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|  | **DIVISION OF CHILD AND FAMILY SERVICES Children’s Mental Health** |
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| **REFERENCES:**  | **CODE OF FEDERAL REGULATIONS**42 CFR § 400 et al. (Balanced Budget Act) 45 CFR § 160, 162, and 164 (HIPPA)**NEVADA REVISED STATUTES (NRS)**Nevada Revised Statutes (NRS) 433, et al**DCFS CHILDREN’S MENTAL HEALTH POLICY** DCFS CMH SP-5 DCFS Targeted Case Management Policy (approval pending)DCFS CMH A-3 Supervision Policy (approval pending)DCFS CMH A-4 False Claims Act Policy (approval pending)DCFS CMH CRR-4 Confidentiality Policy (approval pending)SP-3 DCFS Incident Reporting and Management Policy, March 2013**DHCFP MEDICAID SERVICES MANUAL** MSM 100MSM 400MSM 2500MSM 3300 |

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|  | **JOINT COMMISSION STANDARDS**Provision of Care, Treatment, and Services (PC)Information Management (IM)**CMH Glossary of Terms** (dated 01-17-14) |
| **ATTACHMENTS:** | **Attachment A:** Clinical Supervisor Checklist (pending approval)**Attachment B:** TCM Supervisor Checklist (pending approval)**Attachment C:** Supervisor RMH Checklist (pending approval) |

1. **POLICY**

It is the policy of the Division of Child and Family Services (DCFS) to promote clear, focused, timely, and accurate documentation regarding all services provided for and to clients in order to ensure best practice in service delivery and program development endeavors and to monitor, track and analyze meaningful client outcomes and quality measures.

##### PURPOSE

The policy provides guidance and instruction with regard to documentation requirements and standards for all children’s mental health programs, both residential and non-residential. The policy discusses documentation standards for treatment and service planning, psychotherapy notes and progress notes, and minimum standards for executing the necessary forms required to support best practice and medical necessity for services provided.

1. PROCEDURES AND PRACTICE GUIDELINES
2. Introduction

Documentation in DCFS children’s mental health services is required to memorialize pertinent facts, findings and observations about a client’s psychosocial and medical history, including past and present illnesses, examinations, tests, recovery plans and goals, treatments and interventions, and outcomes. 42 CFR requires all providers of mental health services (e.g., therapy, psychiatric services, residential services, day treatment services, Targeted Case Management services, etc.) to verify that every service provided is accurately documented, signed and billed appropriately. Mental health service providers are not allowed to submit claims for reimbursement from federal programs unless the service is documented and the documentation supports medical necessity for payment reimbursement.

Comprehensive, complete and accurate documentation facilitates:

1. The ability of DCFS staff to evaluate the treatment or care coordination plan or rehabilitation plan hereinafter referred to as “the plan” and to monitor the client’s progress over time;
2. Communication and continuity of care among a wide variety of DCFS staff who are involved in the client’s care;
3. Accurate and timely claims billing, review and payment;
4. Appropriate utilization review and quality of care evaluations;
	1. Evaluation of the adequacy and appropriateness of client care;
	2. Decision making in services and interventions for improved outcomes;
	3. Collection of data to support insurance claims/ensure equitable healthcare reimbursement;
	4. Collection of data for research, studies, outcomes, and statistical analyses; and,
	5. Assisting in protecting the legal interests of the client, DCFS staff and facilities

Documentation may be located in Avatar or on hard copy forms and templates as outlined in this policy.

1. Components of the Client Record

A client record is made up of components which must be present and documented in order to support medical necessity.

The primary service components of the client record include all consents for treatment and services, Authorizations for Release of Confidential Information, the Mental Health Admission Form, assessments including the TCMA (if applicable), the CUMHA, CAFAS/PECFAS, CASII/ECSII, plans (i.e., CCP, CTP, TP, as applicable), 90 - day reviews, educational assessment (if applicable), juvenile justice assessment (if applicable), psychiatric evaluation (if applicable), psychological evaluation (if applicable), diagnosis, SED determination, transfer and/or discharge summary

* 1. Assessment

An assessment is a thorough collection of information and evaluation of the client’s history, strengths and needs, and presenting problem(s). Once the assessment data is gathered, an analysis and/or clinical impression is developed regarding how the client’s mental health issues impact life functioning and/or the type of interventions, services and supports which may be necessary to support recovery. The assessment must identify the critical strengths and needs of a client based on his/her presentation and history. An assessment is required for all DCFS children’s mental health services and is the precursor to the development of the initial plan.

