RECORD KEEPING

Record Keeping Requirements

All Certified Community Behavioral Health Clinic (CCBHC) records must be maintained in an accessible, standardized order and format at the CCBHC's office site in the geographic service area where services were delivered. The CCBHC must have sufficient space, facilities, and supplies to ensure effective record keeping. In addition, the CCBHC must keep sufficient records to document compliance with the Louisiana Department of Health (LDH) requirements for the clients served and the provision of services.

All records must be made available that LDH or its designee finds necessary to determine compliance with all federal or state laws, rules, or regulations promulgated by LDH.

The CCBHC is responsible for meeting the requirements contained in this chapter as well as any requirements as applicable by the license and accreditation held by the CCBHC, by the client's Managed Care Entity (MCE) and by Medicaid for claims processing/billing. For any services in this manual which refer to the Medicaid Behavioral Health Services Provider (BHSP) manual, the CCBHC or the designated collaborating organization (DCO) must also follow the requirements held therein.

Retention of Records

Administrative, personnel and client records must be maintained for whichever of the following time frames is longer:

1. Records are reviewed and all review questions are answered;

2. According to the rules dictated by the CCBHC's license; or

3. Six years from the date of the last payment period.

NOTE: Upon CCBHC closure, all records must be maintained according to applicable laws, regulations and the above record retention requirements, and copies of the required documents transferred to the new agency.

Confidentiality and Protection of Records

All records, including administrative and client records, must be the property of the CCBHC and secured against loss, tampering, destruction or unauthorized use. Employees of the CCBHC must not disclose or knowingly permit the disclosure of any information concerning the CCBHC, clients or their families, directly or indirectly, to any unauthorized person. The CCBHC must safeguard the confidentiality of any information that might identify the clients or their families. Information may be released only under the following conditions:

1. Court order;

2. Client's written informed consent for release of information;

3. Written consent of the individual's legal guardian or legal representative when the client has been declared legally incompetent; or

4. Compliance with the Confidentiality of Substance Use Disorder (SUD) Patient Records (42 Code of Federal Regulations (CFR) Part 2).

Upon request, a CCBHC must make available information in the case records to the client or legally responsible representative. A client's general right to access their protected health information may only be denied by a CCBHC if permitted under 45 CFR § 164.524.

Material from case records may be used for teaching or research purposes, development of the governing body's understanding and knowledge of the CCBHC's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted. Any electronic communication containing client-specific identifying information sent by the CCBHC to another agency, or to LDH, must comply with regulations of the Health and Insurance Portability and Accountability Act (HIPAA), and any applicable confidentiality standards and be sent securely via an encrypted messaging system. A system must be maintained that provides for the control and location of all client records.

NOTE: Under no circumstances shall CCBHCs allow staff to take client's case records from the office without appropriate utilization of standard best practices in compliance with all HIPAA standards related to privacy and security.

Review by State and Federal Agencies

All administrative, personnel and client records must be made available to LDH, or its designee, MCEs, and appropriate state and federal personnel at all times. CCBHCs must always safeguard the confidentiality of client information.

Client Records

The CCBHC must have a separate record for each client served by the CCBHC. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, the CCBHC must have adequate documentation of services offered and provided to clients they serve. This documentation is an on-going chronology of activities undertaken on behalf of the client.

The CCBHC shall maintain case records that include, at a minimum:

1. Entry forms must be reviewed, dated, signed by, and given to the client and/or responsible party, including the following as applicable:

    a. Client rights, including rights to confidentiality and privacy;

    b. Medical and psychiatric advanced directive;

    c. Consent for treatment/informed consent including consent to deliver telehealth services, which must address the following:

        i. Rationale for using telehealth in place of in-person services;

        ii. Risks and benefits of telehealth, including privacy-related risks;

        iii. Possible treatment alternatives and those risks and benefits; and

        iv. Risks and benefits of no treatment.

2. Identifying information including the client's name, date of birth (DOB), address, Medicaid ID number, and social security number (SSN);

NOTE: Each page of the record shall have a client identifier such as client name, client initials, client's client identification (ID) number, etc.

3. See Screening, Assessment and Diagnostic Evaluations section for assessment requirements;

4. See Person-Centered and Family-Centered Treatment Planning section for requirements;

5. Progress notes are documented in accordance with professional standards of practice and as well as the following:

    a. Document implementation of the treatment plan and results as to related to the client's goals, objectives and interventions and are medically necessary and clinically appropriate;

    b. Document the client's level of participation and response to the intervention, noting if progress is or is not being made;

    c. Document observed behaviors, if applicable;

    d. Document missed appointments and follow-up attempts;

    e. Include the signature and name of staff delivering the service(s);

    f. Include date of service contact;

    g. Include start and stop time of service contact; and

    h. Completed within two business days of delivery of services.

