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

A. Ancillary Provider
An agency who is not assigned as the primary case holder or responsible for ensuring the development of the individual plan of service (IPOS), however is a provider that the individual is referred to for and/or receiving services from and is typically listed in the IPOS as an agency providing a particular type of specialty service.

B. Clinical Record
A confidential file of information that is 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.

C. Discharge Summary
A summary of what happened during the time the individual was in treatment. This includes progress toward meeting goals and an individual's disposition at the last session. Completing the Discharge Summary in MCCMH's EMR system discharges the individual from ALL services and closes their case.

D. Primary Provider
An agency at which the designated case manager or mental health professional responsible for ensuring the development of the individual plan of service (IPOS) and their clinical supervisor are assigned.

E. Progress Note
A documentation of each face-to-face, phone, or telehealth contact session with the individual served. This includes the individual's disposition, progress of goals, and any pertinent information related to treatment and outcomes.

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. Signed service plans and service reviews

   c. Signed service progress notes

   d. A closing summary

4. The original copy of each IPOS and service review shall appear in MCCMH's electronic medical record. All ancillary providers shall ensure they have reviewed the individual's IPOS.

5. All case management, clinical, and service activities including completed assessments, individual plans of service, outreach attempts involving a visit to the individual's residence, 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 an IPOS, treatment plan goals, and expected outcomes

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

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

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. Professional staff signatures, including credentials, shall be affixed to all clinical records and progress notes within 48 hours of completion of the service.

9. Clinical documentation by primary treatment teams including contracted substance use disorder (SUD) treatment providers (i.e. case manager, therapist, nurse, psychiatrist, peer supports) shall be completed in MCCMH's EMR concurrently with the service being provided in the spirit of collaborative documentation, but no later than 48 hours of providing the service. This includes professional staff signatures with credentials.

10. Ancillary providers (including CLS, Respite, Private Duty Nursing, Respite Provided by a Nurse, Skill Building, Supportive Employment, and Job Coaching) shall ensure all relevant service provision information is uploaded to MCCMH's EMR within thirty (30) calendar days of providing the service.

11. Applied Behavior Analysis (ABA), Occupational Therapy, Physical Therapy, and Speech Therapy providers shall ensure all relevant service provision information such as progress notes, assessments, etc. are completed and uploaded to MCCMH's EMR within thirty (30) calendar days of providing the service. These should be uploaded in the Services/Planning section of the EMR under 'Other Service Planning Documents.'

12. Action forms provided to behaviorists/authors of a behavior treatment plan shall be scanned into MCCMH's EMR within forty-eight (48) hours of receipt from MCCMH's Behavior Treatment Plan Review Committee (BTPRC). It is the responsibility of the behaviorist to ensure this is completed.

13. Specialized Residential and Crisis Residential Unit providers are required to maintain clinical records according to all MCCMH's standards. These records may be maintained outside of MCCMH's EMR.

14. In addition to the service-line specific requirements outlined in this policy, all service providers in MCCMH's network are required to make clinical records available to MCCMH upon request.

15. If a service is ending with a provider but the case remains in treatment, the provider shall complete a progress note at the conclusion of their line of service and identify who will continue to service the case. The primary case holder shall end their program admission, terminate any existing authorizations for that service, and coordinate a warm transfer of services with a new treatment team, including identifying and assigning the new primary case holder. The person-

centered plan must be amended to reflect this change.

16. Copies of records, documents, and correspondence related to the person's treatment, generated by direct or contract providers and providers not directly contracted by MCCMH, must be given to the primary case holder who will add those to the clinical record.

17. Clinical documents may not be removed from the original clinical record. Each page of a copied document, whether from a printed or electronic version, shall be stamped "COPY" in a contrasting color.

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

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

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 navy 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 2-017, "Abbreviations, Acronyms and Symbols for Record Use."

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

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

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

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

VIII. EXHIBITS

A. MCCMH Outreach Procedure

B. MCCMH Disenrollment from Treatment Procedure