

	DIVISION OF CHILD AND FAMILY SERVICES Children's Mental Health
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REFERENCES:	Department of Health and Human Services, Child and Family Services Division, Records Management Program; Health Insurance Portability and Accountability Act (HIPAA) 45 CFR 164.533(a); 164.524(a); 164.526(a); and 164.528(a); Nevada Revised Statutes (NRS) 433B.050, NRS 433B.070
ATTACHMENTS:	Desert Willow Treatment Center Timelines

- I. POLICY:** It is the policy of the Division of Child and Family Services Children's Mental Health Services to maintain an integrated Medical Records System. The medical record is considered the property of the organization and shall be safeguarded from unauthorized use, loss or destruction.
- II. PURPOSE:** The purpose of this policy is to establish minimum standards for initiating and maintaining a record which reflects the services provided to the patient/client.
- III. DEFINITIONS:**
- A. Accounting of Disclosures: An individual has a right to receive an account of disclosures of protected health information made by the Division of Child and Family Services (DCFS), including temporary suspension of such accounting.
 - B. Avatar Clinician Workstation: The Division's electronic medical record software that integrates the clinical tools necessary for an interdisciplinary approach to the delivery of treatment/care planning, individual and group progress notes, assessments and workflow management.
 - C. Care Coordination Plan: A written individualized plan developed jointly in a Child and Family Team that specifies the goals of providing case management to the child and actions to address the medical, social, educational and other services needed by the child including:

- Ensuring the active participation of the child (as developmentally appropriate) and family.
 - Working with the child, family and others to develop such goals and identify a course of action to respond to the assessed needs of the child.
- D. Child and Adolescent Functional Assessment Scale (CAFAS): This tool, administered to children and adolescents ages 6 through 18, assesses the degree of functional impairment in children and adolescents who have or are at risk for emotional, behavioral, substance abuse, psychiatric or psychological problems that are disruptive to his or her daily functioning in the following domains: Home, School/Work, Community, Behavior Toward Others, Moods/Emotions, Self-harmful Behavior, Substance Use and Thinking as well as Caregiver Resources.
- E. Child and Adolescent Service Intensity Instrument (CASII): This tool, administered to children and adolescents ages 6 through 18 years old, measures the child and adolescent functioning in the following dimensions: Risk of Harm, Functional Status, Co-morbidity, Environmental Stress, Environmental Support, Resiliency, Treatment Acceptance and Engagement (Parent Acceptance and Child Acceptance). The final composite score reflects level of care determination used for level of care service recommendations.
- F. Children’s Medical Records: These records document the medical services provided by Division facilities (See NRS 433B.070) to eligible children (See NRS Chapter 433B).
- G. Children’s Uniform Mental Health Assessment (CUMHA): A widely-accepted (throughout the Division and among community partner agencies and entities) clinical assessment tool that results in documentation of the patient/client strengths; the presenting mental health problems and mental status; emotional, cognitive, family, recreational, environmental and cultural functioning; and developmental, medical, and legal history. This comprehensive assessment is conducted through an interview with the child, family and other relevant persons; a review of previous treatment records; observation and clinical judgment. It includes a DSM or DC: 0-3 diagnosis on all axes and assessment of a functional impairment in daily living. It determines the intensity of needs.
- H. Client: Pursuant to NRS 433B.050 client means a child who seeks, on his own or another’s initiative, and can benefit from care and treatment provided by the Division.
- I. DCFS or Division: Refers to the Division of Child and Family Services.
- J. Diagnostics Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Manual (DC:0-3): The latest text revision of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood published by the Zero to Three Press, National Center for Infants Toddlers and Families.

