COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CLINICAL RECORDS BULLETIN

Edition 2011-06

Program Support Bureau
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Mandatory Keepers of Records Training

August 24, 2011 9:00am-12:00pm 550 S. Vermont 2nd Floor Conference Room

Each DMH Directly-Operated program shall designate a Keeper of Records who shall be involved in ALL requests for Protected Health Information (PHI) to ensure compliance with DMH policies and HIPAA Regulations and to ensure federal and state laws are met and that, when appropriate, there is documentation on the Account Tracking Sheet in the client's record and/or on the Program's PHI Log. These sessions provide specific training for appropriate responses to all types of authorized/unauthorized disclosure of PHI and proper record-keeping. New/Revised policies and procedures, processing of authorization forms, etc. are topics discussed in these Keepers Trainings.

REVISED INITIAL ASSESSMENT FORMS AND EOB/UCC ASSESSMENT

REVISED FORMS AVAILABLE ON INTERNET

(http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_forms—see Assessment)

In conjunction with the Office of the Medical Director, both the Child/Adolescent and Adult Initial Assessment Forms have been revised to include prompts for assessing for physical disabilities and assessing for suicidality/homicidality and access to lethal means. The Revised 07/20/11 MH 532-Adult Initial Assessment and MH 533-Child/Adolescent Initial Assessment can be found on the DMH Internet under For Providers, Clinical Tools, Clinical Forms.

While it has been the expectation that any physical disability would be documented in a client's assessment, the previous revisions of the Initial Assessment Forms did not specifically address this issue. Adding prompts related to special service needs and motor and sensory impairments to the initial assessments will ensure 1) staff are documenting a client's special needs if applicable, 2) clients can adequately access mental health services, and 3) staff can appropriately address the impact of physical disabilities on the client's mental health when treatment planning. Additionally, it is the Department's expectation that if the new physically challenged checkbox is marked on the initial assessment, the physical disability box on the Open Episode Form and in the Integrated System will also be marked. This will allow the Department to reliably track the prevalence of our client's physical disabilities. The Department will monitor co-morbid physical conditions to ensure training needs are identified to assist staff in understanding the manner in which the psychological implications of physical disabilities should be addressed in treatment.

In addition to adding information related to physical disabilities, wording related to performing a thorough suicide/homicide risk assessment has been added to prompt staff to document a client's access to lethal means, such as guns or other weapons, as stated in **DMH Clinical Practice Parameter 2.1 regarding "Assessment/Management of Clients at Risk for Suicide, Section III, D."** Staff should routinely ask clients about this access particularly when a client expresses any suicidal or homicidal ideation, plan or intent. The parameters are located at **http://file.lacounty.gov/dmh/cms1_159948.pdf**

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS? (FOR DIRECTLY-OPERATED ONLY)

1. Must I write the name of the individual who is receiving services on the COS form when I am completing a Community Outreach Service?

Answers on the next page

Important Revisions to the Initial Assessments:

- Added questions related to special service needs on Page 1 of both the initial assessment forms
- Added prompt regarding "access to lethal means" to psychiatric history and mental status on both initial assessment forms
- Added "Sensory/Motor Impairment" under Medical History to both initial assessments forms
- Added note on Page 3 under Psychosocial History of the Adult Initial Assessment reminding staff to link impairments to the client's mental health symptoms/behaviors and to address the client's strengths in the client's psychosocial assessment
- Added prompt to include "assessment for risk of suicidal/homicidal behaviors" under the Summary and Diagnosis

Important to Remember:

- Sensory impairments include blindness, significant visual problems and hearing impairments.
- Motor impairments include paralysis, severe muscle weakness, walking disturbance, and severe tremor.
- The "physically challenged" field should correspond to the Open Episode form and IS field for "physical disability".
- If a client has impairments in life functioning, it should be clear if and/or how the impairment is due to the client's mental illness.
- Staff should always ask about access to weapons or other lethal means when a client expresses any suicidal or homicidal ideation, plan or intent.
- All information gleaned from the assessment should be clearly documented.

Implementation:

Directly-Operated: The revised form should be used immediately.
Contract: Within 6 months of the date of this Bulletin

The EOB/UCC Assessment, **for use by emergency response teams and urgent care programs only**, has been revised to account for recent changes to all Assessment forms.

Important Information about the Revised Forms:

- The COD Assessment forms (MH 659 and MH 633) do not have to be used with this form; however, staff must address substance use when assessing clients. For this reason, specific questions have been added to the form to account for the types of substance use information that should be gathered by emergency response teams and urgent care programs.
- Staff should ensure the appropriate amount of information is gathered and documented to justify any decisions made regarding the client's diagnosis, status, or treatment needs.
- For children, the Child/Adolescent Short Format Assessment may be used instead of the EOB/UCC Assessment.

Implementation:

Directly-Operated: The revised form should be used immediately.
Contract: Within 6 months of the date of this Bulletin

If you have any questions regarding this Bulletin, please contact your Service Area QA Liaison.

c: Executive Leadership Team, District Chiefs, Department QA Staff, Program Heads, Provider Record Keepers, QA Service Area Liaisons, TJ Hill - ACHSA, Nancy Butram - RMD, Dr. Carol Eisen - OMD

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. Yes, if you have the name of the individual or family name, it must be written on the form under AGENCY NAME when providing a COS service to an individual. A copy of the COS form shall be filed in a Non-Open PHI file for the individual. If an episode is subsequently opened for the individual, the COS copy from the Non-Open PHI file shall be placed in the Progress Notes Section of the Clinical Record.