Documentation Requirements

4. RECORDS OF PERSONS SERVED

In addition to the documentation requirements found in the Utah Medicaid Provider Manual for Mental Health Centers, the client record must contain the following documentation, as applicable. This pertains to all clients regardless of whether or not they are an Enrollee.

Requirements for the individual client record:

Intent: The client record serves as a clinical tool in the formulation of a comprehensive representation of the individual served. A complete and accurate record is necessary to ensure that clinical and legal standards are met, that services are matched to the needs of the client and take place in an organized, efficient and timely manner, that there is fiscal accountability and that all appropriate individuals have access to relevant information regarding each person served.

Standards: The record is organized, complete, current, legible and clearly documents all services provided to the client. Service activities provided by the CONTRACTOR will be updated and filed at the time of service. All documents generated by the organization that require signatures will include the appropriate original or electronic signatures. All billing information will be supported by information in the individual record. The client record will be reviewed as one measure of the quality of program services.

The CONTRACTOR will obligate, by contract, all substance abuse Subcontractors to utilize the electronic health record (EHR) chosen by the COUNTY which currently is the Utah Web Based Infrastructure for Treatment Services (UWITS) as the primary record for all County (including Medicaid) clients. The CONTRACTOR and Subcontactors are responsible for keeping their data comprehensive and updated. Those using an alternative certified system must have a COUNTY approved interface to the UWITS system in order to satisfy all the State TEDS and other State and COUNTY data requirements. Costs of producing and testing an interface to the UWITS system will be the responsibility of the individual Provider.

The record will contain all demographic, treatment, billing and outcome information. If there is information that cannot be included in the electronic record, a paper record will be maintained. The file must include correspondence related to the person served, authorization for release of information, grievance procedures, TB test results (for residential treatment), documentation regarding medications, client and staff signatures, where required, and any other information pertinent to the client. Additionally, for non-Medicaid clients proof of residency, valid ID, Medicaid eligibility, fee agreements, continuous review of client fees must be included in the file.

The individual record is maintained in a manner protective of confidentiality and compliant with 45 CFR/HIPAA (Health Insurance Portability and Accountability Act) Part 164 documentation/privacy standards, and other applicable federal privacy guidelines as may be applicable.

The client record will include:

Assessment: All clients entering treatment will meet with a licensed mental health therapist (LMHT), defined as a therapist practicing within the scope of their licensure in accordance with Utah Code Ann. § 58-60-101 et seq. The client and LMHT shall meet individually and face-to-face to complete a comprehensive, individualized Psychiatric Diagnostic Evaluation (PDE) assessment to determine diagnosis and need for services. The diagnosis will be based upon either the Diagnostic Statistical Manual IV – TR or V of the American Psychiatric Association (DSM IV-TR; DSM V) criteria. The assessment will include adequate justification for the diagnosis and will clearly indicate the need for immediate treatment based on medical necessity.

Though an initial assessment is completed, assessments are considered ongoing with these two overarching principles (please refer to the Preferred Practice Guidelines issued by the Division of Substance Abuse and Mental Health for further detail):

1. The client remains at the center of all clinical efforts, whether they are Engagement, Assessment, Planning or Treatment. Relevance to the client and their needs should guide each provider in deciding how to engage the client, what information to gather and document, what strategies to plan and how treatment is delivered. While accurate and complete documentation of services and the gathering of information for organizational purposes and other systemic demands are important, they remain secondary to the needs of the client.

2. An important aspect of effective treatment is the ability for providers to engage clients so that the client has hope for their recovery and desires to participate in treatment. One barrier to effective engagement is the belief that all elements of assessment and planning must be gathered at the very beginning of services. Therefore, these guidelines emphasize that assessment and planning are a process rather than an event, and should be balanced with the process of engagement. A more concerted focus on engagement will result in improvements in client retention and improved treatment outcomes.

With these principles in mind, the assessment shall consist of the following guidelines, where appropriate:

1. Working diagnoses may change and shall be continuously evaluated and updated consistent with new information.

2. Immediate safety needs of the client are addressed.

3. A diagnosis is made based upon the International Classification of Diseases 9 (ICD) and/or Diagnostic Statistical Manual of the American Psychiatric Association (DSM IV-TR) criteria. There shall be adequate justification for the diagnosis and the assessment shall clearly indicate the need for services.

