COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Medical Records Documentation Requirements

Direct Service Staff Expectations: It is expected that the below standards, as specified in the Medical Records Manual, will be adhered to by staff providing direct care to consumers of CMHOC.

1. Supports and services must be based on comprehensive clinical assessments. This includes Psychosocial, Nursing, Psychiatric, Residential, Functional Behavioral, or any other relevant clinical assessments. The assessments must be available in the record within 7 calendar days of the face to face meeting.
2. Consumers must meet criteria for various levels of care both at the time supports and services are initiated, and on an ongoing basis. If at any time it is determined that a consumer is receiving services without meeting clinical criteria, they are considered unauthorized and services must be discontinued.
3. Supports and services must be provided under the direction of an approved Individual Plan of Service developed utilizing the principles of person centered planning. Any non-crisis supports and services provided that are not part of a Plan are considered unauthorized and must be discontinued. The initial Plan must be available in the record within 30 days of the original admission. If additional services are required, with the exception of crisis care, the Plan must be updated prior to the supports and services being provided.
4. The Individual Plan of Service automatically expires 365 days following its development (if an earlier expiration date is not documented in light of the consumer's request or need). Prior to expiration, a new Plan must be developed if services and supports are to be continued and must be based upon updated assessments. In rare instances and with supervisory approval, plans may be extended up to 30 days beyond its expiration date based on consumer request.
5. Plan updates must be completed according to the schedule in the Master Plan of Service and must be in the clinical record within 7 calendar days of each review date. If consumer circumstances prevent timely updates it must be clearly documented in the clinical record.
6. All supports and services provided in a face to face contact with the consumer require appropriate documentation. The documentation must be available in the medical record within 1 working day of the contact.
7. All other supports and services provided on behalf of a consumer must be documented in the clinical record, if considered clinically significant, within 1 working day of the activity.
8. Progress notes must clearly address desired outcomes, as described in the Plan, as well as the response to the intervention provided.
9. Employees, including contractual, are expected to make all possible corrections when the clinical record is evaluated as missing certain required components.
10. All mandatory medical records training must be completed on time.
11. It is the responsibility of each supervisor to provide or assign additional training assistance if medical records documentation is evaluated to be a performance problem.

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Updated 4.26.2019

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Signature Page

I, _____, have received a copy of the Medical Records Documentation Requirements and an orientation regarding the content of the document. I understand my responsibility to adhere to the stated requirements to the best of my ability. I also understand that repeated failure in this regard may result in disciplinary actions up to and including termination. If at any time I am having difficulty with adhering to these standards, I will seek assistance from my supervisor.

_____ _____
Employee's Signature Date

_____ _____
Supervisor's Signature Date

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