CBHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
COMMUNITY BEHAVIORAL HEALTH SERVICES

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POLICY/PROCEDURE REGARDING: **CBHS Medical Record Procedures for Closing Cases**

Issued By: Jo Robinson, MFT
Director of Community Behavioral Health Services

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Manual Number: 3.10-05
References:

Substantive Revision. Replaces 3.10-05 of February 19, 2009

Purpose:
This policy provides guidelines for staff on how to process case closures in an electronic health record system (EHR) and/or paper records.

Scope:
This policy applies to civil service programs and contractors who provide mental health and substance abuse services within Community Behavioral Health Services (CBHS). This policy does not apply to the Private Provider Network (PPN) with the exception of Mission Private Provider Medication Clinic.

Policy:
CBHS staff must close the case when the client terminates treatment with the program or the client is referred to other programs for services or client is deceased.
Staff must process case closures in EHR and/or paper records in an accurate and timely manner in accordance with CBHS policies and procedures pertaining to client confidentiality, data integrity, and integrity of behavioral health records.

Procedures

A. Case Closure

1. **Outpatient Services - Adult and Older Adult (AOA) System of Care, Children, Youth & Family (CYF) System of Care, and Residential Services**

   1.1. When the case is inactive for 90 days from the last service date, staff must proceed to case closure.
   Exceptions:
   - Special Programs for Youth (88116 & 88112) - case closure after 11 months of inactivity from the last service date.
   - MEDS only clients - case closure after 6 months of inactivity from the last service date.

   1.2. AOA
   a. A Closing Summary is required for clients who have received more than five services for the episode.

1.3 CYF

a. A CANS Closing Summary is required for clients whose cases have been opened for more than 30 calendar days after the completion of the Initial CANS Assessment or the most recent CANS OTR / Reassessment.

2. **Residential Services**
   a. When the client discharges from the facility, staff must close the case and complete a Closing Summary form.
   b. The residential facility is responsible for processing and maintaining closed records at the site.

3. **Substance Abuse Services**
   a. Staff must close the case if the client has not been seen for 30 days from the last face-to-face service and complete a Closing Summary form.
   b. Closed records of substance abuse programs are processed and maintained at the site.

Definition of Closing Date

The closing date is the last entry date listed in the "Crystal Client Ledger." This last entry could be a billable or non-billable service. For example, if a "NO SHOW" is listed as the last entry in the ledger, use that date of "NO SHOW" as the closing date.

The Absence of Service Report in myAvatar

The Absence of Service Report is available for staff to identify cases that have been inactive for 90 days.

Menu Path>PM>Operations Reports>Absence of Service

B. AOA staff members are required to complete the following forms in myAvatar:

a. A Closing Summary is required for clients who have received more than five services for the episode.

b. Staff must complete AOA Closing Summary form.
All items including narrative sections on the Closing Summary form must be completed. Use "NA" for items not applicable. All ANSA items must be rated according to the ANSA Manual.
Menu Path>CWS>Assessments>Assessments/ANSA>Adult/Older Adult Closing Summary

c. Staff must complete Diagnosis: "Discharge"
Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis

d. Staff must finalize the Closing Summary form.

e. Staff must complete the "Discharge (Outpatient)" to close the episode for the reporting unit.
Note: Once the episode is closed, staff should not enter any more services into myAvatar.
Menu Path>PM>Client Management>Client Information>Discharge (Outpatient)

f. A Closing Summary is **NOT** required for clients who have received five or less services. Document the disposition in the progress note.

