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| **Policy Name:**  | **Client Records – Documentation and Quality Management**  | **Date Revised:**  | **2/2020** |
| **Purpose:** | **Protocol for current, accurate and quality clinical documentation**  | **Board Approval:** |  |

**Policy:**

Greater New Beginnings is committed to maintaining systems that ensure all required documentation for each client is current, accurate, and exceed all regulatory standards that govern each source of funding.

**Procedure:**

1. Upon entry into Greater New Beginnings, the Operations Manager or QA Compliance shall assemble the client record. This record is labeled with a name label that includes the child’s name, date of birth and placing agency. A child’s record shall include the following:
	1. An admission statement
	2. Mental health assessment
	3. A needs and services/ client treatment plan;
	4. Progress notes;
	5. Written informed consent for prescribed psychotropic medication, pursuant to applicable law;
	6. A copy of any court orders or judgments regarding physical or legal custody of the child, conservatorship or guardianship of the child, the child’s probation, or establishing the child is a ward or dependent of the court;
	7. Documentation indicating each date and name(s) of individuals or groups of individuals who have participated in the development of the Client Treatment Plan and the transition determination: the child, parent, guardian, conservator, tribal representative, child and family team, and/or person identified by the court to participate in the decision to place the child in the short-term residential therapeutic program.
	8. A transition determination plan
	9. Progress notes
	10. Clinical review reports
2. Documentation in each client clinical record shall be sufficient in detail, in wording, diagnosis and procedure coding, to support the billing of services provided.
	1. Services provided shall be documented either during the service, or within 24 hours of service delivery. Documentation shall be fully completed in the County’s Electronic Health Record (EHR), Clinician’s Gateway, no later than five business days after service is provided.
	2. All documentation shall be legible to someone not familiar with the author’s handwriting.
	3. At a minimum, Progress Notes shall include:
		1. Date of service
		2. Date of documentation if different than date of service
		3. Type of service provided
		4. Amount of service (minutes) provided
		5. Medical and/or Service Necessity of service provided (not an Alcohol and Drug Abuse requirement)
		6. Relationship of service provided to treatment goals
		7. Signature (legible) including job classification and license (if applicable) as it relates to job classification
		8. Client’s response to intervention
	4. At a minimum, Care Plans shall include:
		1. Date of plan
		2. Type, frequency, amount, and duration of planned services
		3. Short and long term goals/objectives
		4. Diagnosis or problem statement to support included diagnosis
		5. Signatures - Required signatures may vary depending on requirements of 3rd party payors or regulations, for example Medi-Cal requires a Licensed Mental Health Professional (LMHP), Medicare requires a Medical Doctor’s (MD) signature. Providers shall consult with their supervisor if unsure of requirements.
3. Quality Clinical Documentation Oversight
	1. Charts will be reviewed to assess quality or clinical care and compliance with documentation standards at the following times:
		1. Clients who have been enrolled over 30 and less than 60 days.
		2. Clients with a treatment plan and/or assessment due per their cycle (every 6 months).
		3. Clients who did not pass URC in the previous month (aka returned charts).
		4. Clients who have been discharged within the previous 30 days.
	2. During the Utilization Review, clinicians and super visors from the program will review the chart for:
		1. Quality of Care
		2. Appropriate treatment "dosage" given presented needs
		3. Progress towards discharge
		4. Medical Necessity for services
		5. Compliance with clinical documentation requirements (federal, state, county)
	3. Any charts determined to require corrections to meet compliance standards are sent back to the clinician for updates and requested to return the following month to confirm corrections were made appropriately and that the chart is in full compliance.
	4. Any chart determined to not meet clinical justification for services is referred to the Executive Director/Administrator and Head of Service (HOS) for discussion of case closure.