

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

POLICY

Prepared by:

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Approved by:

Subject: Clinical Documentation  
Standards

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I. POLICY

Clinical documentation serves many important functions for both the individual receiving services and the staff person/Agency providing those services. Functions include:

1. Describing service objectives and providing a focus on wellness, recovery and achieving a meaningful life in the community.
2. Clearly and accurately communicating wellness and recovery strategies, treatment interventions, individual responsibilities, progress toward goals, etc., while promoting continuity of high-quality care and wellness outcomes.
3. Establishing a legal record for billing purposes and/or to meet any contract obligations. Whenever possible, individuals receiving services should be encouraged to participate in the documentation process and be informed of its purpose. Documentation shall be completed in a thorough and timely manner, meeting all internal and external standards. The Agency honors the rights of individuals receiving services to review their clinical record.

II. PURPOSE

To define the standard of quality and timeliness for clinical documentation.

III. APPLICATION

This policy applies to clinical documentation of all CMH services. Documentation for some programs may have more stringent timeframes and assigned staff are held to whichever standard is highest.

IV. DEFINITIONS

Completed Documentation – Clinical paperwork that includes all required information, is signed by the author and co-signed as required, and is present in the clinical chart.

Initial Plan of Care – The beginning steps for addressing the individual's needs until a comprehensive plan is developed. Examples: Interim Care Plan (Specialized Residential settings for people with MI), Initial Plan (Specialized Residential settings for people with DD), and those recommendations regarding services made at the conclusion of an initial psychosocial assessment (Outpatient/DD Intake).

## V. PROCEDURE

The narrative and table of this policy complement rather than duplicate each other. The standards in the table relate to timeliness/timeframes and responsible parties.

### A. Intake and Assessment

1. All clinical issues that are noted on the Admission Report or Call Intake Referral will be addressed in the psychosocial assessment. This may include referral for further assessment. If the episode of care with an individual was closed within the previous 12 months of a new request for service, an updated psychosocial assessment can be completed.
2. The individual's service and support needs must be clearly identified and prioritized. Each assessment will be completed using current electronic format and contain an interpretive summary.

### B. Individual Plan of Service (IPOS)

1. Services provided are based on clinical assessment and the individual's goals and hopes.
2. Preplanning activities must occur prior to meeting to develop a Plan of Service and shall be documented in the current electronic format. When an individual has been receiving Supports Coordination, targeted case management, ACT, or home-based services, the preplanning meeting must be held at least 30 days before the anniversary date of the IPOS so that an independent facilitator can be utilized if desired by the individual receiving services. Preplanning activities will include:
  - a. hopes, goals, desires and any topics about which the individual receiving services would like to talk,
  - b. topics the individual does not want discussed at the meeting,
  - c. who to invite,
  - d. where and when the meeting will be held,
  - e. who will facilitate, and
  - f. who will record the meeting.

An abbreviated version of preplanning is acceptable for MIC and MIA Outpatient services, and persons receiving only vocational or respite services. If an Independent Facilitator is chosen to facilitate the meeting, that person is responsible to document items a through f (above).

3. The IPOS must address identified supports and/or service needs and the priority/severity of those needs.
4. All services and supports must be medically necessary and provided under the direction of an IPOS. All services that are to be provided must be included in the written plan.
5. All services must be open in the electronic system, irrespective of when they are initiated in the service planning cycle.
6. The individual receiving services will be present at the person-centered planning meeting. If an individual is unable to participate in a planning meeting due to their mental health symptoms and/or any other conditions which prevent an individual from full participation, documentation will occur on an Addendum indicating why a full planning meeting did not occur, and a specific timeframe for completion of full plan.
7. Service plans will be Person-Centered, comprehensive, and include:

- a. Documentation of the individual's participation in its development, as well as any other persons providing support;
  - b. Goals expressed in the words of the person served with measurable, time specific objectives.
  - c. Interventions or methods for achieving the goals;
  - d. Description of services to be provided:
    - i. Clearly defined range of service contacts and corresponding units of service for a specific time period (e.g., 1-4 contacts for 15-60 minutes, every 90 days; 2 therapy visits for 50 minutes each, every month).
    - ii. Duration of each service (e.g., 1 week, 3 months, 6 months, 1 year, etc.);
    - iii. The scope of each service to be provided in terms of:
      - Who (professional, para professional, aide supervised by a professional)
      - How (face to face, telephone), and
      - Where (office, community, individual receiving services' home)
    - iv. The date that each service will commence
  - e. The role of natural supports in achieving the identified goals (unless the assessment specifically speaks to the inappropriateness of such supports).
  - f. Review intervals for the plan (schedule of periodic reviews).
  - g. Review intervals for goals which occur more frequently than the periodic review of the plan in its entirety;
  - h. Processes for the individual receiving services to modify the plan.
  - i. The choice to develop a Crisis Plan and/or Advance Directive; and
  - j. Required signatures (author, individual receiving services/representative and supervisor, as applicable).
8. There must be evidence in the clinical record indicating the date that the individual received a copy of his/her plan. This evidence may be found on a Disclosure of Information (C181) if the plan was hand delivered to the individual receiving services or on a cover letter when the plan was sent in the mail. When the plan is mailed, it needs to be sent before the fifteenth business day in order that the plan is received by the fifteenth business day.
9. Periodic reviews will evaluate the person's satisfaction, progress, appropriateness of goals/objectives, and appropriateness of services.
10. At any time, the individual/guardian and the service provider may collaborate to add or remove services or goals. Any change in the plan between review periods must be noted in an addendum to the plan. Changes include but are not limited to: change in contact frequency, change in service(s) or service dimensions, units of service and change in goal or objective. Addendums are part of the plan and need to be included in the review of the plan at the next scheduled review. Addendums should not be used in place of a new plan or periodic review, should a new plan be warranted or a scheduled review required.
11. The IPOS shall be completed in the current electronic format and maintained in the CMHS clinical record as well as at any CMHS contracted or operated service site where the individual is authorized to receive services.