C. CYF staff members are required to complete the following forms in myAvatar:

a. A CANS Closing Summary is required for clients whose cases have been opened for more than 30 calendar days after the completion of the Initial CANS Assessment or

the most recent CANS OTR / Reassessment.

b. Staff must complete the CANS CYF Closing Summary form in myAvatar.
   All items including narrative sections on the Closing Summary form must be completed. Use "NA" for items not applicable. All items with check boxes including "0, 1, 2, 3" are to be scored according to the San Francisco Comprehensive CANS Scoring Manual.
   Menu Path>CWS>Assessments>User Defined Assessments>CANS CYF Closing Summary
c. Staff must complete Diagnosis: Discharge
   Menu Path>CWS>Assessments>User Defined Assessments>Diagnosis
d. Staff must finalize the Closing Summary form.
e. Staff must complete "Discharge (Outpatient)." to close the episode for the reporting unit.
   Menu Path>PM>Client Management>Client Information>Discharge (Outpatient)
f. A CANS Closing Summary is **NOT** required if, at the date of discharge, the case has been opened for less than 30 calendar days after the completion of the most recent CANS Initial Assessment or CANS OTR / Reassessment. Document the disposition in the progress note.

D. MDs and prescribers are required to complete the following in myAvatar:

a. A MD Closing Summary is required for clients whose cases have been opened with an MD or prescriber being the only clinician managing the case, and the client is ending medication services, with no other additional services being provided in that episode.
b. A MD Closing Summary is **NOT** required if the client is ending medication services, but continuing therapy or case management services with another clinician in the same episode.
c. MDs and prescribers must complete a MD Closing Summary form in myAvatar.
   All items including narrative sections on the Closing Summary form must be completed. Use "NA" for items not applicable. All items with check boxes including "0, 1, 2, 3" are to be scored according to the San Francisco Comprehensive CANS Scoring Manual.
   Menu Path>CWS>MD Health Monitoring>MD Closing Summary w/Dx
d. MDs and prescribers complete Diagnosis: Discharge
   Menu Path>CWS>MD Health Monitoring> MD Closing Summary w/Dx
e. MDs and prescribers must finalize Closing Summary form.
f. Staff must complete "Discharge (Outpatient)" to close the episode for the reporting unit.
   Menu Path>PM>Client Management>Client Information>Discharge (Outpatient)

E. Requirements for Case Closure for Residential/24 Hour Service in myAvatar

Staff must complete the following in myAvatar:

a. "Discharge Bundle" or each individual required form for discharge.
b. Staff completes and finalizes the AOA Closing Summary form.
   - All items including narrative sections on the Closing Summary form must be completed. Use "NA" for items not applicable. All ANSA items must be rated according to the ANSA Manual.

F. Requirements for Case Closure for Substance Abuse Services in myAvatar

1.1 Any individual/designee who is responsible for processing paper records:

a. Assemble paper records following Appendix B – Substance Abuse Chart Order.

b. Make sure all chart forms (front and back) have the client's name and BIS number.
c. Remove all blank chart forms from chart except the "Accounting of Disclosures Log, MRD10."

1.2 Required paper/myAvatar forms for Case Closure

Each program may have their own discharge/closing summary form. The form must have the following elements: description of treatment episodes; current alcohol/drug use; vocational and educational achievements; legal status; reason for discharge; continuing recovery or exit plan; transfers and referrals; and participants comments.

1.21 **Outpatient Cal-OMS Discharge**

- Staff completes and finalizes the Discharge/Closing Summary form. All items including narrative sections on the Discharge/Closing Summary form must be completed. Use "NA" for items not applicable.
- Staff completes the Discharge (Outpatient) for closing the episode for the reporting unit.
- Staff completes Cal-OMS Discharge

1.22 **Outpatient Non Cal-OMS Discharge**

- Staff completes and finalizes the Discharge/Closing Summary form. All items including narrative sections on the Discharge/Closing Summary form must be completed. Use "NA" for items not applicable.
- Staff completes the Discharge (Outpatient) for closing the episode for the reporting unit.