Each client record may contain multiple assessments, especially in situations in which a client is receiving multi-disciplinary services such as therapy, medication management, and Targeted Case Management (TCM) for example. Frequently, the client record will include a Children’s Universal Mental Health Assessment (CUMHA) which is completed by a mental health professional at the time of admission to a DCFS program. The client record may also contain a psychiatric assessment or a psychological assessment. All assessments are used to provide additional information about the client, their current level of functioning, and their current service needs.

The Initial Assessment is to be documented in the client record before a plan is developed and needed services are identified and commenced.

Assessment updates provide a review of the presenting issues, the diagnosis (as applicable) and the client’s continuing commitment to treatment and/or services, their current recovery/resiliency goals, and the need for a specific level of care. Updated assessments and treatment plan reviews assist DCFS staff in ensuring the client’s needs are being appropriately addressed and ameliorated and as well as ensuring quality of care and best practice standards. These updated assessments are also required to justify continued medical necessity for payment reimbursement purposes as well. Assessments are to be updated as required by practice and policy in order to ensure a formal review of the client’s current clinical presentation and/or service needs. The CUMHA is to be updated every six months for clients ages 0 to 4 years who are served in DCFS Early Childhood Mental Health Programs and at least annually for all other clients. If the client presents with a CUMHA from a community provider, it may be accepted by DCFS if it is less than a year old, with supervisory approval. If the community provider’s CUMHA is more than a year old, it shall be updated by DCFS staff during the admission process.

Pursuant to Nevada Medicaid and Nevada Revised Statutes, only a Qualified Mental Health Professional (QMHP) or Mental Health Professional may assign a psychiatric diagnosis. The name and license credential, if applicable, of the person who made the diagnosis must be noted in the client record.

Assessments and reassessments occur at initial treatment planning and upon any required or necessary plan review. DCFS children’s mental health programs use a variety of assessment and screening tools such as the CUMHA, the Child and Adolescent Services Intensity Instrument (CASII), the Early Childhood Services Intensity Instrument (ECSII), the Child and Adolescent Functional Assessment Scales (CAFAS), the Preschool and Early Childhood Functional Assessment Scales (PECFAS), the Targeted Case Management Assessment (TCMA), etc. with which to assess the client’s strengths and service needs. For a complete description of the assessment process and concurrent assessment tools, including when these are reviewed, please see the DCFS Assessment Policy.

* 1. Treatment Plan / Care Coordination Plan/Rehabilitation Plan (AKA the plan)

The plan is a written individualized plan that is developed jointly with the client (if developmentally appropriate) the legally responsible person and a QMHP within the scope of their practice under state law.

The Plan is based on a comprehensive assessment and includes:

a. The strengths and needs of the client and their families (in the case of legal minors and when appropriate for an adult);

b. Intensity of Needs Determination (for treatment services);

c. Specific, measurable (observable), achievable, realistic, and time-limited goals and objectives;

d. Specific treatment, services and/or interventions including amount, scope, duration and anticipated provider(s) of the services;

e. Discharge criteria specific to each goal; and for,

f. High-risk recipients accessing services from multiple government-affiliated and/or private agencies, evidence of care coordination by those involved with the recipient’s care.

The plan must reflect what needs to happen, how service/treatment needs will be addressed and strengths used, the anticipated outcome and the timeline for achievement of the outcome with which to address the concerns of the client and/or legally responsible person as identified in the assessment. This is done by the development of measurable, attainable goals and objectives which are time limited and which provide the opportunity for the client to actively focus on the needs reflected in the assessment in a targeted and strategic manner.

The plan is a dynamic, individualized document that drives client services and gives clear direction as to the course of treatment, intervention, and/or services and programming. As the client resolves issues or new issues are identified, the plan shall be updated to reflect these changes. The plan specifies the long term recovery/resiliency goals and the short term objectives for treatment and/or services that DCFS staff, the client (if developmentally appropriate) and legally responsible person have developed together. It also lists the interventions and/or services DCFS staff will be using to assist the client in meeting their recovery/resiliency goals and objectives for recovery.