C. Progress Notes

1. Progress notes are required for:
  - a. All face-to-face service contacts;
  - b. All significant guardian face to face and phone contacts or significant phone calls from an individual receiving services;
  - c. Concerns and staff actions regarding an individual receiving services or guardian satisfaction;
  - d. Receipt of information that may impact the individual's services. Examples include, but are not limited to, contacts regarding legal, medical, financial, educational/vocational, housing and family matters; and
- Progress notes will state the start time, duration, and purpose of the contact and clearly address goals and objectives, or supports as applicable, from the person-centered plan.
- Periodically, an individual's satisfaction with services will be addressed on a progress note.
- Supports Coordination and Targeted Case Management progress notes will document the core elements of those services: advocacy, monitoring of service delivery, response to services, and linking and coordinating.
- Staff utilizing the progress note feature of the electronic system must complete a corresponding progress note when completing assessments and IPOS documents to assure the service is documented for billing purposes. If this feature is not utilized by staff, an entry into "client charge input" is required in order to capture the service information.
- Documentation will be completed for all people seen on an emergency basis by designated Emergency Services Workers. It will be complete and available to Brinks' staff during the first contact requesting placement. If the computer is not available, or the admission occurs before the gate-keeping document is complete, the Emergency Service staff will verbally provide Brinks staff the following information prior to admission:
  - The results of drug screening,
  - current alcohol consumption,
  - overdose treatments,
  - diagnosis,
  - any physical health concerns,
  - allergies,
  - legal issues,
  - emergency contact name and number,
  - and any specific treatment recommendations.

D. General

1. All clinical record entries will be signed and dated and include credentials. The document will include both the date of the service contact and the actual calendar date of signature. Documentation and signatures will not be backdated.
2. Every entry into the clinical record must be legible and easy to read.
3. All billable services must have corresponding documentation in the clinical record.

4. Service location will be noted in the documentation of all service contacts.
5. Services must be medically necessary and meet Service Selection Guidelines criteria for various levels of care -- both at the time services are initiated, and on an ongoing basis. Clinical workers are responsible for assuring and documenting medical necessity for their discipline.
6. Documentation will be submitted for scanning or filing promptly after signature.
7. Clerical staff will transcribe all documents within two business days of receipt. Documents will be scanned or filed within two business days of receipt of signed documents.
8. Before closing a case due to no-shows, the primary worker will send a letter to the individual receiving services informing them of the pending termination of services and specifying what action they may take if they want to continue services.
9. Mental health aides at day programs will document in accordance with the frequency specified on each skill building or community living supports program.
10. When the progress of individuals receiving services is reviewed at a treatment team meeting, the team leader/coordinator will ensure that the attendees and outcomes are documented and kept on file for future reference.
11. If an individual receiving services is being prescribed psychotropic medication by a CMH psychiatrist, Nurse Practitioner or Physician's Assistant, the primary worker will thoroughly complete and forward to the prescriber a Briefing Form (C130) by the end of the work day prior to every medication review unless:
  - a. the primary worker is present for and participates in the medication review, or
  - b. the ACT Psychiatrist is briefed in person at the ACT morning team meeting before seeing the individual receiving services for a med review later the same day.

E. Training and Monitoring:

1. All mandatory clinical records training must be attended. It is the responsibility of the worker to enroll in and attend required training.
2. An employee or person working under contract must request additional assistance or training if clinical record documentation is outside the standards defined in this policy or otherwise evaluated by the employee or supervisor to be problematic.
3. A significant pattern of noncompliance with clinical documentation requirements will result in disciplinary action up to and including termination of employment. It may also result in the termination of a contract.
4. Employees and persons working under contract are expected to make necessary corrections when a clinical record is evaluated as missing certain required components. Corrections will be made according to CMH Procedure 05-008. Corrections will clearly indicate the correction; the person making the correction and the date the correction was made. Clinical record entries will not be obliterated under any circumstance. The use of correction fluid on clinical records is prohibited.