4. Assessments shall consider how culture (Values, traditions, family and religious practices, spiritual beliefs and beliefs about mental illness and addiction, etc.)

impact recovery.

5. Providers should be aware that individual differences in culture can be misinterpreted as problems.

6. Person Centered and strengths-based questions will lead both client and therapist in a solution-oriented direction. This establishes a bridge between assessment and development of a person centered treatment/recovery plan.

7. Assessments should be provided in a manner which does not attribute blame.

8. Family/care givers are a primary source of information about the child/youth and should participate in all aspects of the assessment and subsequent treatment recovery planning and implementation.

9. In addition to family/care givers, other sources such as school teachers and physicians can provide essential/accurate information. Releases of Information should be requested when other sources are identified and efforts should be made to contact these sources.

10. The Appendix contains a list of possible areas to be considered as part of an ongoing assessment. The list is not exhaustive and does not constitute a required set of assessment items. Clinicians should keep in mind the principle of relevance (that relevant information should be gathered).

11. The setting in which and evaluation takes place can be critical to the success of the interview. For children and youth the setting should accommodate the child's cognitive, language and emotional status.

12. With children and youth, evaluation may incorporate specific techniques that may include interactive play, projective approaches, direct discussion, structured observations or other means of seeking information.

13. With children and youth care should be taken to avoid questions that lead a child to answer in a particular way.

14. If the client has dependent children, appropriate referral for evaluation or services shall be made.

15. Inquiring about substance abuse is an essential part of the initial assessment. Because substance abuse often coexists with other conditions, therapists shall continually assess for substance abuse and encourage appropriate treatment/recovery supports as needed. If there is evidence that the individual is dependent upon and/or under the influence of a chemical substance, an evaluation for the need for medical detoxification shall be made.

Additional Areas to be considered as part of the Assessment

1. Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s), mental status examination, including thought (content and process), perception, mood, level of suicidal risk, affect, memory, judgment, appearance, and orientation.

2. Developmental milestones (e.g. receptive and expressive language development).

3. Psychiatric and medical history (e.g. vision and hearing problems).

4. School functioning and performance including any formal testing conducted by the school.

5. Any relevant information or testing from outside agencies.

6. Emotional development and temperament.

7. Peer relations

8. Family relationships, responsibilities, and perceptions of the child/youth and his/her difficulty and the subsequent impact on the family

9. Strengths, interests, and hobbies

10. Natural and informal supports

11. Cultural influences, values, and beliefs

12. Family or environmental circumstances

13. Parental/family medical, behavioral health, substance use history and impact on child/youth

14. Child's/youth's substance use, including in-utero, birth, and second hand exposure, traumatic circumstances (e.g. child abuse, domestic violence, family substance use)

15. Legal involvement

16. Involvement with outside agencies including juvenile court dependency or custody hearings

Areas to be considered as part of the Assessment

1. Assessment information is kept current

2. Clinicians gather comprehensive relevant assessment information based on the client's concerns, in an ongoing manner as part of the treatment process

3. Assessment includes an ongoing focus on strengths and supports that aid in their recovery.

4. Assessment includes identifying those things that motivate the client (Life Goals) and how those motivations have been impeded (Barriers) by mental illness and/or addiction.

5. Assessment information is organized coherently and available in a readable, printable format.

A key principle of long-term, successful recovery is the systematic application of Continuous Recovery Support. Because mental illness and addiction are now understood as chronic conditions, it is preferred practice that providers and systems use whatever resources they have available to them to maintain contact with clients beyond the traditional active treatment phase and provide Continuous Recovery Support services to help clients sustain their recovery throughout their lives.

Recovery Support services are those services that occur prior to, during or after a treatment episode that assist an individual or family in entering into or sustaining recovery from a mental illness or substance use disorder, but are not considered to be treatment services. Continuous Recovery Support can include such activities as ongoing monitoring, ongoing peer support, recovery 'check-in' clinics, outreach via social media and regular communication of recovery topics. The hallmark of Continuous Recovery Support is active outreach to clients.

