MCCMH MCO Policy 2-010

(was MCCMH Administrative Policy 3-01-010)

Chapter: **CLINICAL PRACTICE**
Title: **STANDARDS FOR CLINICAL SERVICES DOCUMENTATION**
Also see MCCMH MCO Policy 10-200, "Service Planning and Review," and 2-018, "Correction, Supplementation, or Deletion of Information from Electronic Medical Record."

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Approved by: _____ 02/24/11
Executive Director Date

I. Abstract

This policy establishes the standards of the Macomb County Community Mental Health Board (MCCMH) for clinical services documentation.

II. Application

This policy shall apply to all directly-operated and contract network providers of the MCCMH Board.

III. Policy

It is the policy of the MCCMH Board that the processes used in MCCMH clinical service documentation are uniformly and consistently implemented in accordance with the Standards set forth in this policy.

IV. Definitions

A. Clinical Record
A confidential file of information maintained, electronically or in paper form, for each consumer of MCCMH services/treatment. The record shall contain, at minimum, information pertinent to the services/treatment provided to the consumer, financial information, informed consent documents, statistical information pertinent to the legal status of the consumer, (demographics, etc.) information required by the Michigan Mental Health Code or other provision of law, and information required by MCCMH policies.

B. Primary Provider Agency
The provider through which the consumer's casemanagement, supports coordination, or psychosocial rehabilitation services are provided, or for consumer's not receiving casemanagement, supports coordination, or psychosocial rehabilitation services, the provider through which psychiatric services are provided to the consumer.

V. Standards

A. Structure and Content of Clinical Records

1. Each individual MCCMH provider shall maintain a clinical record for each consumer/family* served by that provider, regardless of whether or not the consumer is also being served by another MCCMH provider.

2. Each individual MCCMH provider shall establish and adhere to a uniform, standardized system according to which each clinical record shall be organized. A Table of Contents reflecting this standardized system of organization shall be prominently displayed in each clinical record.

3. Each clinical record shall contain, at a minimum:

   a. Assessments;
   b. Service Plans and Services Reviews;
   c. Service Progress Notes; and
   d. Closing Summary.

4. For consumers being served by multiple providers, the original of each integrated Plan of Service and each Service Review shall appear in the record of the primary provider. Copies of integrated Plans of Service and Service Reviews, as applicable, shall appear in the consumer's clinical record at each of the other providers from which the consumer is receiving service(s).

5. All casemanagement, supports coordination, clinical and service activities, including the completion of assessments, Plans of Service, and Service Reviews must be documented in Service Progress Notes.

6. Service Progress Notes shall include at a minimum:

   - A description of the content of each session;
   - Notations regarding services provided;
   - Notations regarding progress made toward PCP goals and expected outcomes;
   - Accurate information regarding services received with date, time, duration of service activity, and service code.

7. Service Progress Notes shall be written in a neutral, non-judgmental style which does not reflect the writer's personal opinions, feelings or attitudes. Service Progress Notes shall not contain documentation of dialogue or conversation among providers, utilization managers or other parties having an interest in the treatment of the consumer.

8. Progress Notes shall be completed within 24 business hours following service delivery.

9. A Closing Summary shall be completed at the conclusion of the consumer's episode of service by a provider regardless of whether the consumer will continue to receive services through other MCCMH providers.

   NOTE: "Consumer" may be an individual or a family.

10. The Closing Summary shall document a summary of the consumer's course of treatment, progress toward goals, reason for closing and follow-up recommendations.

11. Professional staff signatures on clinical records documents shall be affixed within 24 business hours of completion. Supervisor / Therapist III signatures shall be affixed within seventy-two (72) business hours; psychiatrist signature within fourteen (14) business days. Where a psychiatrist's signature is required on a service Plan, and the psychiatrist is in agreement with the Plan, the psychiatrist's signature shall be affixed within fourteen (14) business days and/or prior to implementation of the Plan.

12. Copies of records and documents related to treatment of the consumer and generated by sources outside of the MCCMH service system must be included in the consumer's clinical record at the primary provider and they are to be included in records of other MCCMH providers serving the consumer.

13. Copies of correspondence related to treatment of the consumer, to and from sources outside the MCCMH service system must be included in the consumer's clinical record at the Primary Provider Agency and may be included, as relevant, in records at other providers serving the consumer.

14. Clinical documents may not be removed from the original clinical record, but copies of the documents may be shared with the MCCMH system providers. Each page of each copied document, whether from a printed version or an electronic version, shall be stamped "COPY" in a contrasting color.

15. Document information or reports or working files shall be maintained so as to protect consumer / file confidentiality.

16. Incident or peer review reports, as quality assurance documents, do not constitute summary reports and shall not be maintained in the clinical record of a consumer. These shall be maintained in an on-site administrative file.

B. Documentation Process Requirements

1. Provider-approved clinical records formats form the basic structure within which clinical documentation is done. They may be forms on which to record handwritten documentation, formats for dictation, or templates for word processing of clinical records. They may also be part of an electronic medical records system, such as FOCUS. Providers may not arbitrarily modify formats or deviate from use of these formats. Individual providers may propose revised or additional formats for specialized purposes to be included in the basic packet. These must be approved by management.

2. Signatures on clinical documentation must include, at a minimum, the clinician's first initial, last name, and professional credential(s). Ex: J. Doe, M.D. Service Plans / Service Reviews must also include the signature of the Clinical Supervisor prior to submission of a request for service authorization. The original of any forms requiring client/consumer signatures shall be retained in the original consumer clinical record.

3. Only abbreviations contained in the provider-approved abbreviations policy shall be used in clinical record keeping.

4. Errors in paper clinical record keeping which occur during the recording process may be corrected by the recording clinician via the strike-out procedure contained herein (VI. Procedures.) In no case is white or colored correction fluid to be used to correct a clinical document in paper form. For standards regarding corrections to the active electronic medical records of MCCMH consumers, see MCCMH MCO Policy 2-018, "Correction, Supplementation, or Deletion of Information from Electronic Medical Record."

5. Supervisory staff shall take whatever steps are necessary to ensure that handwritten clinical records are neat and legible.

6. Clinical documents are not to be changed, altered, or removed after having been completed, signed and entered into the clinical record.

7. Handwritten documents shall be completed using blue or black ballpoint ink. Felt tip pens and all other forms of water soluble or light sensitive writing materials are not permitted.

VI. Procedures

A preparing clinician or supports coordination / casemanagment staff shall use the following methods to correct errors which occur during the process of handwriting clinical

documents, creating an electronic medical record, or when proofreading typewritten clinical documents or electronic medical records prior to signature:

A. Paper Medical Records

1. Draw one horizontal line through the word or words which are in error.

2. Above the error write the word "error" and initial it at its upper right-hand corner.

3. Write the correct word or words to the right of the error and continue.

B. Electronic Medical Records

1. For procedures regarding corrections to the active electronic medical records of MCCMH consumers, see MCCMH MCO Policy 2-018, "Correction, Supplementation, or Deletion of Information from Electronic Medical Record."

VII. References / Legal Authority

A. Commission on Accreditation of Rehabilitation Facilities (CARF) 2010 Standards Manual, §2. G. "Records of the Persons Served"

B. MCL §750.492a

C. 2007 MDCH Administrative Rules, R 330.7046

D. Opinion No. 6819 of the Attorney General for the State of Michigan, September 28, 1994

E. MCCMH MCO Policy 6-001, "Release of Confidential Information - General"

F. MCO Policy 10-325, "Minimum Necessary HIPAA Privacy."

G. MCCMH MCO Policy 10-200, "Service Planning and Review."

VIII. Exhibits

A. None.