Homeless & Housing Service Providers'

Medi-Cal Academy

Session #9: Medi-Cal Documentation Standards and Processes, May 3, 2023

Link to recording

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About CSH

CSH collaborates to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities.

Your Trainers for Today

Terri Power, LISW

(she, her, hers)

Cheryl Winter, MPH, LCSW

(she, her, hers)

Ambrosia Crump, MPA, LCSW

(she, her, hers)

What content is covered?

Some Counties are holding contracts with MCPs and subcontracting to homeless service providers- in this case the sessions with the asterisks (*) will benefit providers most.

Topic	Audience	Timeline
Medicaid 101: Medicaid basics, including contracting, documentation, billing and CalAIM CS 101*	Providers, CoC, County Staff	January 11, 2023
Business Planning for Medi-Cal Housing-Related Community Supports	Providers	January 25, 2023
Evidence Based Practices in Housing-Related Community Supports and PSH*	Providers and MCPs	February 8, 2023
Money Matters 101: Services Costs, Cash Flow and Blended Funding	Providers	February 15, 2023
Money Matters 201: Tools for understanding Costs, Cash Flow and Blended Funding	Providers	March 8, 2023
Incorporating Community Health Workers and Peers into your Workforce*	Providers, County Staff and MCPs	April 5, 2023
MCP and Medi-Cal Compliance Requirements and Claims Processes*	Providers, CoC and County staff	April 12, 2023
Common Policies and Procedures for Medi-Cal Providers*	Providers and County Staff	April 26, 2023
Medi-Cal Documentation Standards and Processes*	**Providers and County Staff**	**May 3, 2023**
EHR Elements to Support Documentation, track funding source and medical necessity*	Providers, MCPs, CoC and County Staff	May 17, 2023

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Learning Objectives for Today

Understand The Golden Thread of documentation

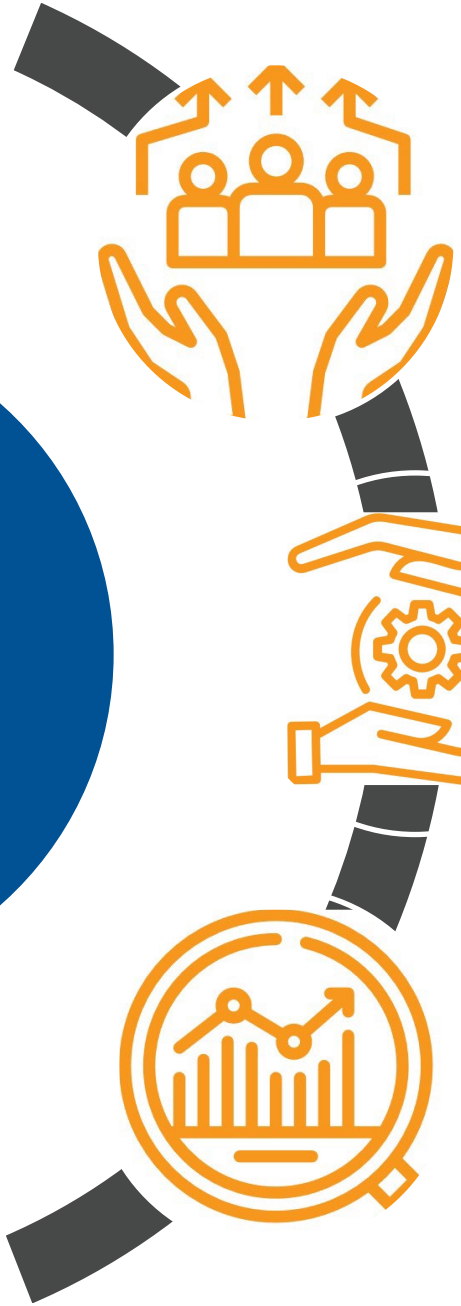
The key elements to ensuring documentation leads to approval

