<table>
<tr><td colspan="3">COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN</td><td colspan="3">Policy and Procedure</td></tr>
<tr><td colspan="3">Department
Clinical Services</td><td colspan="3"># of Pages: 5</td></tr>
<tr><td colspan="3">Policy Name
CLINICAL RECORD</td><td colspan="3">Type of Policy:
[ ] WCHO [X] Regional [ ] Network</td></tr>
<tr><td colspan="3">Policy Number
12.004</td><td>Effective Date</td><td>Revision Date</td><td>Approval Date
3/6/06</td></tr>
<tr><td colspan="6">Administrative/Board of Directors Sign Off</td></tr>
<tr><td colspan="5">Administrative Signature:</td><td>Date:</td></tr>
<tr><td colspan="5">Board of Directors Signature:</td><td>Date:</td></tr>
</table>

I. PURPOSE

To ensure consistency across network providers in meeting the documentation standards through the clinical record structure.

II. APPLICATION

All WCHO Network Providers, Comprehensive Specialty Services Network (CSSN) Providers and Substance Abuse Providers.

III. 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 and paper records.

Electronic Record: The elements of the electronic consumer record contained in Encompass shall consist of the following: Demographics/financial, Emergency Services, Medication Services, Assessment, Health Clinic, ACCESS, Court Services, Legal, Services, Admissions, Budgets, and Other. This record will contain all of these as they pertain to the consumer and the services they receive.

Network Providers: For the purpose of this policy, network providers shall be defined to include any contracted providers for the following services-licensed residential, supported living, respite, child waiver services, licensed independent practitioners, supported employment, clubhouse/psychosocial rehab, hospitals, fiscal intermediaries, and skill building services.

CSSN Providers: An organization that is certified as a CMHSP, including a recipient rights systems, services across all populations, a publicly appointed
Board of Directors, and accreditation from JCAHO. This includes “look alike” CSSN providers.

IV. POLICY

WCHO shall define the Clinical Record to include both electronic and paper records.

Paper copies of documents shall be kept as part of the clinical record including all signatory documents, third party documents obtained, and any grievance and appeal or judicial decision documentation.

The electronic record contained in the Encompass Database includes all consumer information contained in the following fields:

- Demographics/Financial
- Emergency Services
- Medication Services
- Assessment
- Health Clinic
- Access
- Court Services
- Legal, Services
- Admissions
- Budgets
- Other

All clinical records maintained by CSSN and Substance Abuse Treatment Provider **must** contain:

- Consumer name, gender, address, date of birth and authorized representative, if any
- Legal status of individuals receiving behavioral health care, including guardianship or probationary status
- Emergency care provided to the individual prior to treatment, if any
- Documentation and findings of assessments including race/ethnicity and primary language spoken
- Conclusions or impressions drawn from historical and ongoing information related to recipient's physical and behavioral health status and needs
- Reason(s) for admission or care, treatment or conditions
- Goals of the Person Centered Plan/Treatment Plan
- Evidence of known advance directives, do not resuscitate orders
- Evidence of Informed Consent
- 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 PCP/treatment plan:
    - Physical health
    - Community
    - Education
    - Vocational
    - Spiritual
    - Family/Significant other support systems
    - Socio-cultural
    - Special population needs
- Due process/appeal notices, any
- 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.

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

- Current PCP/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.*

V. EXHIBITS

None

1. REFERENCES

A. JCAHO CAMMCO Manual: IM 6.10, IM 6.20

B. JCAHO CAMBHC Manual: IM 6.10, 6.20, 6.30, 6.60

C. BBA (42 CFR Parts 430 & 438): 438.10 (5),(d)ii, 438.224

D. HIPAA (45 CFR Parts 160 & 164)

E. Michigan Mental Health Code: 330.1746, 330.1748

F. Regional Confidentiality and Access to Clinical Records Policy

G. WCHO Security of Consumer Related Information Policy

H. Regional Record Retention and Destruction Policy

VII. PROCEDURES

WHO	DOES WHAT
Providers	1. Define clinical record structure and maintain clinical records. 2. Monitor appropriate documentation of clinical content, timeliness, medical necessity through a predefined process. 3. Be able to submit results of monitoring when requested. 4. Establish a mechanism for improving problems noted in the clinical record.
WCHO Provider Relations Unit	1. Audit selected records upon routine site visits. 2. Identify needed changes or identify and apply any necessary sanctions in accordance with the contract.