- K. Diagnostic and Statistical Manual of Mental Disorders (DSM): The latest text revision of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
- L. DC: 0-3 Diagnosis: The determination of a mental or emotional disorder for a child birth through 48 months of age as described in the latest text version of the manual for Diagnostic Classification: 0 – 3 published by the Zero to Three Press, National Center for Infants Toddlers and Families. The principle Axis I diagnosis of the Axis II PIR-GAS score of 40 or less provides the clinical basis for treatment and must be reassessed every 6 months for children under age 4. The DC: 0- 3 diagnosis may be used in place of the DSM Axis I diagnosis to determine eligibility for and provide mental health services to recipients under 4 years of age.
- M. DSM Diagnosis: The determination of a recipient’s mental or emotional disorders as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The principal Axis I diagnosis provides the clinical basis for treatment and must be reassessed at least annually for recipients under age 18. It is determined through the mental health assessments and any examinations, tests, procedures, or consultations suggested by the assessment; and is entered on a written individualized Treatment Plan.
- N. Discharge Plan: A written component of the Treatment Plan and/or Rehabilitation Plan which ensures continuity of care and access to needed support services upon completion of the Treatment Plan and/or Rehabilitation Plan goals and objectives. The plan must identify the anticipated duration of services, discharge criteria, required aftercare services, identified agencies to provide aftercare services and a plan for assisting the client in accessing these services.
- O. Discharge Summary: Written documentation of the last service contact with the client, the diagnosis at admission and termination, 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 Treatment Plan, Rehabilitation Plan and/or Care Coordination Plan. The summary also includes the reason for discharge, current level of functioning and recommendations for further treatment and/or services.
- P. Early Childhood Service Intensity Instrument (ECSII): This instrument assists providers caring for young children in determining intensity of services need for infants, toddlers, and children from ages 0-5 years. The ECSII is targeted to children with emotional, behavioral and/or developmental needs and their families, including those who are experiencing environmental stressors that may put them at risk for such problems. The ECSII is a service planning tool and rates the child for these domains of functioning: Degree of safety, Child-Caregiver Relationships, Caregiving Environment, Functional/Developmental Status, Impact of Medical, Developmental, or Emotional/Behavioral Problems and Services Profile. The final composite score reflects level of care determination used for level of care service recommendations.
- Q. Preschool and Early Childhood Functional Assessment Scale (PECFAS): This tool administered to children ages 3 through 5 years old, measures the degree of

impairment in the child's daily functioning secondary to emotional, behavioral psychological or psychiatric problems in the following domains: School/Daycare, Home, Community, Behavior Toward Others, Moods/Emotions, Self-harmful Behavior and Thinking/Communication.

- R. Severe Emotional Disturbance (SED): The determination made by a Qualified Mental Health Professional within the scope of their practice and further defined as:
- Persons from birth through 48 months who currently or at any time during the past year (continuous 12-month period) have a: 1. DC 0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or 2. DC: 0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or
 - Persons from 4 to age 18 who currently or at any time during the past year (continuous 12-month period) have a: 1. Diagnosable mental or behavioral disorder or diagnostic criteria that meets the coding and definition criteria specified in the DSM (excluding substance use disorders or addictive disorders, irreversible dementias, mental retardation, developmental disorders, and V codes, unless they co-occur with a serious mental disorder that meets DSM criteria); and have a 2. Functional impairment which substantially interferes with or limits the child from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent, and persistent features are included, however, may vary in terms of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefits of treatment or other support services are included in this definition.
- S. Strengths, Needs, and Culture Discovery: Guided by specific questions, the Discovery includes a description of child/family needs and care coordination recommendations in the following domains: social life, emotional life, medical life, educational life and other domain.
- T. Targeted Case Management Assessment: Includes the following elements: family demographics, family strengths, social life domain, emotional life domain, medical life domain, educational life domain, other domain to include child/family resources and needs in any other areas not previously addressed; summary to include child/family preferences for outcome of services.
- U. Treatment Plan: A written individualized plan developed jointly with the client and their parent/guardian/legal custodian that prescribes the specific treatment services and/or interventions including amount, scope, duration, anticipated providers of the services and discharge criteria.
- IV. PROCEDURES:** The Medical Records System is designed to provide access to all past and current information regarding the mental and health status of each patient/client and to maintain safeguards to preserve confidentiality and to protect the rights of patients/clients in accordance with applicable federal and state laws. The system includes the Avatar Clinician's Workstation and a paper-based medical record.