Tips for writing goals, interventions and activities

Transition and supervision

Best practices in internal monitoring and quality review

Why



To honor and provide our best care to clients

To support staff and organizational needs

To better tell our story with more data

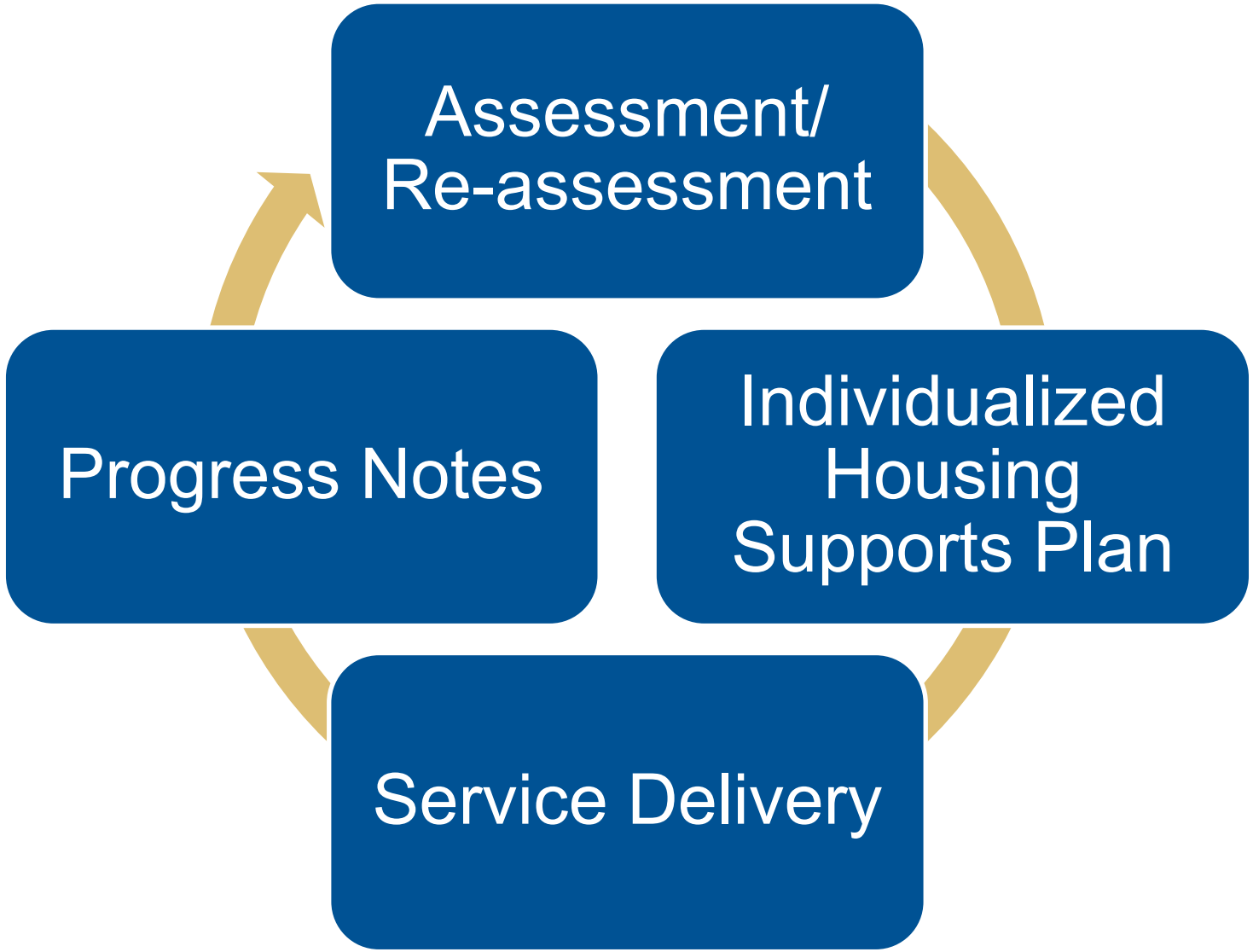
The Golden Thread

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 tenant on the housing supports plan and then the proposed activities are finally into actions, tracked in progress notes.

