Rehab Option Documentation Standards

INTRODUCTION:

The Department of Mental Health (DMH) monitors the following Medical Record Standards for Rehab Option Certification:

- Medical Records
- Assessments
- Determination of Medical Necessity (Clinical Formulation-Interpretive Summary)
- Treatment Plans (Community Service Plan)
- Monthly Notes
- Periodic Reviews
- Transition Plans

The following document identifies the Department of Mental Health Medical Record Standards and indicators for Adult Community Clinical Services (ACCS) and state operated programs providing rehabilitative services and participating in Rehab Option. Additionally, this document provides specific direction to provide further clarification of the indicator.

STANDARD 1: Medical Records

Indicator 1.1
An individual record is created and maintained for each person.

A consolidated, integrated record contains all documentation provided directly by the provider or if applicable the subcontractor. Subcontractor implements the contractor's record keeping system including policies and procedures. For Persons receiving services in a GLE, SIE or Intensive GLE, and where paper records are used the record must be located at the housing setting where the Person is located.

- When creating and maintaining the consolidated medical record ACCS providers are not required to use the Massachusetts Standardized Documentation Project (MSDP) forms. For providers who choose to continue utilizing the MSDP Form set, forms must be modified to include new ACCS requirements.

The medical record will not pass if it is determined that it has not been created or if fraudulent record keeping is evident

Indicator 1.2

Information in the record is logically organized, and consistent with the agency's established protocols.

Records follow a prescribed format:

- Each record (paper) contains a table of contents and the information is filed accordingly. Electronic Health Records (EHR) is not required to have a table of contents but should list titles of documents.
- Records follow a standardized format consistent in all of the providers' service locations.
- For paper documentation correction fluid/tape is not used to make corrections. Proper error correction is for the author to draw a single line through the error in ink and the author should initial and date the entry.
- One year of Community Service Plan documentation is in the record or readily accessible in the EHR. The Initial Comprehensive Assessment must remain in the record and/or be accessible with updates noted and/or available for review and include access to the previous year's Community Service Plan.

Indicator 1.3

The confidentiality of medical records is maintained in accordance with DMH regulations 104 CMR 28.09(1)(a)(b) and all other applicable state and federal laws and regulatory requirements as evidenced by agency's policies and practices.

The agency must have policies and procedures to protect the confidentiality of medical records to include an electronic health record. These policies and procedures must be consistent with DMH Regulations 104 CMR 28.09 to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations.

Medical records (paper) must be in a secure (locked) location.

STANDARD 2: Assessments (Comprehensive Assessment)

Indicator 2.1

A mental health, physical, and psychosocial assessment is written or updated prior to the development of the Community Service Plan. The assessment(s) create a baseline profile of the individual's mental and physical health, and a psychosocial history.

A Comprehensive Assessment (CA) including mental health, physical and psychosocial assessment information, is written within forty-five (45) calendar days of enrollment, or there is a documented clinical rationale that outlines the reason why the (CA) not developed within the 45 day timeline. If further assessment is needed beyond the 45 days, the Community Service Plan must

identify engagement strategies and timelines for completion of the CA and other needed assessments. The (CA) is updated at least annually thereafter and as needs change or significant events have occurred.

Indicator 2.2
The Comprehensive Assessment (CA) is signed, dated and credentialed by the Licensed Practitioner of the Healing Arts (LPHA).

The licensed clinical staff members oversee the collection of information needed for the assessment, meet face to face with the Person and are responsible for developing the Clinical Formulation-Interpretive Summary.

The medical record will not pass if the CA is not signed and credentialed by the LPHA.

Indicator 2.3
A Mental Status Exam (MSE) is completed and signed by a Licensed Practitioner of the Healing Arts.

The signature on the MSE must include the licensure. If the signature and/or licensure are not legible, they should be printed or typed below the hand-written signature.

Indicator 2.4
A Mental Status Exam includes:

- **Cognitive and Psychological Functioning including thought process, judgment and orientation to person, place and time;**
- **A profile of the client's affect and behavior;**
- **Risk factors.**

Providers may choose to use the MSDP form set for the MSE or utilize a document that meets the criteria for this indicator.
If additional risk assessment is indicated, the provider must continue with further assessment as required and be available for review.

Indicator 2.5
The assessment includes the diagnosis in Diagnostic Service Manual (DSM) terms and a history of treatment.

