream at other shoppers. Security was called and escorted client out.
Client is doing much better living indoors.	“Client appeared calm, confident and in good health. Client showed writer how she stores her meds in her weekly pillbox. When asked how she is liking her new unit, client reported “I like this place, I mean I can’t stop smiling. I love it. Especially the A/C unit.”

Objective Writing:

- focus on the facts (what happened?)
- avoid being too subjective or opinionated
- write notes knowing that this is the legal medical record of the individual you support

Connecting The Note To The Goals

Assessment

- **Includes diabetes**

Person-Centered Plan of Care

- **Includes goal of improving health, specifically diabetes A1c**

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

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Ex: Individualized Service Plan- Peer Support

Person-Centered Plan of Care goal, developed by the Care Coordinator

- *"I would like to make friends who support my recovery."*

Individualized Service Plan objectives, developed by the Peer Support Specialist

- *"I want to get involved in my local church."*
- *"I want to volunteer and help others get the help I received."*

Progress Note Examples

- *"Met with Joe. Discussed his religious and spiritual beliefs and researched with local faith communities. This writer acknowledged how important it is to get feedback and information from him on what is important to him in regards to non-treatment related activities. Made a date to attend an open house at the church of Joe's choosing."*

- *"Joe was very anxious about attending this open house to discuss and set goals for himself around managing that anxiety and what people will think of him. We will meet again next Monday 9/27 to go to the open house. We will meet prior to attending to discuss his feelings and concerns before we go. Joe felt optimistic and positive about the process."*

Ex: Individualized Service Plan- Housing Support

Person-Centered Plan of Care goal, developed by the Care Coordinator

- *"I don't want to be evicted and I want to stay in my apartment"*
- *"I want to learn how to get along with my neighbors."*

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

Individualized Service Plan objectives, developed by the Peer Support Specialist

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

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Progress Note Examples

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

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Resources

Individualized Service Plan Template Example:

Client Name:				Client #:	
Goal (Needs and Preferences):					
Desired Results in Client's Words:					
Other community organizations/support people involved					
Linked to Treatment Recommendation:					
Strengths/Abilities and how they will be used to meet the goal:					
Effective Date:				Review Date:	
Measurable Objective	**Intervention**	**Service Type**	**Person Responsible**	**Frequency**	**Target Date**
☐					
☐					

Service Plan Template

Individualized Service Plan Review

Client Name: **Date:**

Previous Plan Date: **Next Review Date:**

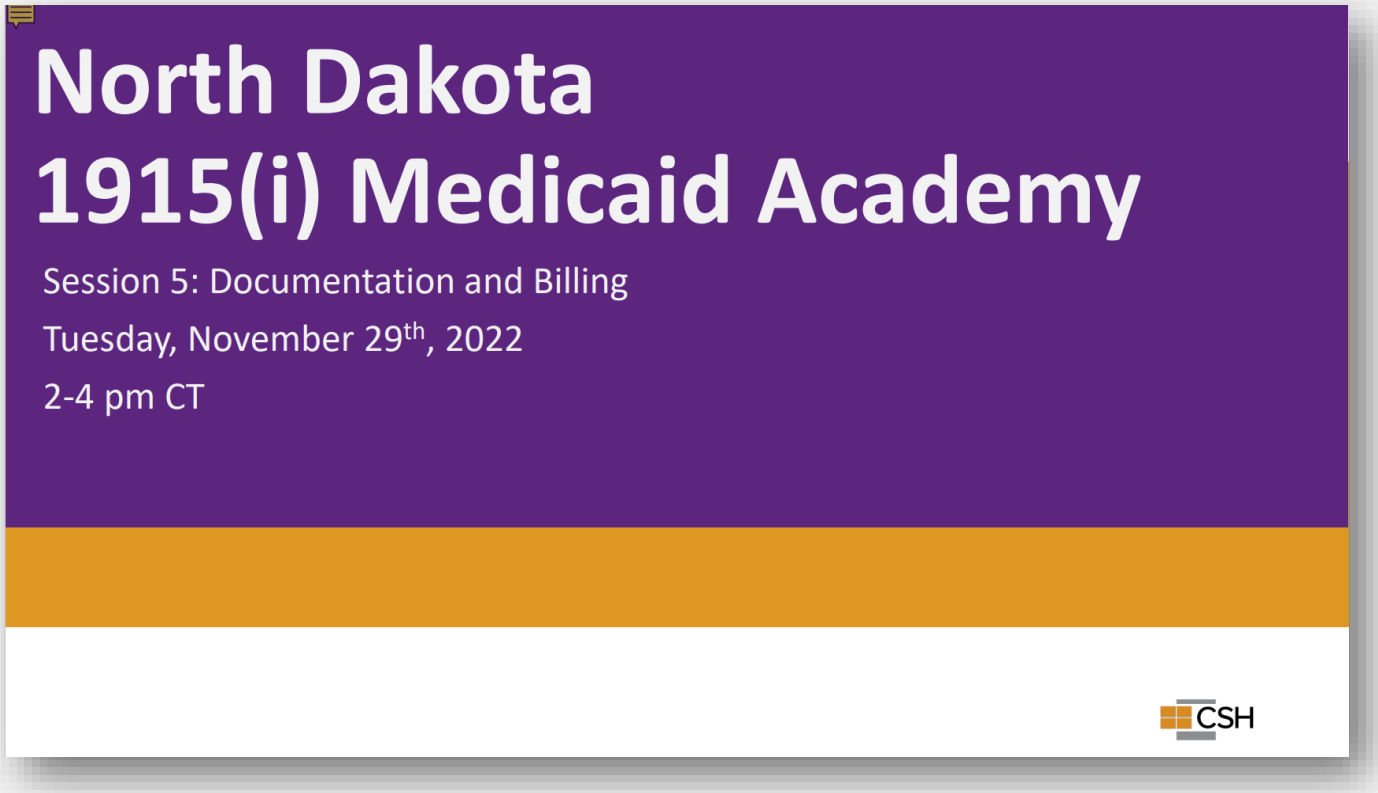
Goals from previous plan:

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

Documentation Portion of Medicaid Academy Session #5

- Step-by-step walk through of web portal process with tips/guidance for claim submission:
  - Slides 12-32

- Recordings and PowerPoint found on ND DHS Site:
  - Recording
  - Slide Deck



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Thank you!

Learn more at www.csh.org

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Stay in Touch!

Reach out to schedule 1:1 TA:

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