1.23 **Cal-OMS Discharge for Youth in Detox Facility**

- Staff completes and finalizes the Discharge/Closing Summary form. All items including narrative sections on the Discharge/Closing Summary form must be completed. Use "NA" for items not applicable.
- Staff completes the "Discharge (Outpatient)" to close the episode for the reporting unit.
- Staff completes the Cal-OMS Discharge or Cal-OMS Youth/Detox Discharge

1.24 **Residential/24 hour Service Discharge**

- Staff completes the Diagnosis
- Staff completes and finalizes the Discharge/Closing Summary form. All items including narrative sections on the Discharge/Closing Summary form must be completed. Use "NA" for items not applicable.
- Staff completes the Discharge (Outpatient) for closing the episode for the reporting unit.
- Staff completes the Cal-OMS Discharge

G. Disposition of Caseload in myAvatar <u>Prior to Staff Leaving the Agency</u>

The program director/designee/supervisor is responsible for:

a. Reviewing the caseload report with staff/interns. Make sure all cases with "DRAFT" progress notes and chart forms such as assessment, ASI, reassessment, plan of care, closing summary, and other pertinent chart documents are finalized prior to the staff leaving the agency. The "To Do List" report is available for end-users to review current

To Do items.
Menu Path>PM>Operation Reports>Staff Activity, Individual (Clinician)
Menu Path>PM>Operation Reports>Staff Activity, Individual (Supervisor)
Menu Path>CWS>RADplus Utilities>Workflow Management>To Do List

b. For clients who do not need continuous services, staff/intern should complete the "Closing Summary" (if applicable) and "Discharge (Outpatient)" for closing the episode for the reporting unit.

c. For clients who need continuing services, a new clinician is to be assigned to the case. The new assigned clinician should document in the progress notes to state "(Name of staff) has left the agency and the case has been assigned to (Name of new clinician). The new clinician should complete a reassessment and re-do the plan of care (POC) on the client.

d. Inform the Compliance Office to deactivate the staff's ID account.

H. <u>Staff Has Left the Agency without Finalizing</u> "DRAFT" Chart Forms and "DRAFT" Progress Notes in myAvatar (Chart forms such as Assessment, ASI, Reassessment, Plan of Care, Closing Summary, and other pertinent chart documents.)

a. The program director/designee/supervisor is responsible for determining if the case is to be assigned to another clinician or to be closed.

b. Leave "AS IS" all "DRAFT" documents and "DRAFT" progress notes entered by former staff.

c. For clients who need continuing services, a new clinician is to be assigned to the case. The new assigned clinician should document in the progress notes to state "(Name of staff) has left the agency and the case has been assigned to (Name of new clinician). The new clinician should complete a reassessment and re-do the plan of care (POC) on the client.

d. For clients who do not need continuous services, the program director/designee/supervisor should complete the "Discharge (Outpatient) for closing the episode for the reporting unit. Document under "REMARKS" to state **"This case is closed administratively as staff has left the agency and is unavailable to complete any clinical disposition nor finalize any "DRAFT" documents and "DRAFT" progress notes in myAvatar."**

e. Inform the Compliance Office to deactivate the staff's ID account.

I. Clerical Responsibilities in Processing Closed Records at the Program

Hybrid / Paper Records

a. Keep charts forms that require the client's signature in paper record.
Exception: At times, programs are asked to print and keep hard copies in paper records for audit and training purposes. If a printed form is filed in the paper record, staff must

NOT write/add any information on the printed copy. All changes/updates/additions must be entered into myAvatar.

b. Assemble paper records in chart order following Appendix A- Mental Health Chart Order.

c. All chart forms (front and back) must have client's name and BIS number.

d. Remove all blank (unused) chart forms except the "Accounting of Disclosure Log, MRD10." This form is used to track all disclosures as required by HIPAA.

e. Civil service programs whose closed paper records are maintained in Health Information Management (HIM) should send records to 1380 Howard Street, Room 427, for processing. For tracking purposes, programs are responsible for keeping a log for all records sent to HIM.

f. Contract programs' medical records are processed and maintained at the site.