Pursuant to MSM 400, temporary but clinically necessary services do not require an alteration of the plan; however such services must be identified in a progress note. The note must indicate the necessity, amount, scope, duration and provider of the service.

The plan must also include a discharge plan which ensures continuity of care and access to needed support services upon completion of the plan. The discharge plan, including discharge criteria, is included in the initial plan and at every review. The discharge plan must identify:

a. the anticipated duration of the overall services;

b. discharge criteria;

c. required aftercare services;

d. the identified agency (ies) or Independent Provider(s) to provide the aftercare

services; and,

e. a plan for assisting the recipient in accessing these services.

A copy of the planwill be provided to the client or legally responsible person at the CFT or upon request Pursuant to NRS 433.494, the plan must be reviewed at a minimum of once every 90 days.

3. Plan Reviews

Plan reviews are required to occur at least every ninety (90) days for both residential and non-residential treatment services (NRS 433.494) and at least annually for non-WIN program TCM services (MSM 2500). TCM service plans provided by the WIN program shall be updated every 30 days. Plan reviews may occur more frequently if warranted based on the client’s progress, service needs and program protocols. Clients, when developmentally appropriate, the legally responsible person, and all other team members shall participate in plan reviews and are to be encouraged to actively participate by providing input and feedback about services and treatment, as applicable. The client’s or person’s legally responsible participation must be documented and their understanding confirmed (NRS 433.494) by a notation in the progress note or by their signatures on the plan. Plan reviews are scheduled to occur every 90 days from the date of the initial plan or more frequently if the client’s status warrants.

The review shall address whether progress made has been sufficient in achieving goals, that the intervention strategy or services are still appropriate, and that intervention or services should continue as currently authorized in the plan. For TCM services, the plan review must address whether the needed services were provided and whether these services were effective in ameliorating the client’s needs, if any services need to be reduced, increased or transitioned toward discharge and what, if any, additional services may be needed.

The occurrence of the plan review shall be documented in a progress note and in the updated or revised plan. These reviews are to be signed and dated by the DCFS staff involved, the client, the person legally responsible (NRS 433.494) and any other members of the treatment team.

1. Progress and Psychotherapy Notes

Progress and psychotherapy notes are required documentation. Each service provided to or on behalf of a client must be documented, including non-billable services. Notes must be documented not more than 72 business hours from the date of service.

Notes must be tied to the goals and objectives of the plan. The note must describe the service provided to achieve the goals on the plan and they must also describe the progress the client is making toward the identified goals and objectives of the plan, including the effectiveness of services. For therapy and rehabilitative services, the client’s progress is described in relation to the effectiveness of the plan and goals achieved. For TCM services, the quality, effectiveness and access to the needed services are evaluated and described; such an evaluation is the purpose of TCM monitoring activities.

1. Discharge Summary and Case Closing Documentation

The discharge summary must be in written format and shall include (at a minimum) the following elements:

* + 1. the last service contact with the client;
		2. the diagnosis at admission and termination/discharge;
		3. a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives, as documented in the plan;
		4. the reason for discharge;
		5. current level of functioning; and,
		6. recommendations for further treatment and referrals for aftercare services/community support services, as needed or warranted.

Pursuant to MSM 400,

“*Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge. In the case of a recipient’s transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer. The Discharge Summary is a summation of the results of the Treatment Plan, Rehabilitation Plan and the Discharge Plan”* (MSM 400).

Although TCM services are governed by MSM 2500, the same timeline standards apply to TCM program services as noted herein and pursuant to this DCFS SP-4 Documentation Policy.

Inactive cases are to be reviewed for closing not more than 45 calendar days from the date of the last client contact. If DCFS staff has determined the case is to remain open, they must consult with their supervisor with regard to this determination for approval to leave the case open and on inactive status. Inactive cases are to be reviewed by the DCFS staff in consultation with the supervisor at a minimum of every 45 calendar days thereafter and justification for keeping the case open is to be documented in the notes by the DCFS staff each time this consultation occurs. At no time may a case remain open and on inactive status for more than 90 calendar days unless reviewed, approved and justification is documented by the supervisor. DCFS supervisors will review and approve to close a case not more than 10 calendar days after the case is submitted to them for closing.