The diagnosis should be expressed as an axial diagnosis, as indicated in the most current version of the DSM diagnosis and code.

History of treatment as well as the symptomatology characterizing the illness must be included.

Indicator: 2.6

The assessment includes documentation of need for psychotropic and/or other medications and identifies the level of independence or assistance required to manage medication administration.

List current medications prescribed; dosages, frequency, and the purpose for which the medication is being taken. If there is no involvement in medication administration and/or person served refuses to disclose medication information, documentation noting such should be in the record.

Indicator 2.7

The assessment includes physical health status, including physical and dental examinations conducted annually, and other evaluations, as appropriate, of the individual's medical and dental condition.

In the event that a physical and/or dental exam does not appear in the record, there is documentation which explains why an annual physical and/or dental exam is not present. The documentation must be signed by the person served or his/her Legally Authorized Representative (LAR).

Indicator 2.8

The assessment includes social and environmental support, including: an evaluation of the Person's community, family and key support person(s) in his/her life.

Social supports include an evaluation of the individual's family history of mental health, substance use, developmental issues, sexual history/concerns, key supports and the extent of involvement. This section may include pertinent psychiatric history for the Person.

Environmental supports include an evaluation of community integration, recreation and leisure activities. Meaningful activities should be noted but the frequency of activity not required.

Indicator 2.9

The assessment includes cultural and ethnic factors, including the Person's evaluation of his/her religious, racial and cultural context.

Record cultural, ethnic and religious/spirituality factors considered important to the Person/or family and those that are pertinent to mental health and/or substance use treatment and support needs. Identify issues necessary to provide culturally competent treatment and support to the Person. Also note any relevant issues relating to immigrant status or assimilation into American culture.

If interpretive services are indicated to complete assessment for the active participation of the Person served, these services are arranged. The delivery of interpretive services to complete the assessment is documented.

Indicator 2.10

The assessment includes language and communication skills, including the Person's ability to hear, understand and use the English language, as well as an assessment of the individual's ability to communicate and make his/her needs known in their preferred language.

If interpretive services are indicated to complete assessment for the active participation of the Person served, these services are arranged. The delivery of interpretive services to complete the assessment is documented.

Indicator 2.11

The assessment includes: educational background, including: a history or evaluation, as appropriate, of the Person's educational background or schooling and current educational plan, if any.

Identify barriers to learning, history of learning difficulties, educational interests/skills and the person's preferred learning style.

If additional assessment is indicated, it should be documented in the assessment and available for review.

Indicator 2.12

The assessment includes a history or evaluation of the Person's vocational or occupational readiness skills and interests, and employment record.

If additional assessment is indicated, it should be documented in the assessment and available for review.

Indicator 2.13

The assessment includes an evaluation of daily living skills (ADL's) and identifies the level of independence or assistance required to manage the following areas through the use of the Arizona Self Sufficiency Matrix:

- Money management (including budgeting)
- Personal care skills
- Self-preservation
- Grocery shopping/food preparation
- Housekeeping/laundry skills
- Transportation skills
- Exercise
- Problem Solving
- Time Management

Indicator 2.14

The assessment includes identification of the Legally Authorized Representative (LAR), scope of authority, name and location of the

representative payee, terms of trusts, factors that suggest the continued need or cessation for protective services.

Factors that suggest the need for protective services refer to those contributing characteristics that preclude the Person from making his/her own informed decisions. Characteristics include a behavior or group of behaviors that indicate impaired judgment or functioning, which resulted in the court rendering that person incapable of making informed decisions or there is documentation to support a recommendation that protective services is no longer necessary, if applicable.

Information regarding any legal/court involvement or forensic issues should also be noted.

If additional assessment is indicated, it should be documented in the assessment and available for further review.

Indicator 2.15
The assessment includes resource availability, including financial resources and health insurance for Person's served.

Identify the resources available to the Person served including BH CP if appropriate. Financial information should also include income if applicable and the types of medical insurance the individual receives.

Indicator 2.16
The assessment includes the Person's preferences, interests, and aspirations.

Describe the personal qualities including strengths/capabilities, as identified by the Person that can be put into service toward achievement of goals. This is an opportunity to paint a picture of the Person and begin to identify and incorporate his/her strengths.

Indicator 2.17
The assessment includes the involvement of outside agencies including identifying public and private agencies that are part of the Person's integrated service system in which the Person has contact and the extent of that contact.