J. HIM Responsibilities in Processing Closed Paper / Hybrid Records

a. The Health Information Clerk checks in paper and hybrid records and ensures records are assembled following Appendix A- Mental Health Chart Order.

b. The Registered Health Information Technician (RHIT) performs chart analysis on paper and hybrid records:

- Ensures all paper chart forms are completed and signed.
- Ensures all myAvatar documents such as assessment, reassessment, treatment plan of care, and closing summary, etc. for the episode are finalized.
- Looks up the "Client Account Ledger" to determine if a closing summary is required for the episode.

c. During the chart analysis, when a deficiency is noted in the paper record, RHIT tags the page and returns the record to the program. The clinician must **complete the deficient item and return the record to HIM within 7 days. DO NOT remove deficiency slip and tag from the record** as HIM staff has to ensure all deficiencies have been corrected before removal. Likewise, clinicians are informed to finalize any "draft" documents in myAvatar via email.

K. Sanctions from the Board of Behavioral Sciences (Referenced from Policy 3.10-11 Behavioral Health Progress Notes)

As stated by the Board of Behavioral Sciences, "the board may deny a license or may suspend or revoke the license of a licensee if he or she has been guilty of unprofessional conduct due to the failure to keep behavioral health records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered."

Appendix A - Mental Health Chart Order
Appendix B - Substance Abuse Chart Order

Contact Person: Manager, Health Information Management, 255-3488

Distribution:
CBHS Policies and Procedures are distributed by the Office of Quality Management for Community Programs

Administrative Manual Holders
CBHS Programs
CBHS Substance Abuse Programs
SOC Managers
BOCC Program Managers
CDTA Program Managers
HIM Staff

Appendix A

2-7-13 Mental Health Chart Order - Combined Paper and Electronic Chart Forms in Avatar

CYF=Children
AOA=Adult & Older Adult

Please note that some forms may not apply to your provider

LEFT SIDE	RIGHT SIDE
AOA Outpatient Services Tracking Form – UR02 (Optional) **PAPER**	Administrative Closure MRD100 (if applicable) **PAPER**
Client Service Authorization(CSA) Request and Annual Client Episode Summary(CES) Update – MRD 76 **PAPER**	Episode Closing- MH_EP_CL **PAPER** **AVATAR –"DISCHARGE (OUTPATIENT)"** Episode Opening MH_EP_OP **PAPER** **AVATAR – ADM (OUTPT)** **or** One Shot Episode Opening & Closing MH_EP_ONESHOT PAPER
Notification of Authorization (if applicable) **PAPER**	AOA Closing Summary **PAPER** **AVATAR** AOA Closing Summary/ANSA **AVATAR** Program Discharge Form Inquiry **AVATAR** Diagnosis Report (Discharge) CYF CANS Closing summary **PAPER** **AVATAR** CYF CANS Closing Summary **AVATAR** CYF Treatment Plan Summary - Closing **AVATAR** Program Discharge Form Inquiry **AVATAR** Diagnosis Report (Discharge)
CSI Transition Form (if applicable) **PAPER**	Face Sheet MRD05 **AVATAR – CLIENT INFORMATION**
Client Registration - MH_CLT_REG **PAPER** **AVATAR - ADM (OUTPT)**	SFMHP Central Access Referral Information **PAPER** (if applicable)
Summary DPH Notice of HIPPA Privacy Practices SFDPH-5795021 **SIGNATURE FORM REQUIRED IN PAPER CHART**	AOA Initial Risk Assessment MRD 03 **PAPER** AOA Assessment – MRD 89 & 90 **PAPER** AOA Assessment or Evaluation Data Base Continuation – MRD91 **PAPER** **AVATAR** Initial Risk Assessment **AVATAR** AOA Assessment/ANSA(long and short/initial version) **AVATAR** AOA ANSA OUTCOMES RATING **AVATAR** Diagnosis Report (Admission)
Consent for Community Behavioral Health Services - BHRD80 **SIGNATURE FORM REQUIRED IN PAPER CHART**	CYF Assessment – MRD85 **PAPER** CYF CANS Assessment MRD85A **PAPER** CYF Assessment Update - MRD87 **PAPER** CYF Outpatient Treatment Report-UR05/UR05A **PAPER** **AVATAR** CYF CANS Initial Assessment **AVATAR** Diagnosis Report (Admission) **AVATAR** CYF Treatment Plan Summary - Assessment **AVATAR** CYF Clinical Alerts (if applicable)

