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 that is not assigned as the primary case holder, or responsible for assuring the development of the plan of service but is typically listed in the plan of service as an agency providing a particular type of specialty service.

B. 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.

C. Discharge Summary
A summary of what happened during the time the person was in treatment. This includes the person's presentation, progress toward meeting goals, and disposition at last session.

D. Primary Provider
The agency at which the designated case manager or mental health professional

responsible for assuring the development of the plan of service and their clinical supervisor are assigned.

E. Progress Note
Documentation of each face-to-face, phone, or telehealth contact session with the person served. This includes the person's disposition, progress of goals, and any pertinent information related to their 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. 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.

    a. 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.

    b. Applied Behavior Analysis (ABA) providers shall provide all relevant service provision information to the primary case holder/primary provider agency/electronic medical record within 30 calendar days of providing the service due to the nature of the program and supervision requirements by a Master's Level BCBA and/or Exception Staff.

10. If a service is ending with a provider, but the case is remaining 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 provider shall close their admission layer, terminate any existing authorizations for that service, and coordinate with the treatment team to identify and assign a primary case holder. The person-centered plan must also reflect this change.

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

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

13. 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.

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

15. 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 described in 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 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 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

B. MCCMH Disenrollment from Treatment Procedure