HEALTHWEST

POLICY AND PROCEDURE

No. 06-015

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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 expectations for documentation which include the type, standards of quality and time frames.

APPLICATION

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

III. 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.

Pre-Plan - The beginning steps for addressing the individual's needs until a comprehensive plan is developed.

Person-Centered Plan - A plan which is based on the strengths and needs of the consumer to determine an individualized plan of care and support the person-centered planning process.

Service Entry Assessment - The initial completion of a CANS/ANSA assessment for a consumer entering services which identifies needs and strengths of the consumer and determines the appropriate level of care. This assessment includes the functional tools such as the Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), Level of Care Utilization System (LOCUS), and, Supports Intensity Scale (SIS) to inform the decision making process regarding level of care.

Support Plan - A plan that is completed with the input of the consumer to outline steps that can be taken to prevent a crisis as well as respond to a crisis.

Person-Centered Plan- Review (PCP-R) - The document that describes the results of the periodic review which summarizes all services that were provided within a review period as well as assesses how the services are working. This process occurs at least annually.

Person-Centered Plan-Change (PCP-C) - The document that describes what additions, deletions or changes in desired changes, outcomes, and interventions or timeframes for interventions which are described in the plan.

Health Services Team (HST) Staffing- The form that is used to document either the status or concerns related to consumers that are seeing a prescriber.

Level of Care Utilization System (LOCUS) - The functional assessment tool used to determine the appropriate level of care for adults with mental illness.

Child and Adolescent Functional Assessment Scale (CAFAS) - The functional assessment tool used to determine the appropriate level of care for children with serious emotional disturbance.

Preschool and Early Childhood Functional Assessment Scale (PECFAS) - The functional assessment tool used to determine the appropriate level of care for preschool age children.

Progress Note - The format for documenting either direct or indirect services provided to a consumer/guardian.

Supports Intensity Scale (SIS) Adult Version - The functional assessment tool used to determine the supports that are necessary to support adults with intellectual/developmental disabilities.

Services Request - The form that is used to document when a consumer needs to be referred to another level of care or service.

Transition Plan - The form that is used when a consumer is ending services with the agency.

Collaborative Documentation - A process in which clinicians and consumers/guardians collaborate in the documentation of the assessment, service planning, and ongoing service provision.

IV. 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. Screening, Assessment, and Pre-Planning

1. If a referral occurs through the Request line, an intake screening document is completed. The document will address current symptoms, needs, risk factors, what services are requested and what the disposition is.

2. The CANS/ANSA is completed to determine the needs and strengths of an individual and inform a level of care and service needs. 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. This assessment must clearly lead to a clear clinical rationale for the recommended service.

3. The Service Entry Pre-Plan is the initial plan of service which is completed for all individuals who have been assessed and have been assigned to a level of care. The Pre-Plan will formally assign (after an authorization by the Utilization Management staff) the level of care based on their population and the scope of treatment based on their assessed need. The relative functional assessment tool (LOCUS, CAFAS, PECFAS, Columbia and SIS) score will also be taken into consideration when determining level of care decision. The Pre-Plan will authorize specific number of units/ services within a level of care for thirty (30) days. The Support Plan should be completed on all consumers as a part of this process.

   The CANS/ANSA shall be completed quarterly prior to the treatment plan review or updates if an individual's needs have changed.

B. Person-Centered Plan

1. Services authorized in the plan of service 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 thirty (30) days before the anniversary date of the PCP 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.

   If an Independent Facilitator is chosen to facilitate the meeting, that person is responsible to document items a through f (above).

3. The PCP 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 the PCP. All services that are to be provided must be included in the written plan.

5. All services must be documented on the plan and opened 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 the 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 and scope of each service to be provided in terms of:

            - Who (professional, paraprofessional, aide supervised by a professional),
            - How (face to face, telephone), and
            - Where (office, community, individual receiving services' home), and

        (iii) The date that each service will commence.

    e. The role of natural supports (others will statements) in achieving the identified outcomes.

    f. Review intervals for the plan (PCP 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 complete the PCP change.

    i. A support plan is expected for all consumers.

    j. PCP-R (reviews) will evaluate the person's satisfaction, progress, appropriateness of goals/objectives, and appropriateness of services.

8. 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 a PCP change. 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. PCP change should not be used in place of a new plan or PCP review, should a new plan be warranted or a scheduled review required.

9. The PCP shall be completed in the current electronic format and maintained in the HealthWest clinical record as well as at any HealthWest 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 no shows, cancellations.
   c. Indirect contact (non-billable) such as attendance at medication reviews, attempts at client contact, phone interaction with the individual or guardian.
   d. All significant guardian face to face and phone contacts or significant phone calls from an individual receiving services.
   e. Concerns and staff actions regarding an individual receiving services or guardian satisfaction.
   f. 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.
2. 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.
3. Periodically, an individual's satisfaction with services will be addressed on a progress note.
4. 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.
5. Staff must complete a corresponding progress note when completing assessments and PCP documents.

D. Transition Plan

1. The transition plan when possible is completed prior to a consumer's ending of services with the agency.

2. The transition plan is completed to document the ending of services with the agency and assist the consumer in planning for maintaining recovery.

E. HST Staffing

1. The HST staffing is used to communicate information to the prescriber regarding the consumer's functioning and progress in treatment. This should be completed prior to the consumer being seen by the prescriber.

2. The HST staffing may be completed to share information with the prescriber related to the consumer's functioning in between prescriber appointments.

F. Service Request

1. The Service Request form is completed when referrals to another program, level of care, or service is indicated.

2. The Service Request form will be reviewed by the receiving program, and feedback should be communicated between programs or services related to the referral.

G. General

1. All clinical record entries will be signed electronically. The electronic signature will include the clinician's 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. Collaborative Documentation is recommended and preferred as the way in which services are documented.
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. Supervisors are responsible for ensuring that the individuals receiving services in their programs are receiving the correct level of care and scope of services. They are also responsible for assisting their staff in transitioning individuals to other community agencies as appropriate when specialty services are no longer needed.
7. In those instances where a document is not electronic, documentation will be submitted for scanning or filing promptly after signature.
8. 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 electronically forward to the prescriber an HST staffing form 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.

H. 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.

V. 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
05-008 Authentication and Modification of Documents in the Clinical Record
06-004 Professional Assessment
06-010 Medication Management

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Submitted –refers to either a self-generated document (handwritten 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	RESPONSIBILTY
Intake and Assessment		
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 1st* FTF, and completed minimally every 365 days	Primary Worker
	Assigned, reviewed, and signed within 7 days	Senior RN, Staff RN
Service Entry Assessment	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**
Quality of Living 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[3]	Prescriber
	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[1]	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[2]	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
PECFAS, CAFAS, LOCUS	Submitted within 14 days of first* FTF, quarterly (HBS, CBS,ACT,ICM); Every 6 months other programs	Primary Worker
DD Data Set, C031	Updated annually, prior to or during the PCP meeting	Support Coordinator
Service Plan		
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
PCP	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
Other		
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[4]	Primary Worker
Transition Plan, C069	Submitted and distributed prior to the transfer occurring	Primary Worker
Discharge Summary	Submitted the day of discharge[5]	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.

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