HealthWest
Muskegon's Behavioral Wellness Connection

Policy/Procedure Title: Clinical Documentation Standards	Policy and Procedure #: 06-015	Review Dates	
Category: Clinical **Subject:** To define the expectations for documentation which include the type, standards of quality and time frames.	**Prepared by**: Name: Linda Anthony Title: Director of Health Information **Approved by:** DocuSigned by: Rich Francisco AA7FBD48ABB04A3... Rich Francisco, Executive Director	10/23/2025	
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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. 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. For staff who are part of a Community Benefit Program, please reach out to your supervisor for clarification on your specific workflow.

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.

Individual Plan of Service (IPOS) - 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.

Initial Evaluation - The start of a Biopsychosocial and CANS/MichiCANS 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 Michigan Child and Adolescent Needs and Strengths (MichiCANS), and Level of Care Utilization System (LOCUS), to inform the decision-making process regarding level of care.

Crisis Prevention 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.

IPOS Review - 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.

IPOS Addendum - 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.

Provider Briefing - The form that is used to document either the status or concerns related to consumers that are seeing a prescriber.

Michigan Child and Adolescent Needs and Strengths (MichiCANS) – The tool used by providers in Michigan to determine the level of care for children and youth under 21.

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

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

Chart Memo: The format for documenting indirect services provided to a consumer/guardian.

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

Discharge Summary - 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. Staff should document according to current state mandates the standards in the table relating to timeliness/timeframes and responsible parties.

Screening, Assessment, and Pre-Planning

1. When an individual contacts the agency for services or walks in, a contact log is completed. The document will address current symptoms, needs, risk factors, what services are requested and what the disposition is. The contact log routes to the Access Follow-up Queue. Access stabilizer with meet with the individual and complete the request for service. Access stabilizer will determine if the individual is referred to an outside agency or referral for an initial evaluation.
2. The Initial Evaluation workflow is completed by the Access Stabilizer. This includes the Consent for Treatment, the Consent to Share Information, Financial Determination, and screening tools. The Initial Evaluation, which includes the CANS/MichiCANS, 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 the current electronic format and contain an interpretive summary. This assessment must lead to a clear clinical rationale for the recommended service.

3. The Preliminary 30-Day 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 Preliminary 30-Day 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 or MichiCANS) score will also be taken into consideration when determining level of care decision. The Preliminary 30-Day Plan will authorize specific number of units/ services within a level of care for thirty (30) days. The Crisis Prevention Plan should be completed on all consumers as a part of this process.

   The CANS/MichiCANS shall be updated quarterly prior to the IPOS review or updates if an individual's needs have changed.

B. Individualized Plan of Service (IPOS)

1. Services authorized in the plan of service are based on clinical assessment and the individual's goals and hopes. Individuals will be referred to the appropriate evidence-based practices as needed.

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 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, strengths, 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,

   f. Who will record the meeting, and

   g. What accommodations you may need to meaningfully participate in 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 IPOS must address identified supports and/or service needs and the priority/severity of those needs based on the CANS/MichiCANS assessment.

4. All services and supports must be medically necessary and provided under the direction of the IPOS. 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 (IPOS Review).

    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 IPOS Addendum.

    i. A Crisis Prevention Plan must be offered to all individuals.

    j. An assessment will be completed prior to the review of the IPOS.

    k. IPOS Reviews will evaluate the person's satisfaction, progress, appropriateness of goals/objectives, and appropriateness of services. A review will occur no less frequently than 90 days for SMI/SED/SUD and no less than 180 days for those with mild to moderate needs.

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 an IPOS Addendum. 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. IPOS Addendum should not be used in place of a new plan or IPOS review, should a new plan be warranted, or a scheduled review required.

9. The IPOS 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.

Progress Notes

1. Progress notes are required for:
   a. All direct service contacts.
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 IPOS.
3. Periodically, an individual's satisfaction with services will be addressed on a progress note.
4. 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.

