SECTION 12: DOCUMENTATION STANDARDS

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

12.0 Client and Service Information (CSI) Changes

The State of California is required to report certain data in order to maintain Federal Block Grant funding. The required changes have been incorporated into the Assessment, Plan of Care, Reauthorization, and Progress Notes when possible. A CSI Supplement form was developed to record data that could not be added easily to existing forms and is a required component for authorization. The additional or updated fields are: Client Index Number, Trauma, Ethnicity, Race, Preferred Language, Special Populations, Client as Caregiver, Substance Abuse/Dependence, General Medical Conditions, and Global Assessment of Functioning. The CSI Supplement form is available at the end of this section.

12.1 Assessment

An assessment is a process of gathering information about a patient with the purpose of making a diagnosis. The following areas are described as a part of a comprehensive patient assessment record:

- Presenting problems affecting the beneficiary's mental health status and relevant physical health/general medical conditions are documented; for example, living situation and impairment in daily activities. The client's responsibilities as a caregiver to dependent children and adults are documented.

- Relevant general medical conditions reported by beneficiary are prominently identified 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.

- Documentation describes beneficiary's strengths and social supports in achieving plans or goals.

- Recent trauma or special status situations that present a risk to beneficiary or others are prominently documented and updated as appropriate.

- Beneficiary's self-report of allergies and adverse reactions to medications or lack 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 and review of symptoms is documented.

- A complete 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. Diagnosis should include any existing substance abuse/dependence.

12.2 Plan of Care

A Plan of Care is a treatment plan that outlines and documents the plan of treatment and proposed intervention(s). If the beneficiary's medical record does not have a valid Plan of Care, or there are services provided prior to the existence of a Plan of Care, then those services may be disallowed.

12.2.1 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) and the client or their representative.

12.2.2 Plan of Care Standards

- Plan of Care addresses the symptoms associated with the diagnosis and impairment.
- Focus of intervention is consistent with the plan goals.
- Beneficiary signature on the plan will be used as the means by which the FCMHP documents the participation of the beneficiary in development of the plan.
- If the beneficiary refuses to sign the plan of care, or is unavailable for signature, a written explanation of the refusal or unavailability will be included.

> 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.

- The FCMHP will offer a copy of the plan to the beneficiary at the time of signature.

12.3 Progress Notes

Progress Notes are used to document all client contacts while the client is in treatment. Every claim for service must be supported by a progress note or clinical documentation.

12.3.1 Progress Notes Standards

- The client record provides timely documentation of relevant aspects of beneficiary's care.
- The record is legible.
- All entries include the date of service, start and end time, and duration of services.
- Providers use beneficiary's records to document encounters, including relevant clinical decisions, interventions, and service strategies employed.
- 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.

- The medical record documents beneficiary's progress in treatment or impediments to treatment.

- The progress note includes space for updating changes in diagnosis, housing, recent trauma, general medical condition, and substance abuse.
- The medical record documents referrals to community resources and other agencies, when appropriate.

- The medical record documents client contact following missed appointments, a timely discharge summary, and any necessary follow-up care.

Section 12:

Documentation Standards

Forms and Attachments

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FRESNO COUNTY MENTAL HEALTH PLAN
Client and Service Information (CSI)—SUPPLEMENT

Consumer Name: **Social Security No.**

ETHNICITY Ask client—Are you of Hispanic or Latino Heritage?

☐ Yes ☐ No ☐ Unknown

RACE: Ask client to select the race(s) that best identifies him/her.
If "Hispanic/Latino only" select (8) Other.

☐	1	White or Caucasian	☐	M	Samoan
☐	3	Black or African American	☐	N	Asian Indian
☐	5	American Indian or Alaska Native	☐	O	Other Asian
☐	7	Filipino	☐	P	Native Hawaiian
☐	C	Chinese	☐	R	Guamanian
☐	H	Cambodian	☐	S	Mien
☐	I	Hmong	☐	T	Laotian
☐	J	Japanese	☐	V	Vietnamese
☐	K	Korean	☐	8	Other
☐	L	Other Pacific Islander	☐	9	Unknown/Not Reported

LANGUAGE: Primary – Primary language utilized by the client.
Preferred – Language which the client would prefer to receive mental health services.

Primary	Preferred	Code	Language	Primary	Preferred	Code	Language
☐	☐	0	American Sign Language (ASL)	☐	☐	H	Hmong
☐	☐	1	Spanish	☐	☐	I	Lao
☐	☐	2	Cantonese	☐	☐	J	Turkish
☐	☐	3	Japanese	☐	☐	K	Hebrew
☐	☐	4	Korean	☐	☐	L	French
☐	☐	5	Tagalog	☐	☐	M	Polish
☐	☐	6	Other Non-English	☐	☐	N	Russian
☐	☐	7	English	☐	☐	P	Portuguese
☐	☐	A	Other Sign language	☐	☐	Q	Italian
☐	☐	B	Mandarin	☐	☐	R	Arabic
☐	☐	C	Other Chinese Dialects	☐	☐	S	Samoan
☐	☐	D	Cambodian	☐	☐	T	Thai
☐	☐	E	Armenian	☐	☐	U	Farsi
☐	☐	F	Ilocano	☐	☐	V	Vietnamese
☐	☐	G	Mien	☐	☐	9	Unknown/Not Reported

SPECIAL POPULATIONS

☐ IEP (3632/26.5) ☐ CALWORKS ☐ Child Welfare (CPS) ☐ Probation ☐ Parole

☐ Healthy Families ☐ Governor's Homeless Initiative (GHI) ☐ Assisted Outpatient Treatment Services (AB 1421)

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