1. Documentation Standards and Guidelines

The client record is the client’s information and care is to be used in documenting client actions, statements, and ways of dressing or behaving by avoiding labels and using descriptors of what the client did or said or behavioral descriptions about their behavior. All professional opinions and judgments are to be documented as such in the client record.

1. Services may or may not include direct contact with clients. The DCFS staff that provides the service is responsible for documenting the service timely, completely and accurately in the client record pursuant to the timelines established in this policy.
2. Timeliness Standards

All services provided to the client or on behalf of a client are to be documented in the client record timely as follows:

* 1. Assessments and assessment reviews are to be documented in the client record within 10 working days of the face-to-face assessment.
	2. Treatment plans and plan reviews are to be documented in the client record within 30 days.
	3. Progress notes and psychotherapy notes are to be written within 72 business hours of the service and/or contact.
	4. Incident Reports are to be written timely pursuant to the DCFS SP-3 Incident Reporting and Management Policy. July 2013.
	5. Discharge summaries are to be written pursuant to Section III. B. 5 of this policy.
1. DCFS staff is prohibited from knowingly submitting claims or billing for services that have not been documented completely and accurately in the client record pursuant to this policy (Refer to DCFS CMH A-4 False Claims Act Policy).
2. DCFS staff that execute agency forms shall ensure the form is completed in its entirety, including dates, signatures, and narratives when indicated. Medical records staff is prohibited from filing incomplete forms in a client record. In the event a DCFS staff submits an incomplete form to medical records staff or other support staff for filing, those staff members shall timely return any incomplete forms to the DCFS staff for completion before filing them in the client record.

Supervisors are required to review the hard copy client record as part of their routine supervisory review and at case closing in order to ensure all documents and forms are legible and completed correctly (Please refer to Attachment A, B, and C of this policy for further information about supervisory review requirements).

1. Late documentation entries and documentation errors in Avatar

Pursuant to Section IV., D., 2, timeliness of documentation is required in all DCFS children’s mental health programs. Exceptions to this rule are made at the discretion of the applicable Clinical Program Manager II and shall only be allowed when DCFS staff is unable to enter documentation timely due to unforeseen circumstances such as a staff illness, office or program emergency, or family emergency which calls them unexpectedly away from their duty station. Other than unforeseen circumstances which prohibit DCFS staff’s ability to comply with the documentation timeliness rules, DCFS staff is responsible for immediately informing his or her supervisor about what has occurred to create a late entry in the client record. Supervisors are to ensure that timeliness issues in documentation is part of the performance evaluation standards for DCFS staff providing services to clients.

In the event a documentation error occurs, the DCFS staff responsible for documenting the error is also responsible for correcting the error in the client record immediately upon discovering the error. In order to correct an error, an appended note must be submitted.

1. What to Document in Progress and Psychotherapy Notes

The minimum is to be documented in a note includes:

1. reason for the contact;
2. with whom contact was made and the relationship to the client (e.g., DCFS phoned client or legally responsible person or collateral or vice versa, client in office for scheduled appointment, DCFS staff visited client or person legally responsible or service provider at home, school, work, etc.);
3. assessment of client’s current treatment needs and/or service needs;
4. relevant history and any issues of risk (if applicable) and how these are being addressed;
5. specific mental health/clinical/service interventions or services provided by DCFS staff as these relate to the goals and objectives on the plan, per type of service and scope of practice or specific services needed and referrals/linkages made;
6. client’s response to interventions and/or services;
7. unresolved issues from previous contacts, if applicable; and,
8. plans, next steps, and/or clinical decisions. If little or no progress toward recovery/resiliency goals and objectives is being made, describe the reasons for the lack of progress. Include date of next planned contact and/or next action. Indicate referrals made. Address any issues of risk and the plan to address risk to better ensure client safety.
9. How to Document Progress Notes and Psychotherapy Notes

For all services except TCM services and “X” codes, DCFS uses the “Data, Assessment, and Plan” (DAP) model of documentation for notes entered into the client record.

 The following guidelines for documenting notes using the DAP model are as follows:

1. Data is the description of the facts of the session or interaction/contact. It includes both subjective and objective information.

Subjective data includes what was said, what was expressed as his/her thoughts and observations.

Objective data includes what was observed about the client/family member/collateral contact, etc. (e.g., mood, affect, appearance, etc.)

