Chapter: **CLINICAL PRACTICE**
Title: **STANDARDS FOR CLINICAL SERVICE DOCUMENTATION**

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Chief Executive Officer Date

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I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, for clinical service documentation.

II. APPLICATION

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

III. POLICY

It is the policy of MCCMH that documentation of clinical services be uniformly completed in accordance with the standards set forth in this policy.

IV. DEFINITIONS

Clinical record
A confidential file of information maintained, electronically or in paper form, for each MCCMH person served. The record shall contain, at a minimum, information pertinent to the services/treatment provided; financial information; informed consent documents; statistical information pertinent to the person's legal status; demographics; and other information required by the Michigan Mental Health Code, other provisions of law, and MCCMH policies.

V. STANDARDS

A. Structure and Content of Clinical Records

1. MCCMH providers shall maintain a clinical record for each person served, regardless of whether the person is also being served by another MCCMH provider.

2. MCCMH providers shall establish and adhere to a standardized system for clinical record organization. A table of contents shall be prominently displayed in each clinical record.

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

    a. Assessments;

    b. Service plans and service reviews;

    c. Service progress notes; and

    d. A closing summary.

4. The original copy of each integrated plan of service and service review shall appear in the person's clinical record at their primary provider. For individuals receiving services from multiple providers, copies of integrated plans of service and service reviews shall appear in the person's clinical record at each of the other providers' service locations.

5. All case management, clinical, and service activities (including completed assessments, plans of service, outreach attempts, and service reviews) must be documented in service progress notes.

6. Service progress notes shall include, at a minimum:

    a. A description of the content of each session;

    b. Notations regarding services provided;

    c. Notations regarding progress made toward person centered plan (PCP) individualized treatment plan goals and expected outcomes;

    d. Response to current level of care and/or treatment interventions; and

    e. Accurate information regarding services received with date, time, duration of service activity (start-stop time), and service code; signed by a qualified professional.

7. Service progress notes shall be written in a neutral, non-judgmental style that 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 person served.

8. Clinical documentation shall be completed concurrently with the service being provided in the spirit of collaborative documentation, but no later than 48 hours following the date of service delivery.

9. Ancillary providers without direct access to the electronic medical record (EMR) shall provide all relevant service provision information to the primary case holder/primary provider agency within 7 calendar days of providing the service. All ancillary service notes shall be uploaded to the person's EMR in

the appropriate section by the primary provider agency/primary case holder within 7 calendar days of receipt.

10. A closing summary shall be completed at the conclusion of the person's episode of service by a provider regardless of whether he/she will continue to receive services through other MCCMH providers.

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

12. Professional staff signatures, including credentials, on clinical records and progress notes shall be affixed within 48 hours of completion.

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

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

15. Document information, reports, or working files shall be maintained to protect the confidentiality of the person served.

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 person served. These shall be maintained in an on-site administrative file.

B. Documentation Requirements

1. Providers may not arbitrarily modify or deviate from use of MCCMH approved clinical record formats. Individual providers may request or propose a revised or additional format for specialized purposes, such as data tracking, etc., to be included in the clinical record. Only forms and formats approved by the MCCMH Chief Clinical Officer can be used to document and/or included in the clinical record.

2. Signatures on clinical documentation must include, at a minimum, the clinician's first initial, last name, professional license(s) and/or credential(s) (Ex: J. Doe, M.D.), and the date signed. Any original form requiring a person's served signature shall be retained in their original clinical record.

3. Only the abbreviations contained in MCCMH MCO Policy 2-017, "Abbreviations, Acronyms, and Symbols for Record Use," 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 this policy. In no case is white or colored correction fluid to be used to correct a clinical document in paper form.

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

6. Clinical documents shall not be changed, altered, or removed after being completed, signed, and entered into the clinical record.

7. Supervisory staff shall ensure that handwritten clinical records are neat and legible.

8. 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.

9. Information contained in any clinical record or document shall not be misleading or inaccurate.

10. Information contained in any clinical record shall not be altered or deleted to conceal responsibility of injury, sickness, or death of a person served.

VI. PROCEDURES

A. Errors in 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.

B. Additional procedures are contained in the exhibit documents. These procedures are to be followed by all individuals involved in the coordination of care for persons served.

VII. REFERENCES / LEGAL AUTHORITY

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

B. MCL §750.492a

C. MDHHS 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. MCCMH MCO Policy 10-325, "Minimum Necessary HIPAA Privacy."

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

H. MCCMH MCO Policy 2-018, "Correction, Supplementation, or Deletion of Information from Electronic Medical Records."

I. MCCMH MCO Policy 2-017, "Abbreviations, Acronyms and Symbols for Record Use."

VIII. EXHIBITS

A. MCCMH Outreach Procedure