	AVATAR CYF CANS Reassessment/OTR **AVATAR** CYF Clinical Alerts (if applicable)
Acknowledgement of Receipt of Materials - BHRD84 **SIGNATURE FORM REQUIRED IN PAPER CHART**	CYF CRAFFT for Youth Age 12 and Older **PAPER**
Checklist for Minor Consent – MRD80M2 (CYF) (if applicable) **SIGNATURE FORM REQUIRED IN PAPER CHART**	CYF Adolescent Alcohol and Drug Involvement Scale for Youth 12-18 (AADIS) **PAPER**
Payor Financial Information - PFI8702 old form Episode Guarantor Information - BILLING EGFIv.1,12/20/12 new UMDAP Sliding Fee Determination – USFDv,1, 12/20/12 new Consent for Billing (half sheet) new **SIGNATURE FORM REQUIRED IN PAPER CHART**	**TREATMENT PLAN OF CARE** **(Signature form required in paper chart)**
UMDAP Adjustment Authorization Form (if applicable) **- SIGNATURE FORM REQUIRED IN PAPER CHART**	AOA Treatment Plan of Care MRD86 **PAPER** **AVATAR** AOA Treatment Plan of Care/Reassessment AOA Psychiatric Plan of Care MRD86Meds **PAPER** **AVATAR** AOA MD Treatment Plan of Care CYF CANS Treatment Plan of Care-MRD86,86A **PAPER** **AVATAR** CYF CANS Treatment Plan of Care
Payment Plan Agreement (if applicable) **SIGNATURE FORM REQUIRED IN PAPER CHART**	**MEDICATION SUPPORT SERVICES**
Advance Beneficiary Notice – CMS-R-131-G (A&OA) (if applicable) **SIGNATURE FORM REQUIRED IN PAPER CHART**	Consultation Request-CYF - MRD92(CYF) **PAPER**
Insurance/Medi-Cal/Medicare Information e.g. Cal Med Printout/BIC Card (if applicable) **PAPER**	Mental Health Provider/PCP Coordination MRD14-04(CYF) **PAPER**
Healthy Families, Healthy Kids, Healthy Kids Extension (if applicable) **PAPER**	Psychiatric Evaluation Form MRD94 **PAPER** **AVATAR** Psychiatric Evaluation Form
Healthy Families Mental Health Response Form (CYF) (if applicable) **PAPER**	Informed Consent for Psychiatric Medication - MM05(CYF), MM05(A&OA) (if applicable) **SIGNATURE FORM REQUIRED IN PAPER CHART**
Accounting of Disclosure Log - MRD10 (every chart must have a copy for tracking purpose - do not remove blank form even when the case is closed) **PAPER -REQUIRED IN PAPER CHART**	Prescriber's Order – MRD16 **PAPER** Actual Prescription Orders - NCR copy **PAPER** **AVATAR** Medication List and Allergies **AVATAR** Medication Medical History
LEGAL/ADMINISTRATIVE FORMS	Medication Sheet – MRD17 **PAPER** (if applicable) **-REQUIRED IN PAPER CHART**
Advance Directives (if applicable) **REQUIRED IN PAPER CHART**	Pharmacy Documents **PAPER** e.g. prescription refill request to/from pharmacy
Tarasoff Report of Warning Form-CMHS104 (if applicable) **PAPER**	Antipsychotic Metabolic Monitoring MRD30 (A&OA) **PAPER** **AVATAR** Health Monitoring
Authorization for Use or Disclosure of Protected Health Information – MRD04 (if applicable) **PAPER/AVATAR** **SIGNATURE FORM REQUIRED IN PAPER CHART**	MD Progress Notes – MRD18-MD **PAPER** **AVATAR** Progress Notes (Medical)
CYF Authorization for Release/Request and Exchange of Information (used only by Intensive Care Management Programs) –HIPAA ICM Consent (if applicable) **SIGNATURE FORM REQUIRED IN PAPER CHART**	Mini Mental (AMMSE) – Lumetra (if applicable) **PAPER**