Outside agencies refer to those agencies that are external to ACCS. This section may also include services within the agency that the Person is receiving.

DMH Case Management and Behavioral Health Community Partners (BH CP) should be noted as a service if applicable.

Indicator 2.18

The assessment includes prioritized assessed needs which are either active, Person declined, deferred or referred out for services.

Deferral, referred out and declined statements and rationale are required for all need areas identified in the assessment that will not be addressed in the Community Service Plan. This is only required for the prioritized need areas.

Indicator 2.19

The assessment includes a Clinical Formulation-Interpretive Summary as the determination of medical necessity.

Include an analysis and assessment of information provided within the comprehensive assessment and the opinions of the LPHA and preferences of the Person, LAR and significant other(s)

The LPHA does not necessarily determine the diagnosis however there must be a documented diagnosis in the assessment to develop the clinical formulation. The LPHA uses the information available in the CA and the Person's preferences to develop the clinical formulation to attest to its accuracy to determine medical necessity for rehabilitative services. Medical necessity is defined as "the type, intensity and duration of any intervention as provided by a qualified practitioner and ordered by a qualified practitioner in the current action plan as needed to prevent worsening and/or produce improvement of symptoms, behaviors and/or functioning level related to an approved diagnosis and assessed needs."
A new Clinical Formulation-Interpretive Summary must be completed at initial assessment, annually or when new needs are identified that were not previously assessed and that will be addressed on a revised Community Service Plan.

The medical record will not pass if a Clinical Formulation-Interpretive Summary is not present, signed and credentialed.

STANDARD 3: Community Service Plan

Indicator 3.1

A Community Service Plan is developed within forty-five (45) calendar days of the Person's initial enrollment into ACCS services, or there is clinical rationale that outlines the reasons why the plan was not developed within the forty-five (45) day timeline.

A written Community Service Plan is developed by using information gathered through assessments, including the Clinical Formulation-Interpretive Summary. The Community Service Plan is the well-integrated, person-centered strategy used to measure and track delivery of services. The Community Service Plan ensures that services are well defined and focused; services are delivered with the appropriate intensity and relevancy that meet the needs of the Person. The Community Service Plan reflects the preferences, needs and cultural considerations of the Person.

Developing a Community Service Plan is a collaborative effort with the Person, licensed clinical staff and team members and including family members or other persons of their choice.

The medical record will not pass if the Community Service Plan is not present signed and credentialed by the LPHA.

Indicator 3.2

A Community Service Plan is based on the findings and recommendations of the Comprehensive Assessment including the Clinical Formulation-Interpretive Summary

Goals, objectives and interventions of the Community Service Plan reflect the Clinical Formulation/Interpretive Summary and the Prioritized Assessed Needs section of the Comprehensive Assessment. If further assessment is needed the Community Service Plan must identify strategies and timelines for completion of additional assessments.

Indicator 3.3

Transition criteria are developed at the time of the Person's initial Community Service Plan, reviewed regularly and modified as necessary.

Criteria for successful completion of ACCS and transition to other behavioral health services, including those provided by DMH must be identified at the time of the Person's initial Community Service Plan and are reviewed regularly and modified as necessary. For Persons residing in supervised GLE's, SIE's or Intensive GLE's, Community Service Plans must identify criteria for transitions to more independent housing types, and include barriers that need to be addressed and anticipated lengths of stay.

Indicator 3.4

For Persons receiving DMH Case Management services, there is evidence that the DMH Case Manager is included in the planning activities and a copy of the Person's Community Service Plan and modifications thereto are submitted to the case manager as required in 104 CMR 29.11(2)(d).

DMH Case Manager's signature is present on the Community Service Plan (as determined by the agency) and /or there is documentation noting participation/ contact type.

If the person does not have a DMH Case Manager a copy of the Community Service Plan will be forwarded to DMH upon request.

Indicator 3.5

The Community Service Plan is compatible with the Person's Individual Service Plan (ISP) as required in 104 CMR 29.11.

The medical record and/or EHR should include a copy of the ISP, if applicable.

If there is a discrepancy between the ISP and chosen Community Service Plan goals and/or objectives, documentation noting a dialogue with the DMH Case Manager is documented in the record, including the outcome resolution.

Indicator 3.6
The Community Service Plan includes a baseline level of functioning and skills.

Describe the Person's strengths, skills, abilities and resources related to the identified need areas. (Strengths include those people, places, and things that the Person has available to help them achieve their goal).