Treatment Plan: The CONTRACTOR agrees that at the time of admission a LMHT will establish a formal, individualized, person-centered Treatment Plan for every client. The plan shall: be consistent with standards for individual treatment/recovery plans; incorporate the goals of the client and include the involvement of family and natural supports; respect the wishes and needs of the client within funding limitations; and, follow clinical best practice standards. The treatment plan will be written in the following format:

a. Goal. The Goal is a statement that summarizes the individual's or family's desires for change and resolution to a problem or need, captured in their own words. Goals are identified throughout the assessment. They are not necessarily measurable, but are reasonably attainable or recognized within an episode of continuing care.
b. Objectives. Objectives will be established that address the client's aspirations as stated in the Goal statements. Objectives are short term goals/steps that help the individual reach their Goal. They describe desired changes in status, abilities, skills, or behaviors. Objectives will be measurable and will describe the progress anticipated in the near future.
c. Methods. Methods are the strategies, interventions and tasks that the client, family, peers, community support and/or staff will provide in order to reach the goal and

objectives. Methods will be short-term, behaviorally measurable and use action verbs and identifiable outcomes such as what, who, when, where and why.

It must be evident that the client was included in the planning process, that the plan addressed the client's individual needs, and that information from the PDIE, and any other pertinent documentation was considered in the planning process. A LMHT will be responsible for any clinical action, and will sign off the treatment plan in the EHR. A copy of the treatment plan will be made available to the client.

Treatment Documentation: Services will be documented in the EHR at the time of service, will include date, exact time of service, duration, type of service, identify the rendering staff with verifiable signature, credentials and evidence of supervision, if necessary. Written documentation will be developed and maintained for each service or session for which billing is made and will be recorded and coded as outlined in the Utah Medicaid Provider Manual. Services will be provided by a practitioner with the proper credentialing and/or training, or is developing skills with appropriate supervision from a properly credentialed or trained practitioner. The note will be signed off and saved in the EHR.

Documentation will be specific to the client of record and will be related to areas addressed in the Treatment Plan. Notes will include changes in client behavior, attitude and beliefs, progress or lack of progress and how the service provided related to the Treatment Plan. Gaps in service such as sickness, vacation, incarceration, home visits, no shows and cancellations will be documented in the EHR as a "Miscellaneous Note."

Treatment Plan Reviews: Treatment Plan Reviews shall be documented in the EHR. The review will include the date and duration of service; an update of progress towards established treatment goals, the appropriateness of services being offered, explain the need for continued participation; include the signature and credentials of the individual rendering service; and incorporate OQ/YOQ data to support the current treatment plan or any changes made to the plan.

Treatment Plan Reviews will be conducted by a LMHT meeting in an individual, face-to-face interview with the client to review the Medical Necessity, appropriateness of treatment interventions and measure progress on the treatment plan. Based on the needs of the client, changes to the Goal, Objectives, and Methods will be made on the treatment plan in the EHR with an attached note justifying the changes. Treatment Plans must be kept current.

Discharge Summary: At the time of discharge, a summary will be prepared in EHR that includes the current diagnosis, the extent to which the treatment plan Goal, Objectives and Methods were achieved, services provided, reason for discharge or referral and recommendation for additional services. An LMHT will be involved in the discharge process and is responsible for any clinical action.

The CONTRACTOR agrees that clients will be discharged and the case closed in EHR no later than 90 days after the last contact for non SPMI clients and 180 days for all SPMI clients from date of last contact. However, if a non SPMI client receives only medication management services the client will discharged and the case closed no later than 180 days from date of last

contact. Prior to discharge the CONTRACTOR agrees to demonstrate outreach attempts when a client fails to attend prescribed services.

Concurrent Utilization Review: The CONTRACTOR agrees to comply with all the COUNTY Utilization Review (UR) policies and procedures and will document that participation as required in the client record (See Section B, Fiscal and Reporting Requirements, B 4 A).

Reporting Requirement: The CONTRACTOR agrees to comply with all Mental Health Event Data Set (MHE) reporting requirements in SAMHIS.

The CONTRACTOR further agrees to track outcomes systems data utilizing the OQ/YOQ and maintain a record of client OQ/YOQ scores within the EHR. OQ/YOQ will be given to clients at intake, every thirty days or every visit (whichever is less frequent), and at discharge. The instrument is to be completed by the client or by the parent/guardian for clients under the age of 12.