Psychotherapy Notes

1. Under HIPAA, psychotherapy notes are defined as notes that document or analyze the contents of a therapy session and are separated from the rest of the medical record. The definition of psychotherapy notes specifically excludes patient information that is considered to be part of the medical record. The following information is not considered to be part of a psychotherapy note:
   a. Medication prescription and monitoring
   b. Session start and end times
   c. Modalities and frequency of treatment
   d. Results of clinical tests and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.
2. Distinguishing characteristics of progress notes versus psychotherapy notes:

Progress Notes	Psychotherapy Notes
What to include: • Session start and stop times • Medication information • Treatment modalities • Frequency of treatment • Functional status • Symptoms • Prognosis • Progress	What to include: • Documentation or analysis of the contents of conversation during a private counseling session • Nothing else
Purpose: • Communication between client, family, and care team • Legal record of care history	Purpose: • To help the practitioner recall the therapy discussion or content

• To help practitioner recall between sessions • To ensure best practice • HIPAA Compliance	
Who has the right to view: • Practitioner • Client • Care Team • Courts	Who has the right to view: • The practitioner alone

3. All progress notes held within HealthWest's electronic health record to include therapy progress notes may be released to another individual/agency with the proper signed authorization.

Chart Memos

1. Chart Memos are required for:

4. Indirect contact (non-billable) such as attendance at medication reviews, attempts at client contact, phone interaction with the individual or guardian.
5. All significant guardian face to face and phone contacts or significant phone calls from an individual receiving services.
6. Concerns and staff actions regarding an individual receiving services or guardian satisfaction.
7. 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.

Case Closure

1. Case Closure could happen once 3 or more diligent outreach attempts have been made over a 7–21-day.

   a. A diligent outreach effort consists of a phone call, email, engagement letter in mail, and/or physically looking for the consumer and documenting attempts in the clinical record. If the individual is experiencing homelessness, this could include getting a hold of emergency contact, visiting shelters, etc.

   b. If a consumer has recently being released from a post-institution, reached out to the warm line, or otherwise had increased contacts, more effort needs to be placed in outreach.

   c. If a consumer is currently on an AOT or ATO, more effort needs to be placed in outreach.

d. If a consumer contacts the warm line or HealthWest, the discharge process could stop because the consumer is actively looking for services.

e. A client who is entered into the Suicide Care Pathway or is deemed to be at risk for suicide should not be discharged.

f. If no meaningful contact has been made within 21 days, a Notice of Adverse Benefit Determination (NABD) will be sent out giving the consumer the appropriate time to respond based on insurance type.

g. If there is still no response the team will start the discharge process.

Discharge Summary

1. The discharge summary, when possible, is completed prior to a consumer's ending of services with the agency.

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

Provider Briefing

1. The provider briefing 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 provider briefing may be completed to share information with the prescriber related to the consumer's functioning in between prescriber appointments.

Internal Referral

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

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

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. Should you require to inform the chart at a later date, please use the current date and add relevant details. Seek supervisor/manager input for further clarification.
3. Service location will be noted in the documentation of all service contacts.
4. 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.

5. 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.

6. In those instances where a document is not electronic, documentation will be submitted for scanning or filing promptly after signature.

7. If an individual receiving services is being prescribed psychotropic medication by a HealthWest psychiatrist, Nurse Practitioner or Physician's Assistant, the primary worker will thoroughly complete and electronically forward to the prescriber a provider briefing form prior to every medication review unless:

   a. The primary worker or a member of the treatment team 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.

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 Complaint Process and Appeal Process
04-023 Managed Care Complaints, Grievances, and Appeals.
05-003 Records Retention06-010 Medication Management

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 Service Appointment	Conducted face-to-face within 14 days of referral	Primary Worker
Biopsychosocial	Forwarded to RN. Assigned, reviewed, and signed within 7 days.	RN/MA
Psychiatric Evaluations	Submitted by the end of the next scheduled workday	Prescriber
	Signed the same workday 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 the next scheduled workday. If unable to complete same day, document, to include SAL, is started and saved same day as 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
Pre-Admission Screening	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 prior to request for continued inpatient services	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
Service Plan		
Pre-Plan	Completed at least 30 days prior to the anniversary date of the last IPOS. Progress Note completed for billing and submitted by end of the next workday. If unable to complete same day, document, to include SAL, is started and saved same day as contact.	Primary Worker
Individual Plan of Service	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. Submitted within the next working day. If unable to complete same day, document, to include SAL, is started and saved same day as contact.	Primary Worker
Ongoing service	Begins within 14 days of non-emergent assessment	Primary Worker
IPOS Review	Completed by scheduled due date	Primary Worker
	Submitted within the next working day. If unable to complete same day, document, to include SAL, is started and saved same day as contact.	Primary Worker
Other		
Provider Briefing	Submitted by the end of the workday prior to the med review	Primary Worker
Progress Notes	Submitted within the next business day after contact. If unable to complete same day Progress Note, to include the SAL, is started and saved same day as contact.	All workers
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.
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 notification of death.

Authors Initials LA/hb