

Focused Community Support Audits - Sharing of Learning Points

3/07

CenterPoint Provider Relations employees and several providers from our area participated in the recent focused Community Support Audits. We all found it to be a learning experience. Providers and LME employees who participated in the audit were asked to share what they learned during the audit. We have compiled a list of brief, bulleted learning points in an effort to share what we learned with those that were not involved in the audit. We expect more information will be forthcoming from the Division and will pass it along as received. This is NOT a comprehensive list and should not be used in lieu of other internal controls your agency has devised. It is simply meant to be used as a supplement so that all providers may learn some of the key points reiterated during the audit. Please review the information below.

- Treatment plans must be individualized.
- If a consumer comes to you from another agency (even if the plan is current), you must revise that plan upon admission to your program because at that point you are considered to be the clinical home (unless the agency that use to serve the consumer revised the PCP to reflect the change in providers).
- Community Support Service may NOT include interventions such as monitoring and observing; it must be about active therapeutic treatment.
- Community Support Service is NOT about provision of habilitative services rather it is about providing rehabilitative services.
- If a consumer has both a DD and a MI and/or SA diagnosis then the Community Support goals and notes must clearly identify that services are delivered to address the MI and/or SA diagnosis; NOT the DD diagnosis.
- Symptoms/Observations noted on with the goals on the Person Centered Plan (PCP) must clearly correlate to the symptoms/observations noted on the bottom of page 6 of the PCP. In other words, you should not restate the goal under symptoms/observations next to the goal but instead reference the symptom/observation from page 6 that the goal is designed to address.
- Once the PCP format is utilized, the service order is not effective until the PCP is signed by the physician or other permissible professional.
- The PCP is not effective until the date of the last signature on the plan.
- The PCP revision page is not adequate for the first use of the PCP. The entire plan needs to be re-written using the PCP format.
- Value Options does NOT approve PCP; they review for medical necessity.
- The 30 day window for development of the PCP is for individuals new to the MH/DD/SAS system; not individuals transferring to a new provider. If the consumer has transferred, you may revise the PCP to show a change in the provider and obtain all necessary signatures and then revise additionally as needed at a later date.
- You may not bill community support for transportation.
- The QP must monitor and mentor the Associate and Para Professional employees.
- Transcripts in personnel files should be official transcripts with the raised seal.

- If you haven't already, familiarize yourself with core rules, the service records manual, service definitions and the PCP instructions.
- As of the first use of the PCP format, old service orders are no longer in effect, services must be ordered via signature of the appropriate professional on the PCP.
- Order is to be signed on or before the date of service.
- Service plans used prior to the date that the PCP format had to be used should have been reviewed and put on the PCP format at the next required review stating 06/01/06 based on: (1) needs of the person changing; (2) target dates; (3) change of provider.
- Target dates on plans may not exceed 12 months.
- Signatures of team members are to be obtained for each required/completed review of the plan, even if no change occurred.
- In order for the plan to be current and therefore valid, the authorizing signatures must be on or before the date of service.
- The service must be clearly identified in the service plan.
- Signatures should be the full signature, no initials, and should include credentials, license, or degree for professionals and position name for paraprofessionals.
- Service note should be a full narrative service note (no checklist) and must include: (1) purpose of the contact as it relates to a goal in the service plan, (2) description of the intervention(s)/activity/treatment, and (3) assessment of the person's progress toward goals/effectiveness for the individual.
- Do not provide services related to expired goals.
- Goals should be related to skill building. For example, don't just document, "went grocery shopping"; instead document what skills were being worked on while grocery shopping, in order to empower the individual to learn the skills. Skill building needs to be geared toward teaching/assisting the individual to become independent in the skill.
- CS in schools should involve more than setting next to a child to deter inappropriate behavior. Should include what the provider is doing to assist the child in developing internal controls. The providers should have participated in the IEP process and should spend time with the teacher to determine appropriate responses to behavior, etc. Goals should foster independence and autonomy.
- Community Support contains a 'case management' component.
- Service notes and goals should not be so generic that they could be used for anyone.
- Documentation must reflect treatment for the duration of service. It must be reasonable that the activity took place in the time indicated. The activity must reflect "treatment", not just ADLs, chores, etc for the time indicated.
- Initial authorizations are for 30 days; reauthorization will occur a minimum of 90 days thereafter.