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

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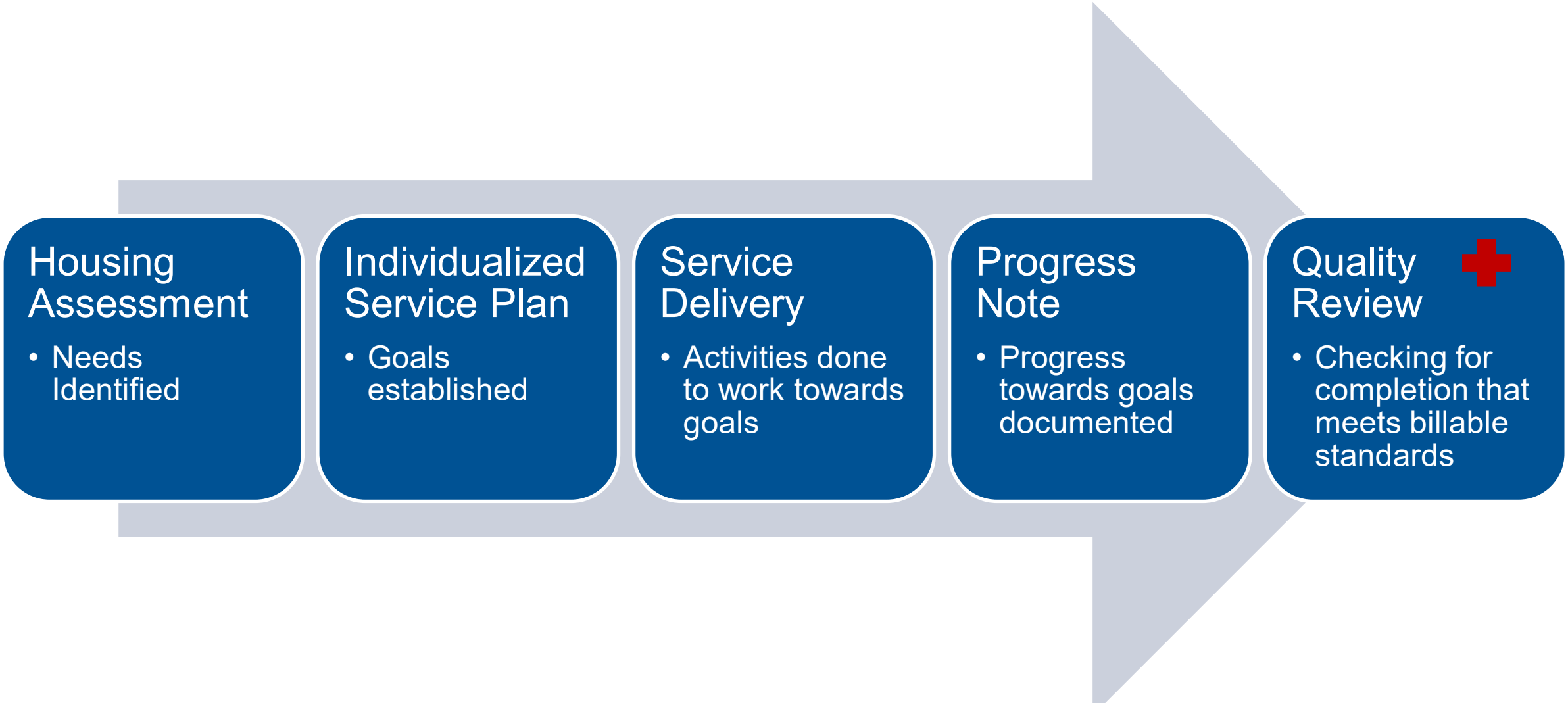
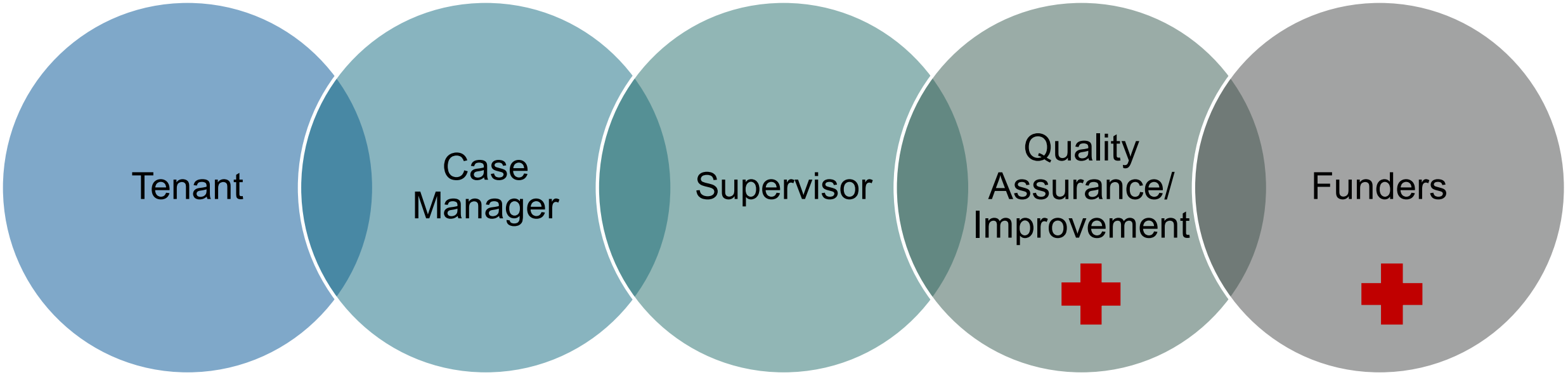
Documentation Compliance: The Golden Thread