NOTE: Each progress note must include sufficient detail to support the length of the contact. The content must be specific enough so a third-party will understand the purpose of the contact and support the service and claims data. The only staff who may complete a progress note is the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.

6. Crisis plan (as part of the treatment plan);

    a. Crisis plan must be directed by the client and/or the responsible party, i.e., guardian/caregiver, if applicable;

    b. Crisis plan must include area resources and crisis numbers; and

    c. Crisis plan must include signatures of the client and/or the responsible party, i.e., guardian/caregiver, if applicable.

7. Continuity and coordination of care:

a. The record includes the primary care physician (PCP) name, address, phone number, and documentation of continuity and coordination of care between PCP and the client's treating CCBHC;

b. The record includes any other treating behavioral health clinician's name, address, phone number, and documentation of continuity and coordination of care between any other treating behavioral health clinician's and the client's treating CCBHC;

c. The record includes documentation of any referrals made on behalf of the client, if applicable; and

d. The record must include a signed Release of Information form by the client and/or responsible party, i.e., guardian/caregiver, if applicable, for communication and coordination of care to occur; if client and/or responsible party refuses, then this refusal must be noted within the record.

8. Medication management, if applicable:

a. The record must indicate the following:

i. Medication type;

ii. Medication frequency of administration;

iii. Medication dosage;

iv. Person who administered each medication;

v. Medication route;

vi. Ordered laboratory work that has been reviewed by the clinician ordering the laboratory work as evidenced by date and signature of clinician;

vii. Evidence of client education on prescribed medication including benefits, risks, side effects, and alternatives of each medication;

viii. Signed consent for psychotropic medications by the client and/or responsible party, i.e., guardian/caregiver, if applicable; if client

and/or responsible party refuses, then this refusal must be noted within the record;

ix. Abnormal Involuntary Movement Scale (AIMS) preformed when appropriate (e.g., client is being treated with antipsychotic medication);

x. Initial and ongoing medical screenings are completed for clients prescribed antipsychotic medication including but not limited to weight, body mass index (BMI), labs, and chronic conditions to document ongoing monitoring; and

xi. Documentation of monitoring medication adherence, efficacy, and adverse effects.

9. Discharge summary details the client's progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a client's discharge.

Electronic Signatures

A client or provider can sign electronically. An electronic signature will be deemed valid under federal law if it is authorized by state law. Under the Louisiana Uniform Electronic Transactions Act, La. R.S. 9:2601 et seq. ("LUETA") an electronic signature is valid if:

1. The CCBHC that maintains electronic records must comply with applicable state and federal laws, rules and regulations to ensure each record is valid and secure;

2. Electronic signature is attributable to signer (i.e., be sure to have patient's printed name under signature); and

3. Appropriate security measures are in place which can authenticate the signature and prevent alteration of the signature (i.e., date and signature cannot be modified in the electronic health record).

Organization of Records, Record Entries

The CCBHC must maintain electronic records that comply with applicable state and federal laws, rules and regulations to ensure each record is valid and secure. Organization of individual client records and the location of documents within the record must be consistent among all records.

All entries and forms completed by staff in client records must include the following:

1. Name of the person making the entry;
2. Signature of the person making the entry;
3. Functional title, applicable educational degree and/or professional license of the person making the entry;
4. Full date of documentation; and
5. Reviewed by the supervisor, if required.

Health Information Technology

The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as:

1. Population health management;
2. Quality improvement;
3. Quality measurement and reporting; and
4. Reducing disparities, outreach, and for research.

The CCBHC uses technology that has been certified to current criteria under the Office of the National Coordinator (ONC) for Health IT Certification Program for the following required core set of certified health IT capabilities that align with key clinical practice and care delivery requirements for CCBHCs:

1. Capture health information, including demographic information including:
    a. Race;
    b. Ethnicity;
    c. Preferred language;

d. Sexual and gender identity; and

e. Disability status (as feasible).

2. At a minimum, support care coordination by sending and receiving summary of care records;

3. Provide clients with timely electronic access to view, download, or transmit their health information or to access their health information via Application Programming Interface (API) using a personal health app of their choice;

4. Provide evidence-based clinical decision support; and

5. Conduct electronic prescribing.

The CCBHC develops and implements a plan within two-years from state CCBHC certification to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.

Psychiatric Advance Directives are entered in the electronic health record of the client so that the information is available to providers in emergency care settings where those electronic health records are accessible.