Describe significant issues and potential obstacles that (may) impede attainment of identified need areas addressed within the context of the Community Service Plan.

Indicator 3.7
The Community Service Plan includes goal(s) which are person centered, and are directed toward need resolution and may include target date(s) for completion.

A goal identifies a desired outcome that results from the rehabilitation plan. Goals are long term, global and broadly stated which may reflect life changes as a result of services. They are written in positive terms and are expressed in the Person's own words that document his or her desired outcomes.

A goal identifies a desired outcome that is based on an assessed need in the CA or on a Person's broadly expressed hopes and aspirations. If the Person and provider agree on a realistic target date for completion and/or the Person chooses a specific target date for completion, it should be noted on the Community Service Plan. If the goal is broadly stated and not conducive to a specific target date for completion, it is not necessary to document the target date for completion on the Community Service Plan.

Indicator 3.8
The Community Service Plan includes objectives expressed in behavioral and measurable terms that are directed toward need resolution and include target date(s) for completion.

Smaller steps are necessary to structure the rehabilitation process. Objectives are the sequential, interim points along a continuum of progress toward the desired goal. Smaller steps enhance the Person's commitment to the rehabilitation process because they make the outcome appear more manageable.

Objectives are specific, measurable/concrete, attainable/achievable, realistic and time-framed. (SMART)

S= Specific
M= Measureable/Concrete
A= Attainable/achievable
R= Realistic
T= Time-Framed

The medical record will not pass if projected target dates for completion are not noted or are outdated and not documented in the periodic review.

Indicator 3.9
The Community Service Plan includes rehabilitative interventions used to teach the skills needed to achieve the rehabilitation goals and objectives.

Interventions are skill teaching and/or engagement strategies including support used to facilitate the achievement of the rehabilitation goals and objectives. The intervention(s) and rehab strategies chosen take into consideration the Person's strengths/needs/barriers. Interventions are the methods used to facilitate accomplishment of the objectives. They include: who will be involved in the process of assisting the Person; what activities will be performed; what assistance will be provided; and duration/frequency of the activity.

The medical record will not pass if interventions in the Community Service Plan only demonstrate support and supervision and lacks rehab.

Indicator 3.10
The Community Service Plan includes the staff person currently responsible for implementing and/or overseeing the implementation of each action step or intervention.

There may be instances when more than one person is involved with implementing the treatment plan (e.g. specialty staff, peer worker). Each intervention of the Community Service Plan should include the functional title(s) of the responsible staff implementing the interventions within the plan, what they will do, and how often. At times, where interventions are being implemented by a number of different staff, "ACCS staff" may be used.

Indicator 3.11
The Person served, LAR, significant other(s) and multidisciplinary team, as indicated by the person (i.e. relatives, friends, advocates, service providers, staff, etc.) were involved in the development and/or implementation of the Community Service Plan as evidenced by team participants being listed on the Community Service Plan document.

The Person served and/or LAR signatures indicates acceptance of the Community Service Plan and /or there is documentation in the monthly note documenting the reason for lack of signature(s).

The medical record will not pass if there is not an LPHA signature and credentials on the Community Service Plan.

STANDARD 4: Monthly Progress Notes

Indicator 4.1

Monthly progress notes are completed and entered into the record within 10 business days of the following month. Monthly notes are used to inform the treatment planning process and document progress and/or barriers towards achievement of goals and objectives.

Monthly progress notes replace the Service Notes that were previously required to meet Rehab Option requirements. Providers can utilize the MSDP Monthly Progress Note Summary but not required. Providers must have policies and procedures addressing record documentation identifying how information is gathered and documented during the month about interventions to inform the preparation of monthly notes and Rehab Option claiming.

Monthly progress notes continue to occur on a monthly base, including when the Periodic Review falls within that month.

Indicator 4.2

Monthly progress notes include significant events in the person's life that may have affected his/her progress in meeting rehabilitation goals. Progress notes should include an overview of significant events experienced by the Person over the past month. They should also include events effecting the Person's day to day living and functioning.

Significant life events that may impact the implementation of interventions should be documented in the monthly progress note. This may require a revision to the CA and the Community Service Plan if a new need is identified as an outcome to a significant event.

Other agency/community supports and resources supporting the Community Service Plan should be included into the monthly progress note as applicable.