Important Documentation Considerations for Quality Review

- Current state of client charts
- Location and security of client charts
- Defining medical necessity
- Golden thread
- Review forms for needed revisions
  - Agency intake/assessment
  - Individualized service plans
  - Progress note templates
  - Quality Review forms and tools

Who is involved in the documentation process?



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

Documentation Submission

Documenting Need for Services (Medical Necessity)

Client needs the service based on assessment

Clear connection of service plan goals to the assessment

Writer must explain the rationale and “tell the story” of why writer’s assistance will be of help

Reader must understand the service rationale

Progress notes are tied to service plan goals

Type and frequency of services is appropriate to interventions and goals

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

Documentation Best Practices

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

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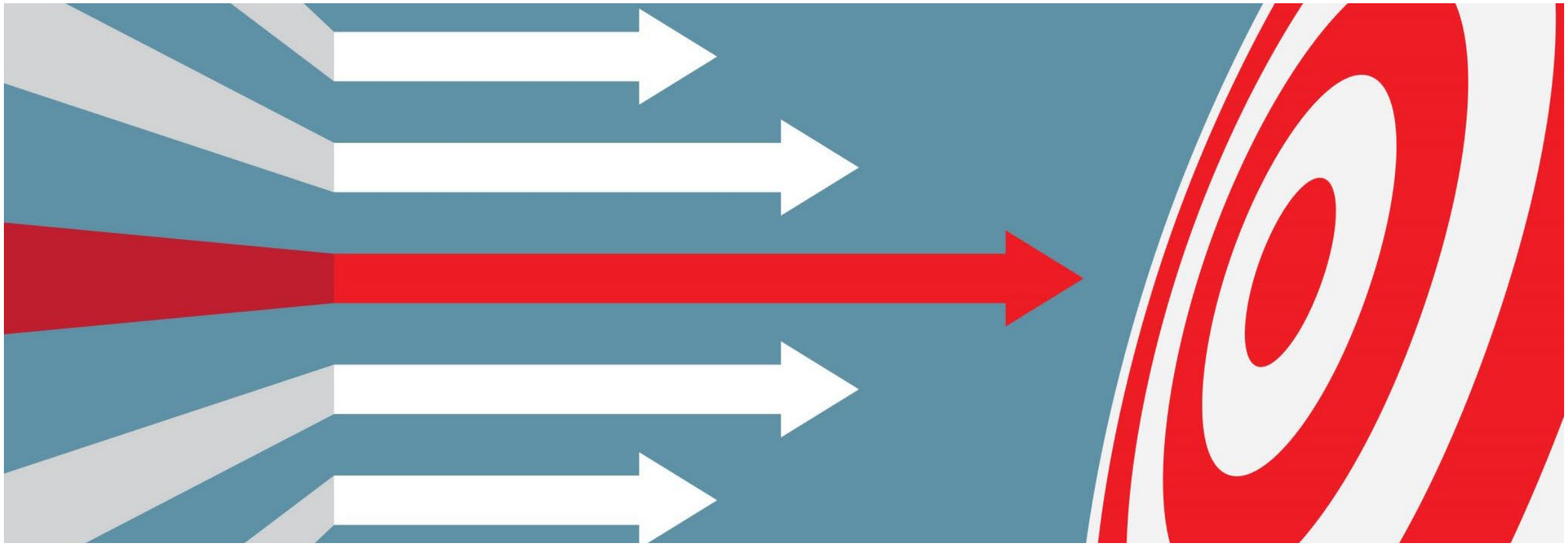
Goal and Intervention

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



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

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“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?

