| Community Mental Health Partnership of Southeast Michigan/PIHP | *Policy*<br><br>*Clinical Record Content* |
|---|---|
| **Department:**<br>**Clinical Performance Team** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date**<br>**2/27/17** | **Implementation Date**<br>**6/1/17** |

## I. PURPOSE

To ensure consistency across the region in meeting clinical documentation standards.

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| 10/2/2013 | 1 | Revised to reflect the new regional entity effective January 1, 2014. Policy was formerly known as Clinical Services. |
| 2/2017 | 2 | 3-year review |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers and/or contractual agencies within the regional provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

## IV. POLICY

The clinical record will include both electronic and paper records.
All clinical records maintained by CMHPSM and Substance Abuse Treatment Provider will be complete and accurate.

## V. DEFINITIONS

Clinical Record: The medical and billing records, including protected health information that is maintained for the purpose of enrollment, treatment and decision making, payment and claims adjudication. This record shall include both electronic the health record and any historical paper records.

Network Providers: An individual or organization contracted to provide mental health or substance use disorder services.

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves and is comprised of the four-county affiliation of Lenawee, Livingston, Monroe, and Washtenaw.

## VI. STANDARDS

A complete and accurate clinical record will include**:**

- Consumer name, gender, address, date of birth, race/ethnicity, authorized representative, preferred language, and special accommodation needs if any
- Legal status of individuals receiving behavioral health care, including legal issues, court/probationary/parole information, and guardianship status
- Emergency care provided to the individual
- Documentation and findings of assessments
- Conclusions or impressions drawn from historical and ongoing information related to recipient's physical, behavioral health and trauma status and needs
- Reason(s) for admission or care, treatment or conditions
- Goals of the Individual Plan of Service (IPOS)/Treatment Plan
- Evidence of known advance directives, do not resuscitate orders
- Evidence of Informed Consent
- Evidence that notice of privacy practices was provided
- Diagnostic and therapeutic orders
- All diagnostic and therapeutic procedure, test and results
- All operative and other invasive procedures
- Progress notes made by authorized individuals toward meeting treatment goals
- All reassessments and plan of care revisions, when indicated
- Relevant observations
- Response to care, treatment and services provided
- Releases of information
- Primary Care Physician, name and address and a signed release or documentation or refusal for coordination of care.
- Consultation reports
- Allergies to foods and medications
- All medication ordered or prescribed, every dose of medication administered (including the strength, dose or rate of administration; adverse drug reactions), and every medication dispensed or prescribed on discharge
- Evidence indicating that medication side effects information was given
- All relevant diagnoses/conditions established during the course of care and treatment
- Records of communication with the individual regarding care, treatment and services (i.e. phone calls, mail, etc.)
- Referrals or communications made to external or internal care providers and community agencies
- Documentation of clinical research interventions this distinct from entries related to regular care
- Member-generated information (i.e. information entered into the record over the Web or in Computer systems), if applicable
- Discharge planning
- Documentation of how services are integrated across the continuum of care based upon identified need in the IPOS/treatment plan:

    - Physical health
    - Community
    - Education
    - Vocational
    - Spiritual
    - Family/Significant other support systems
    - Socio-cultural
    - Special population needs
- Due process/appeal notices
- Record Release log: An accounting of disclosures for each consumer, indicating any information which is released.
- Evidence that Recipient Rights information was provided initially and at least annually thereafter.
- Evidence that the consumer was offered self-determination, independent facilitation, and choice of provider where applicable, and the consumer's response
- Any other information required by policy

All clinical records maintained by network provider records must contain, at a minimum:

- Current IPOS/treatment plan
- Progress notes documenting service(s) delivered and the specific dates of delivery or other documentation of each service delivery.
- Medication administration records (including the strength, dose or rate of administration; adverse drug reactions) if medications are being dispensed by the provider
- Signed Releases of Information if any protected health information is being released or exchanged.
- An accounting of disclosures for each consumer, indicating any information which is released without a signed ROI form.

All information shall be protected in keeping with all state and federal laws regarding confidentiality and security. See Regional Confidentiality and Access to Clinical Records Policy.

The clinical record shall be retained in accordance to all Federal and State Laws and standards. See Record Retention and Destruction Policy.

## VII. REFERENCES

A. Joint Commission Standards
B. BBA
C. HIPAA (45 CFR Parts 160 & 164)
D. Michigan Mental Health Code
E. Regional Confidentiality and Access to Clinical Records Policy
F. Regional Record Retention and Destruction Policy
G. Regional Communicable Disease Policy
H. The HITECH Act