Subpoenas (if applicable) **PAPER**	**LAB/DIAGNOSTICS**
Conservatorship Reports (if applicable) **PAPER**	Parameter Tracking Form – MRD81 **PAPER**
5150 Evaluation – MH302 (if applicable) **PAPER**	Lab Reports (Lab ordered by CBHS) **PAPER**
Legal correspondence (if applicable) **PAPER**	Abnormal Involuntary Movement Scale (AIMS) MRD99 **PAPER**
IEP	Growth Chart (Boys/Girls) MRD83 (CYF) **PAPER**
Individualized Education Program-MH Services Addendum/AB3632 Information –MRD62(CYF) **PAPER**	**PROGRESS NOTES**
OUTSIDE INFORMATION	Progress Notes - MRD18 **PAPER** **AVATAR** Progress Notes
Information received from outside agencies Laboratory report from outside laboratories (if applicable) **PAPER**	CYF Day Treatment Progress Note - MRD97 **PAPER** **AVATAR** Day Treatment Progress Note
Information received from CBHS programs (if applicable) **PAPER**	Choosing Your Therapist –C-SOC (CYF) **PAPER**
MISCELLANEOUS	Do You Feel Me? –C-SOC (CYF) **PAPER**
Letters to/from Clients, Drawings, contracts (if applicable) **PAPER**	**GROUP NOTES**
CPS/APS/Domestic Violence reports in an envelope marked "DO NOT RELEASE" to prevent unauthorized disclosure **PAPER**	Group Progress Notes - MRD12 (CYF) **AVATAR** Group Progress Notes
	Socialization Documentation Log -MRD96(A&OA) **PAPER**
	SYSTEM OF CARE
	CAFAS/PECFAS Checklist Child & Adolescent Functional Assessment Scale (CAFAS) **PAPER** Preschool & Early Childhood Functional Assessment Scale (PECFAS) **PAPER**
	Depression Scales & other Scales (if applicable) **PAPER**
	Revised 2-7-13

Appendix B

Substance Abuse - Chart Order (PAPER / AVATAR)
Please note that some forms may not apply to your program.

LEFT SIDE	RIGHT SIDE
*Episode Opening PAPER AVATAR – ADM (OUTPATIENT)	**Episode Closing PAPER AVATAR – DISCHARGE (OUTPATIENT)
Client Registration Form PAPER AVATAR – ADM (OUTPATIENT)	*Episode Opening PAPER AVATAR – ADM (OUTPATIENT)
Summary DPH Notice of HIPPA Privacy Practices PAPER / AVATAR	**Discharge Summary PAPER
Consent for Behavioral Health Services PAPER / AVATAR	INTAKE DIVIDER
Accounting of Disclosures Log (every chart must have a copy and do not remove blank form even when the case is closed) PAPER / AVATAR	Intake Assessment/Mental Health Screening PAPER / AVATAR
LEGAL/ADMINISTRATIVE DIVIDER	Health Questionnaire PAPER / AVATAR
Authorization Form (if applicable) PAPER / AVATAR	Other relevant intake information/forms
Subpoena (if applicable)	TREATMENT PLAN OF CARE DIVIDER
Court Order (if applicable)	Treatment Plan of Care PAPER / AVATAR
Other Legal Correspondence (if applicable)	MEDICATION SUPPORT SERVICES DIVIDER
OUTSIDE INFORMATION DIVIDER	Dispensing medication information PAPER
Medical History/Information from other providers *e.g. Drug Medi-Cal Admission Physical Examination Wavier, Justification to Continue Treatment Services*	LAB/DIAGNOSTICS DIVIDER
Integration partnership related information	Lab reports PAPER
Other client related information received from outside agencies	PROGRESS NOTES DIVIDER
MISCELLANEOUS DIVIDER	Progress Notes PAPER / AVATAR
All other information	GROUP NOTES DIVIDER
	Group Progress Notes PAPER / AVATAR
	2-7-13