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	

The Importance of Documenting 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 (harm reduction, motivational interviewing, trauma informed care)
- Note any functioning limitations that would cause session to be longer
- Document impact service had on individual

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

Examples

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

Ex: Individualized Service Plan - Housing Support

1. Individual Service Plan Goal, developed by the ECM Provider/Tenancy Sustaining Services Provider

- *"I don't want to be evicted and I want to stay in my apartment"*
- *"I want to get along better 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

2. Individualized Service Plan objectives, developed by the Peer Support Specialist

- *"I will learn some new skills to calm down when upset- so that I can communicate what I need and be understood"*
- *"I will find a few new things to do so I don't feel like I have too much time on my hands with nothing to do."*

3. Goal, Objective, then Intervention…
The Intervention is where the service provider outlines THEIR actions that they will do to support the client's goals and objectives.

"Case manager will work with client to model and practice phone calls with landlord and communication techniques that include anger management and mindfulness interventions to support with anxiety and frustration."

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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 with neighbors 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 also discussed events and people’s approaches that can trigger anxiety for Jane and brainstormed ideas for calming techniques”*

- *“We will meet twice weekly for 3 weeks to practice calming techniques and review progress on neighbor interactions. After 3 weeks we will then meet weekly, if client feels more stabilized and feels comfortable using new skills.*
- *Jane is hopeful about this plan and keeping her housing. This writer offered much support and encouragement to her.”*

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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

Supervision Oversight and Support

What do you and your agency currently do to support new staff in the documentation learning curve?

What will new case managers need?

- To access past progress notes and documentation
- to understand tenants' needs, preferences, motivation, values
- extra time & coaching to complete forms

What can supervisors do to support?

Supervision Occurs Throughout Documentation Processes

Checking in on what is and isn't working, ensuring staff feels supported and client is satisfied. Supporting with care coordination to other services.

Brainstorming interventions, possible challenges, client strengths, support staff member will need from you. Review and sign the HSP.

Encourage transparency, taking notes with client for progress note documentation, ensuring client satisfaction. Regular review of PNs during supervision to check on staff members feelings of efficacy and to troubleshoot.

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Supervision & Support for Success

- Review HSP during case conferencing in supervision
- Prep staff for upcoming TSS Extensions and schedule reviews of TSS Evaluations for extension of services prior to submitting
- Ask staff about and assess the time it takes for completing documentation- is there opportunity for efficiency?
- Staff training in documentation at onboarding and quarterly for those with need for quality improvement
- Staff 1:1 coaching and feedback from staff on how to simplify documentation and clarify what is needed
- Write supervision notes that are shared with staff to access and track development goals.
- When possible, add in **FUN**

Staff Training & Onboarding

- Documentation Training in 1st two weeks
- Regular documentation coaching
- Clear policies & examples of documentation expectations
- Ramp up period for seeing fewer clients at first to have more time to write notes

Internal Monitoring and Audits

Internal Monitoring and Quality Reviews

Conduct reviews of agency charts & quality of care

This is proactive and done regularly

Have a plan for how internal audits are conducted

Include frequency and follow up

Re-evaluate this plan regularly

Identify areas at risk for external audits

Learn from other agencies in your network

When risk areas are found, determine the appropriate corrective action plan- including updating policies, procedures, staff training and supervision

