Documentation Best Practices: Using the "Golden Thread"

In healthcare, the Golden Thread is the cohesive narrative woven through every piece of client documentation, ensuring that relevant information is consistently presented. In 1915i, the Golden Thread links the plans of care, and progress notes to chronicle the individual's experience and clearly demonstrate the necessity of services. It enables an external reviewer to trace the rationale for services from the initial evaluation and its recommendations, to see how those recommendations become goals and proposed activities in the individualized plan of care and confirms that those activities have been carried out through actions documented in case notes.

Review the Documentation Requirements for Medicaid Services section of the Provider Requirements policy

See the Telehealth policy for remote supports. Each service policy will detail if that service has a telehealth options.

Suggested Training Areas for Staff

- Trauma-informed care and organizational practices used throughout member services
- Technical training around compliance
- Cultural competency
- Motivational Interviewing
- Develop a mandatory annual training on 1915i policies

Person-Centered Planning Best Practices

- Care Coordinators collaborate with other providers
- Plan of Care goals is a living breathing document that is used to set the framework for services
- Plan of Cares are strengths-based
- Client's voice is reflected in their plan of care
- Goals are created with the client and reflect client's own goals
- Goals are reviewed with progress and barriers noted and new goals established

Good documentation supports the goal and continuation of services. This allows other team members to rely on documentation to understand all the services rendered via the Golden Thread.

Key Words and Actions

Provide Education
Model Behavior
Assess for Risks
Identify Strengths
Refer for Services
Assisted With
Shared
Helped Member
Role Play
Advocate For
Redirected
Facilitate
Utilize Motivational Interviewing
Identify Triggers
Demonstrate
Evaluate
Develop

Subjective	Objective
“The apartment was a mess.”	“Writer observed food, garbage, clothing and papers blocking walkways and vents.”
“Member was out of control and kicked out of the store.”	“Member appeared to be experiencing active paranoia and persecutory thoughts. Member began to scream at other shoppers. Security was called and escorted client out."
“Member is doing much better living indoors."	“Member appeared calm, confident and in good health. Member 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
- Avoid being subjective or opinionated
- Write notes knowing that this is the legal medical record of the individual you support

Connecting The Case Note To The Goal: Peer Support Case Note Example for the member Testt Testt.

- Assessment Example: The member's plan of care includes that the member has diabetes.

- The Person-Centered Plan of Care for this member includes a peer support goal of improving health, specifically diabetes. This is an area the peer support could help with, as it falls under Skills Development; specifically, the "building community living skills" subline in the Peer Support Policy

"Observed Testt had no food when I was visiting with Testt in his apartment. Testt stated that he was asking neighbors for food which resulted in complaints to property management. One area of Testt's peer support goal is to build his community living skills. I accompanied Testt to the grocery store. During the trip, we discussed several important items. First, the importance of buying healthy food to help with his diabetes. Second, discussed how to alert his team if he needs food instead of asking neighbors. Third, provided resources for healthy meals and diabetes information. When we returned to his apartment, we role played how he can reach out to all the members of his team when he is running out of food, or if any other emergency arises. We then set up our next meeting for Friday at 2pm to go over more resources for him to engage with. Met with Testt from 2pm to 4pm."

Individual Name testt testt
Date of Birth 01/02/1976

Case Note

Form ID	CN-SPAND-PAE4QAMYLYFKD
Status	Submitted
Time Zone	US/Central
Individual Name	testt testt
Provider	1915i State Plan Amendment Oversight Account, SPA-ND
Entered By	Cody Stanley, Therap Admin on 08/12/2025 12:28 PM
Submitted By	Cody Stanley, Therap Admin on 08/12/2025 12:28 PM
Last Updated By	Cody Stanley, Therap Admin on 08/20/2025 11:26 AM

Case Note Details

Template Name	Supportive Services 2.6.2025
Service Provider	Stanley, Cody / Therap Admin
Service Date	08/12/2025
Time Duration (Minutes)	120
Billing Unit(s)	8.00
Activity Type	H0038 - Peer Support
Location	12 - Home
Face to Face	Yes
Note	In here you can put any extra items that you think are important, but don't fit into the questionnaire.

Supportive Service Case Note Questionnaire 2.6.25

Question	Answer
1. Billable Units	8
2. Provider NPI	123456
3. Medicaid Provider ID	654321
4. Member diagnosis	F30
5. What plan of care goal is this service related to?	Peer Support goal.
6. What services did you provide to help the member achieve their plan of care goal?	Observed Testt had no food when I was visiting with Joe in his apartment. Testt stated that he was asking neighbors for food which resulted in complaints to property management. One area of Testt's peer support goal is to build his community living skills. I accompanied Testt to the grocery store. During the trip, we discussed several important items. First, the importance of buying healthy food to help with his diabetes. Second, discussed how to alert his team if he needs food instead of asking neighbors. Third, provided resources for healthy meals and diabetes information. When we returned to his apartment, we role played how he can reach out to all the members of his team when he is running out of food, or if any other emergency arises. We then set up our next meeting for Friday at 2pm to go over more resources for him to engage with. Met with Testt from 2pm to 4pm.
7. How does this service relate to the member's plan of care goal?	This service helps the member work towards growing their community living skills as it relates to their peer support goal. It also helps with the member work on their diabetes needs.

Housing Support (Tenancy Services) Case Note Examples:

Met with Jane to discuss her housing issues regarding a potential eviction due to recent interactions with her neighbors. This writer offered a non-judgmental approach which allowed Jane 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 three weeks and then weekly, after things get more stabilized. This could change depending on how Jane states she is doing with the classes, and her other housing needs. Jane stated that she is hopeful about this plan and keeping her housing. This writer offered support and encouragement to her. Met with Jane from 1pm to 2:30pm.

Housing Support Policy