VI. References:

- 04-001 Confidentiality of Recipient Information/Records and Privileged Communication
- 04-010 Services Suited to Condition, Dignity, and Respect
- 04-011 Change in Type of Treatment
- 04-022 Complaints, Appeals and Dispute Resolution
- 04-023 Denial of Service, Managed Mental Health Care Grievances, and Disputes
- 05-003 Client Record Retention

- [05-005](#) Client Record Security
- [05-008](#) Authentication and Modification of Documents in the Clinical Record
- [05-010](#) Order of Clinical Record/Filing of Documents in Clinical Record
- [06-004](#) Professional Assessment
- [06-010](#) Medication Management
- [06-013](#) Transfer and Discharge of Clients

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Submitted –refers to either a self-generated document (hand written or electronic) that has been finalized or given to clerical staff for filing/scanning, or dictation/tape that has been given to clerical staff for transcription;  
 “Days” when unqualified, refers to calendar days. Time frames referring to business days state so explicitly.

ITEM	STANDARD	RESPONSIBILITY
<b>Intake and Assessment</b>		
First appointment	Conducted face-to-face within 14 days of referral	Primary Worker
Status Change, C056	Submitted within 3 business days of any change	Receiving Worker
Health Screen, C073	Forwarded to Senior RN by noon the business day after 1 <sup>st</sup> * FTF, and completed minimally every 365 days	Primary Worker
	Assigned, reviewed, and signed within 7 days	Senior RN, Staff RN
Psychosocial Assessment, Initial	Submitted within 5 business days after the initial face to face contact (or the last contact if more that one contact is needed)	Clinical Staff**
Psychosocial Assessment, Annual	Updated at least annually during the 30 day period before IPS	Primary Worker
Psychiatric Evaluations	Submitted by the end of the next scheduled work day	Prescriber
	Signed the same work day as receiving transcribed document	Prescriber
	Updated when clinically appropriate	Prescriber
Medication Reviews	Conducted at least every 90 days <sup>3</sup> Presc	riber
	Submitted by the end of the next scheduled business day	Prescriber
All other assessments	Conducted within 21 days of referral or within 30 days of date of physician's signature on a prescription (OT/PT/ST)	Clinician
	Submitted within 7 days of contact	Clinician
	Updated annually in the 30 days prior to the planning meeting <sup>1</sup>	Clinician/Worker
	For OT/PT/ST Updated when clinically appropriate, but not to exceed 3 years	Clinician
Gatekeeping Assessment	Conducted within 3 hours of request for inpatient services	Utilization Specialist
	Submitted the same day of the contact <sup>2</sup> Utilization	Specialist
Continued Stay Review	Conducted FTF prior to request for continued inpatient services	Utilization Specialist
	Submitted by noon the first business day after the contact	Utilization Specialist
Aftercare appointment	Conducted within 7 days of discharge from inpatient care	Primary Worker
CAFAS (CMI only )	Submitted within 14 days of first* FTF, quarterly (HBS), and annually (Outpatient services)	Primary Worker
DD Data Set, C031	Updated annually, prior to or during the PCP meeting	Support Coordinator
<b>Service Plan</b>		
Pre-Meeting Record	Completed at least 30 days prior to the anniversary date of the last IPOS	Primary Worker
Pre-Meeting Record	(MIC-OP and MIA-OP ) Given at time of Initial Assessment	Author of IA
Initial Plan of Care	Submitted the first day of service in new level of care	Primary Worker
IPOS	In the chart and received by the individual receiving services 15 business days after meeting and updated minimally every 365 days	Primary Worker
Ongoing service	Begins within 14 days of non-emergent assessment	Primary Worker
Periodic Reviews	Completed by scheduled due date +/- 10 days	Primary Worker
	Submitted within 15 business days of review	Primary Worker
<b>Other</b>		
PA/Physician Briefing, C130	Submitted by the end of the work day prior to the med review	Primary Worker
Progress Notes	Submitted by noon the next business day after contact	All workers
Case Closures	Completed within 90 days of last contact <sup>4</sup> P	Primary Worker
Transition Plan, C069	Submitted and distributed prior to the transfer occurring	Primary Worker
Discharge Summary	Submitted the day of discharge <sup>5</sup> P	Primary Worker

\* = non-emergent

\*\*Clinical Staff can be Intake, ES, OP Staff, Team Leaders, etc.

1 When the desire/need for an assessment is discovered at the planning meeting, the assessment may be done later, using the time frames above.

2 If admitted to Brinks, Assessment must be completed prior to initial request for residential placement.

3 Cancellations or no shows are exceptions.

4 Rationale should be documented if the case is kept open longer.

5 When an individual receiving services dies, the discharge summary will be submitted within ten business days of receiving the death certificate.

**Abbrevs:** FTF = Face to Face, RB = Reimbursement staff, ES = Emergency Services, CMI = Children with Mental Illnesses, P.A.=Physicians Assistant