In addition to noting monthly progress relative to goals and objectives, progress notes should include an overview of all significant events that have occurred during the month (e.g. birthday, changes, such as; day program or other service, room-mate/house mates, staff, financial status, etc.); significant events may effect progress toward Community Service Plan goals.

Indicator 4.3
Monthly progress notes include a description of the Person's response to implementation of the Community Service Plan.

Monthly progress notes document the Person's skills and functioning demonstrated in meeting the Community Service Plan goals and objectives as reported by the Person or by others who have observed or interacted with the Person.

Indicator 4.4
Monthly progress notes are signed, dated and titled by the person responsible for ensuring the implementation of the Community Service Plan or designee.

Monthly progress notes are signed and dated within 10 business days of the following month.

STANDARD 5: Periodic Review

Indicator 5.1
For Person's served, the progress and current status in meeting the goals set forth in the Community Service Plan are reviewed at 3 months, 6 months, 12 months and annually thereafter and as needs or circumstances change including during key times of care transitions.

Indicator 5.2
If the need for additional assessments is identified during the implementation of the Community Service Plan, the assessment is provided and timely arrangements are made to procure the assessment(s).

Indicator 5.3
The Person served and/or LAR participated in the Community Service Plan review, as evidenced by their signature, or there is an explanation for the lack of a signature.

Every effort is made to schedule the Community Service Plan review at a time that is convenient for the Person served, LAR, significant other(s) and if applicable other treatment providers responsible for the integrated treatment plan. In the event that the Person and/or LAR are unable to attend, an evaluation of progress must occur at prescribed timelines and the reason why the person was unable to attend is documented in the record.

When significant changes are made to the Community Service Plan, revisions are reviewed with the Person and/or LAR and accepted in writing prior to implementation. In the event that the Person and/or LAR are unable to accept, the record must include documentation as to the reason the person and/or LAR has not signed the revised Community Service Plan.

Indicator 5.4

The Community Service Plan review contains an evaluation of the Person's progress toward attaining stated goals and objectives.

Evaluations should include an overview of the Person's progress throughout the review period, as well as insights staffs have regarding the Person's response to implementation of specific Community Service Plan interventions. The description of progress is a quantitative and qualitative description of the result of the intervention(s) (i.e. the Person's progress or lack of progress made relative to the goals and objectives).

Indicator 5.5

When the objectives are not met, there is an analysis of the clinical, social, familial and/or reasons for lack of delay in progress.

In the event that the Person does not meet stated Community Service Plan objectives, documentation should include the specific reasons why progress was not made. This analysis should be considered when the team meets to assess the efficacy of current Community Service Plan goals, objectives, interventions and actions to be taken.

Indicator 5.6

The Person's goals and objectives, related target dates for achievement and rehabilitative interventions are revised in the Community Service Plan according to the findings of the review.

Indicator 5.7

The names and titles of the participants are included in the Community Service Plan periodic review.

The names and titles of other agencies/community supports and resources supporting the Community Service Plan are included in the review. The LPHA must sign document and include credentials.

Indicator 5.8

In cases where the Person has an LAR, and there are substantive Community Service Plan modifications which may or may not require a new Clinical Formulation- Interpretive Summary, the LAR has signed the revised Community Service Plan.

Indicator 5.9

For Person's receiving DMH Case Management and/or BH CP services, there is evidence that the DMH Case Manager/BH CP Coordinator is included in the Community Service Plan review process.

The DMH case manager and BH CP Coordinator are considered part of the individual's multidisciplinary team and should be noted.

STANDARD 6: Transition Plan (Previously known as Discharge Summary)

Indicator 6.1

The closed record contains a signed and dated Transition Plan and is entered into the record within thirty (30) days of the person's disenrollment from ACCS.

A copy of the approved plan is shared with the Person, the Care Coordination Entity and other appropriate services providers.

Indicator 6.2

The Transition Plan includes the course of progress related to the goals identified in the Community Service Plan.

A Transition Plan, at minimum, must address the reason for transition, identify options for services and include a list of follow up appointments with DMH and non DMH services, as well as any recommended community services. Contact information for DMH and non DMH services must be specified. Any aftercare services the current provider will be providing with frequency and timelines is noted. Demonstrates DMH and Care Coordination Entity were involved in the Transition Plan.

Indicator 6.3

The Transition Plan and disenrollment date are approved by the Area Director or designee.

At no time shall a person who is currently or at immediate risk for homelessness be transitioned until such time that a Transition Plan is developed that addresses the Person's housing need.