



MACOMB COUNTY

COMMUNITY MENTAL HEALTH

DATE: 08/13/2025

SUBJECT: NOTICE OF POLICY UPDATE

<u>Revised Policy</u>	<u>Update</u>
MCCMH MCO Policy 2-010, “Clinical Service Documentation”	<ul style="list-style-type: none">• Policy language added to Section IV. to include additional definitions.• The definition for ‘discharge summary’ was updated to specify that completing a discharge summary discharges the individual from all services and closes the entire case in MCCMH’s FOCUS electronic medical record (EMR) system.• Section V.A.9. was updated to detail that, “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.”• Section V.A.10. was updated to detail that, “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.”• Section V.A.11. was updated to detail that, “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

	<p>under ‘Other Service Planning Documents.’</p> <ul style="list-style-type: none"> • Section V.A.12. was updated to detail that, “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.” • Section V.A.13. was updated to detail that, “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.” • Section V.A.14. was updated to detail that, “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.” • Section V.A.15. was updated to detail that, “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.”
--	--

MCCMH Policies may be accessed directly from the [MCCMH internet website](#) by clicking on “MCCMH Policies.”

Questions and comments regarding these policy revisions may be made to the MCCMH Policy Administrator, Brienna Szatkowski at brienna.szatkowski@mccmh.net or at (248) 953-5997.

This notice is being sent electronically to all MCCMH staff and providers. Please note that it is the responsibility of the receiving party to view the policy updates, become knowledgeable of policy content, disseminate information to appropriate staff within your agency, and ensure staff compliance.