Data also includes the general content and process of the encounter or interaction, type of service provided and activities which occurred and who was present or part of the encounter or interaction.

1. Assessment is the evaluation of the client’s needs and strengths, progress toward meeting goals and objectives on the plan. The assessment should include the DCFS staff’s understanding of the problem, the working hypothesis, the results of any testing or screening or inquiry, and the response to the plan.

For TCM services, assessment is the evaluation of client service needs and the effectiveness of the services the client is receiving pursuant to the goals on the plan.

1. Plan is what is going to happen next and addresses aspects of treatment or services which may need revision, goals and objectives which were addressed, what the DCFS staff will do next, what the client or collateral will do next, the next session or meeting time, discharge planning, etc.
2. **Quality Assurance and Quality Improvement for DCFS Documentation Standards**

Supervisorial and quality oversight and monitoring of documentation in client records is required to confirm compliance with this policy and to ensure improved child and family outcomes and well being.

* 1. Client Record Reviews
		1. Supervisors shall discuss documentation requirements with DCFS staff periodically and as individual practice needs warrant.
		2. Supervisors shall confirm that information in client records reflect each client’s current status and progress toward achieving goals and objectives by reviewing client records as required in the DCFS CMH A-3 Supervision Policy (pending approval) or more frequently when warranted to confirm client well being or for those clients who may have significant risk factors which may impact their safety, permanency or well being.
		3. Supervisors shall regularly confirm the documentation standards as set out in this policy are met by each DCFS staff. Exceptions to these standards are to be noted by the supervisor and, when necessary, corrective action plans are to be developed in collaboration with DCFS staff.
		4. Supervisors shall review, at a minimum, 15 client records every quarter to confirm conformity to practice standards (including documentation standards) and shall document each review by using the applicable Supervisor Checklist Form (Attachment A: Clinical Supervisor Checklist, Attachment B: TCM Supervisor Checklist, Attachment C: Supervisor RMH Checklist, attachments are pending approval).

Clinical supervisors are required to confirm client records are current within 30 days pursuant to MSM 400 therefore, clinical supervisors shall adopt a record review schedule to ensure compliance to MSM 400 regulations.

* + 1. Supervisors shall conduct regularly scheduled supervision meetings with DCFS staff, pursuant to DCFS CMH A-3 Supervision Policy, at which time feedback about client record reviews shall be provided; such consultation is documented by the supervisor pursuant to the DCFS CMH A-3 Supervision Policy.
		2. Supervisors will provide the necessary oversight in reviewing client records with which to ensure claims for reimbursement are not knowingly submitted by DCFS Staff until such time as services are fully documented in the client record pursuant to the DCFS CMH A-4 False Claims Act Policy.
	1. Planning and Evaluation Unit (PEU)
		1. The PEU shall develop QA protocols with which to routinely review client records and confirm documentation standards are met; these protocols shall include a review of Supervisor Checklists. These reviews are to occur on a selected sample of a variety of children’s mental health cases. The findings from these reviews are to be provided to the DCFS Administrator and Deputy Administrator on a quarterly basis or sooner, if requested.
		2. The PEU shall analyze the data from client record documentation reviews in order to identify patterns and trends and to provide consistent recommendations for improvement on a recurring basis, as determined by the DCFS Deputy Administrator and/or the DCFS Administrator.

**V. DEFINITIONS** (*Please refer to Glossary of Terms dated 01-17-14 for universal definitions*)

1. Data Assessment Plan (DAP): The documentation format which is used by all DCFS programs with the exception of Targeted Case Management (TCM) program services. The acronym is DAP and is documented in the client record as follows:

**D = Data/Describe**: observable, concrete; what was said by the child/youth/family.

**A = Assess**: the writer’s assessment of the situation, services rendered, effectiveness of the service or treatment plan, and overview analysis of the data.

**P = Plan**: the intervention (i.e., treatment plan or care coordination plan) agreed upon by the legally responsible person, the client, and the Child and Family Team.

1. Discharge Summary: Written documentation of the last service contact with the recipient (client), the diagnosis at admission and termination, and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives, as documented in the mental health Treatment and/or Rehabilitation Plan(s). The Discharge Summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment. The Discharge Summary is a summation of the results or outcomes of the Treatment Plan, Rehabilitation Plan and the Discharge Plan. (MSM 400**).**