Internal Chart Reviews & Audits Process

Timing

Frequency

Number of records for each type of review

Designated Staff

Correcting Mistakes

Reports

Internal Monitoring and Audits

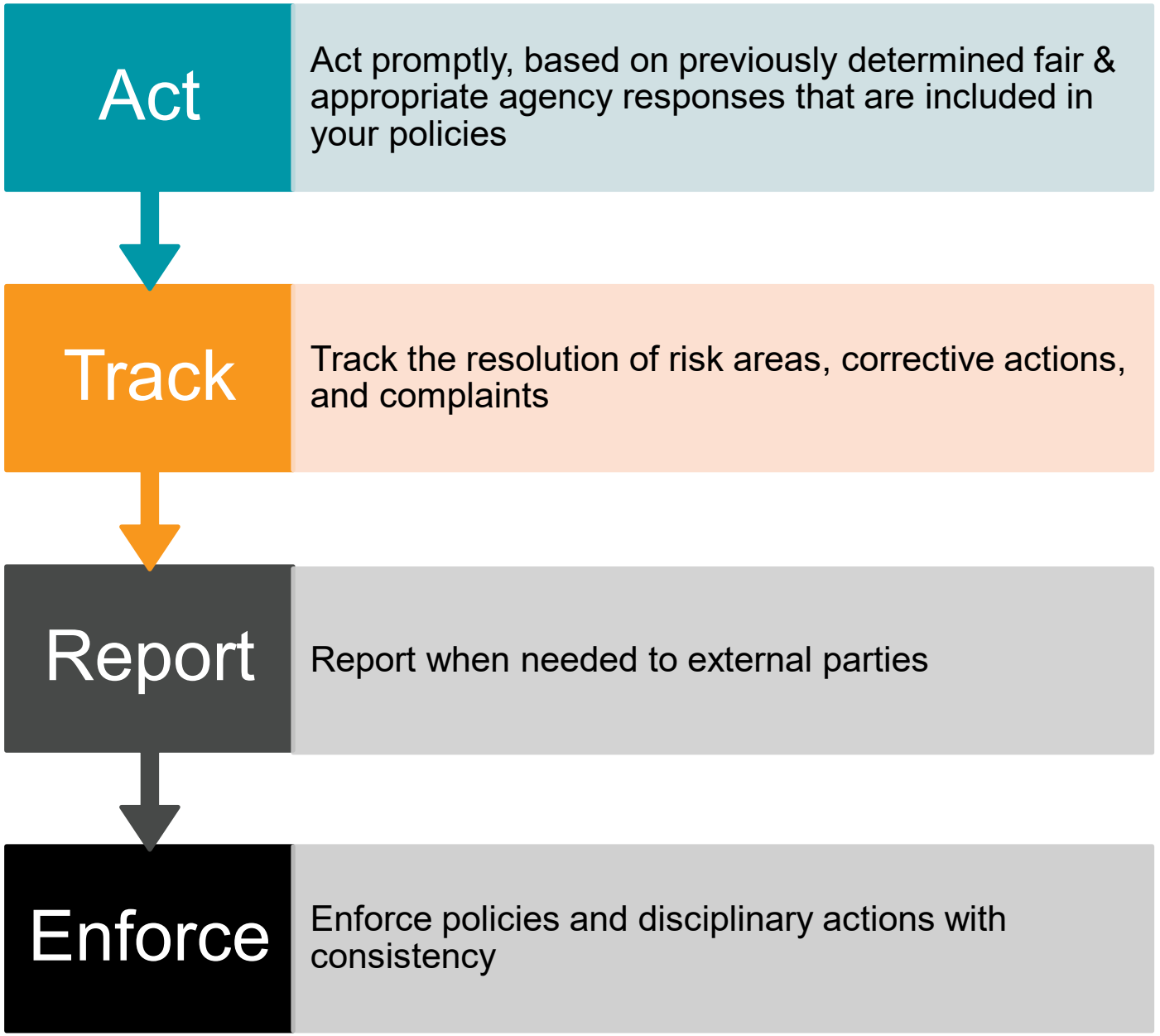
CONDUCT REVIEWS OF AGENCY BILLING CODING, CHARTS AND QUALITY OF CARE

HAVE A PLAN FOR HOW INTERNAL AUDITS ARE CONDUCTED

IDENTIFY AREAS AT RISK FOR EXTERNAL AUDITS

Corrective Action Planning and Enforcement:

Begins with Identification

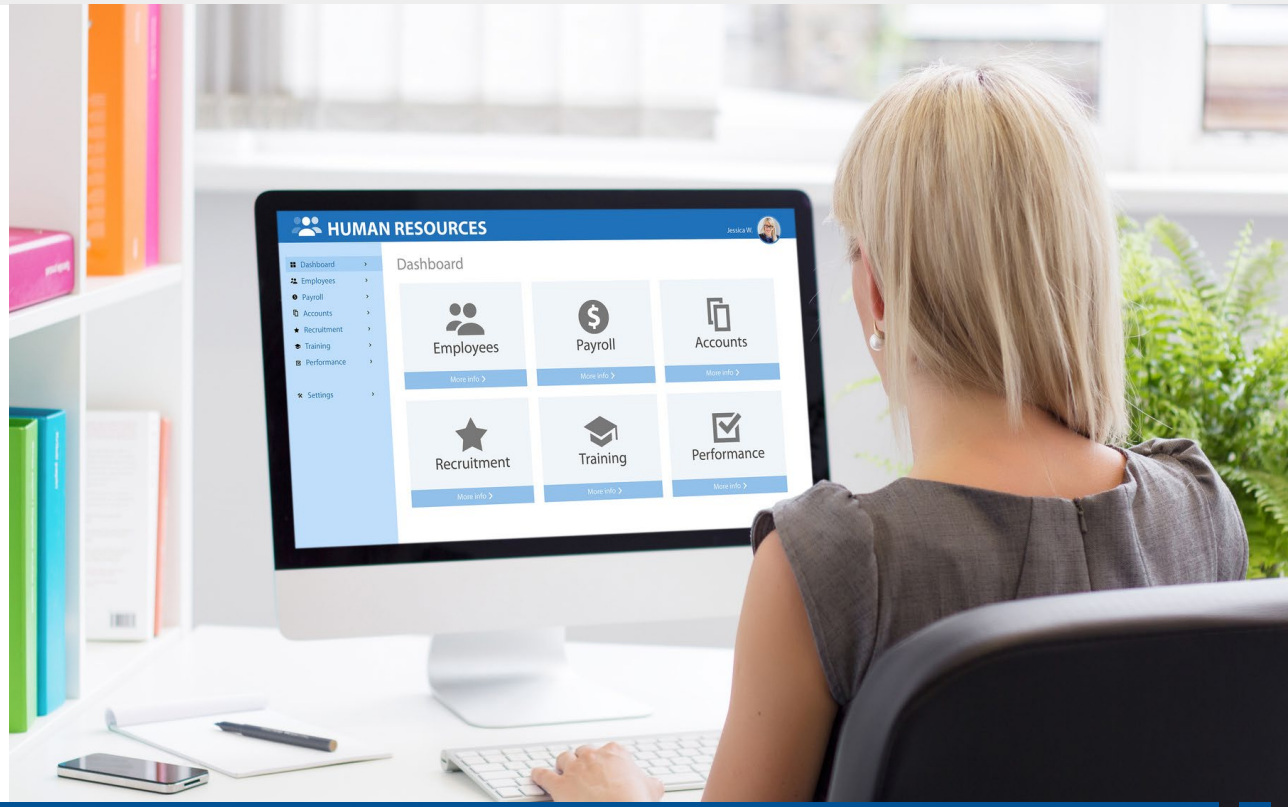


Documentation Training and Education Programs

- **Regularly review and update training programs. Use “real-life” examples.**
- **Make training completion a part of onboarding, a regular job requirement and offer ongoing coaching.**
- **Maintain documentation to show which employees received training.**

Onboarding Trainings for Documentation: suggested time frame - first month

- Client Rights and Responsibilities (intake forms)
- Staff Rights and Responsibilities
- Collecting and Storing Client Data, Data Security (HIPAA)
- Mandated Reporting and Documentation
- Corrective Action and Disciplinary Processes



Documentation Training: suggested time frame - first 90 days

- Records Requests, Sharing, Storing, and
  Auditing
- Quality Improvement Activities and Internal Auditing
- Assessments and Service Planning
- Client Grievance Processes
- Staff Supervision Standards and Processes
- Documentation

Quality Improvement Best Practices

Quality and Compliance requires regular review & ongoing learning support

Client & Staff Centered Quality Improvement

Managing risk, ensuring services aren’t disrupted, supporting staff & centering tenants in all

Next Steps: R.E.A.C.H.

Read

- Read Code of Federal Regulations for Medicaid documentation requirements typical of case management services eCFR :: 42 CFR 440.169 -- Case management services. and typical requirements to include in an assessment eCFR :: 42 CFR 440.169 -- Case management services.

Explore

- Sample Housing Supports Plan, progress note, and re-authorization of services assessment

Attend

- Next Training Session!
  - EHR Elements to Support Documentation, Track Funding Source and Meet Funder Requirements
    - 5/17/23 1-3PM:

Complete

- Course evaluation for this session

Have ready

- List of data you currently track for funders and internal quality improvement

Next Academy Training

EHR Elements to Support Documentation, Track Funding Source and Meet Funder Requirements

05/17/23 1-3 p.m.

Thank you!

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