SECTION 12: DOCUMENTATION STANDARDS

The Fresno County Mental Health Plan (FCMHP) requires its providers to follow the documentation standards set by the California Department of Health Care Services (DHCS).

12.0 Assessment

The following areas are described as a part of a comprehensive patient assessment record:

- Relevant physical health conditions reported by beneficiary are prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the beneficiary's physical health and mental health status are documented, for example; living situation, daily activities, and social support.
- Documentation describes beneficiary's strength in achieving plans or goals.
- Special status situations that present a risk to beneficiary or others are prominently documented and updated as appropriate.
- Documentation includes medications that have been prescribed by FCMHP physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Beneficiary's self-report of allergies and adverse reactions to medications, or lacks of known allergies/sensitivities are clearly documented.
- A mental health history is documented, including:
- Previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant laboratory tests, and consultation reports.
- For children and adolescents, prenatal and perinatal events and a complete developmental history are documented.

- Documentation includes past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the counter drugs.

- A relevant mental status examination is documented.

- A five-axis diagnosis from the most current DSM, or diagnosis from the most current ICD, is documented, consistent with the presenting problems, history, mental status evaluation, and/or other assessment data.

12.1 Plan of Care

12.1.1 Plan of Care Contents

The beneficiary's Plan of Care must:

- State specific, observable or quantifiable goals
- Identify the proposed type(s) of intervention(s)
- State a proposed duration of intervention(s)
- Be signed by the person providing the service(s)

12.1.2 Plan of Care Standards

- Plan of Care is consistent with the diagnoses
- Focus of intervention is consistent with the plan goals
- Beneficiary's participation in and understanding of the plan is documented when feasible.

Examples of documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the plan, beneficiary's signature on the plan, or a description of the beneficiary's participation and agreement in progress notes.

- Beneficiary signature on the plan will be used as the means by which the FCMHP documents the participation of the beneficiary when the beneficiary is a long term beneficiary as defined by the FCMHP, and

the beneficiary is receiving more than one type of service from the FCMHP.

- When the beneficiary's signature is required on the plan and the beneficiary refuses or is unavailable for signature, the plan will include a written explanation of the refusal or unavailability.
- The FCMHP will give a copy of the plan to the beneficiary on request.

12.2 Progress Notes

12.2.1 Progress Notes Standards

- The client record provides timely documentation of relevant aspects of beneficiary's care.
- Providers use beneficiary's records to document encounters, including relevant clinical decisions and interventions.
- All entries in the medical record include the signature of the person providing the service, professional degree or licensure or job title, and the relevant identification number, if applicable. All entries include the date that service(s) were provided.
- The record is legible.
- The medical record documents referrals to community resources and other agencies, when appropriate.
- The medical record documents follow-up care, or, as appropriate, a discharge summary.
- The medical record documents beneficiary's progress in treatment or impediments to treatment.

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