- A. The general content of a child's medical record follows:
1. Record will contain appropriate patient/client identification data.
 2. Record will contain a signed Division of Child and Family Services Notice of Privacy Practices.
 3. Record will contain a signed DCFS Freedom of Choice and Consent to Provide Targeted Case Management Services for Children Medicaid Eligible OR a signed DCFS Freedom of Choice and Consent to Provide Targeted Case Management Services for Children Not Medicaid Eligible if targeted case management services are provided.
 4. Record will contain a signed DCFS Client's Rights and Consent to Treatment.
 5. Record will contain a signed DCFS Client Statement of Understanding Regarding Automated Information.
 6. Record will contain a signed DCFS Notice to Patients Regarding the Destruction of Health Care Records.
 7. Record will contain signed DCFS Authorization(s) for Release of Confidential Information Form.
 8. Record will contain a concise statement that describes the reason for admission.
 9. Record will contain an admission diagnosis and Severely Emotionally Disturbed (SED) determination or non-SED determination. All diagnoses will be written in the terminology of the Diagnostic and Statistical Manual of Mental Disorders, current edition or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, current edition.
 10. Record will contain a Children's Uniform Mental Health Assessment (CUMHA), an Individualized Treatment Plan, and a Discharge Plan.
 11. Record will contain a Child and Adolescent Functional Assessment Scale (CAFAS), and a Child and Adolescent Service Intensity Instrument (CASII) for children ages 6 through 18.
 12. Record will contain a Preschool and Early Childhood Functional Assessment Scale (PECFAS) for children ages 3 through 5, and an Early Childhood Services Intensity Instrument (ECSII) for infants, toddlers and children ages 0-5.
 13. Record will contain all assessments and evaluations as required per program within prescribed timelines. Note: Desert Willow follows the most stringent timeline, see Attachment A.
 14. All treatment received by the patient/client will follow the Individualized Treatment Plan and/or Rehabilitation Plan and will be documented by the staff member providing the therapeutic treatment in a timely manner.
 15. When the parent/guardian requests case management services, the record will contain a Targeted Case Management Assessment and a Care Coordination Plan.
 16. When the client/family is involved with Wraparound in Nevada or receiving targeted case management services from a psychiatric caseworker in Early Childhood Mental Health Services, Children's Clinical Services or Outpatient Services, the record will also contain a Strengths, Needs and Culture Discovery and a Care Coordination Plan.
 17. All staff members involved with the therapeutic treatment and delivery of services for the patient/client will be responsible for documentation of treatment modalities.
 18. Only staff appropriate to the treatment program may write or dictate entries into the patient/client medical record.

19. All diagnosis, treatment and discharge plan changes will be documented in the Individualized Treatment Plan; and, in the case of Desert Willow, the Weekly Treatment Plan Review.
20. Record will contain a Discharge Summary.
21. Record will contain the Accounting of Disclosures of patient/client protected health information.
22. Record will contain documentation of any restrictions or denials of access, and amendments to the patient/client protected health information.

B. Medical Record Flow:

1. Information from patient/client records will be provided to intra-agency departments upon request in a timely manner to provide continuity of care. Every effort will be made to obtain a release from the child's caregiver/legal custodian prior to intra-agency release.
2. Records will be indexed in the Patient/Client Database, according to the patient's name and final diagnosis, to facilitate retrieval for research or administrative purposes.
3. The medical record for Desert Willow patients will be completed within 15 days of the patient's discharge. The Medical Record for Outpatient and Early Childhood clients will be completed within 30 days following a planned discharge and 45 days following an unplanned discharge.

C. Reviews:

1. Clinical staff members; specifically, supervisors and managers, will conduct regular supervisory reviews of direct service and targeted case management activities and documentation contained in both the electronic and paper-based medical record. These reviews will be quantitative and qualitative to assure treatment provision follows Nevada statutory requirements, Division policies and Medicaid requirements in addition to ensuring optimum client care, treatment and safety.

C. Retention of Medical Records:

1. The medical record shall be maintained as required by law, in accordance with Federal Regulations and Nevada State Statutes (Refer to Patient/Client Records Retention and Disposition Schedule Policy).