APA-1
Revised 4/2018

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control 580 Department or Agency **Alabama Department of Mental Health**
Rule No. **580-2-20-.08**
Rule Title: **Recipient Records**
____ New **X** Amend ____ Repeal ____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	**YES**
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	**NO**
Is there another, less restrictive method of regulation available that could adequately protect the public?	**NO**
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	**NO**
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?	**NO**
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	**YES**
Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule?	**NO**

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Does the proposed rule have an economic impact? **NO**

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

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Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer _____
Date 10.14.22

(DATE FILED)
(STAMP)

APA-2

Alabama Department of Mental Health
Mental Health and Substance Abuse

NOTICE OF INTENDED ACTION

AGENCY NAME: **Alabama Department of Mental Health**

RULE NO. & TITLE: **580-2-20-.08 Recipient Records**

INTENDED ACTION: **Amend**

SUBSTANCE OF PROPOSED ACTION: We have created Chapter 580-2-20-.08 to eventually combine the current rules for Mental Illness in Chapter 580-2-9 and Substance Abuse in Chapter 580-9-44

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments in writing to Altorvis (Allie) Ligon, Director, Office of Certification Administration, Alabama Department of Mental Health, 100 North Union Street, Suite 540, Montgomery, Alabama 36130 by mail or in person between the hours of 8:00AM and 5:00Pm, Monday through Friday, or by electronic means to contactoca.dmh@mh.alabama.gov until and including December 5, 2022. Persons wishing to submit data, views or arguments orally should contact Ms. Ligon by telephone at (334)353-2069 during this period to arrange for appointment.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
December 5, 2022

CONTACT PERSON AT AGENCY:
Persons wishing a copy of the proposal may contact:
Altorvis (Allie) Ligon
Department of Mental Health
100 North Union Street, Suite 540
Montgomery, Alabama 36130
(334)353-2069
A copy of the proposed change is available on the department's website at https://mh.alabama.gov/division-of-administration/certification-administration/

(Signature of officer authorized to promulgate and adopt rules or his or her deputy)

DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
ADMINISTRATIVE CODE

580-2-20
PROGRAM OPERATION

580-2-20.08 Recipient Records.

(1) A single case file must be established for each recipient which includes any clinical and case management documentation. The case file may be maintained in physical or electronic format. All requirements in this section apply regardless of format.

(2) If the recipient is involved in more than one program, ready access to recipient information necessary for the safety of the recipient, obtaining emergency medical attention and coordination of services across programs shall be assured.

(3) The provider organization shall establish a formal system to control and manage access to recipient records that shall include, at a minimum:

(a) Procedures for control and management of access to paper and electronic records.

(b) Establish a system to secure recipient records from unauthorized access.

(c) Designated staff position(s) responsible for the storage and protection of recipient records.

(d) A process in which the location of a record can be tracked and documented at all times.

(e) Identification of program personnel with access to recipient records.

(f) A process for providing recipients access to their records.

(g) A process for storing closed recipient records and for disposing of outdated records.

(h) Recipient records shall be retained after termination, discharge, or transfer of the recipient for a minimum of seven (7) years.

(i) Adolescent recipient records shall be retained after termination, discharge, or transfer of the recipient for a minimum of seven (7) years after age of majority for children/adolescents.

(4) All entries and forms completed by the service provider in the recipient record shall be:

(a) Dated and signed.

(b) Made in ink and be legible or recorded in an electronic format.

(c) Appropriately authenticated in the electronic system for organizations that maintain electronic records.

(5) Corrections are made in a manner that clearly identifies what is being corrected, by whom, and the date of correction. White-out in paper record is not permitted. Corrections in electronic records shall have an audit trail.

(6) The following information shall be documented in the recipient record:

(a) Case number.

(b) Recipient name.

(c) Date of birth.

(d) Sex assigned.

(e) Race/ethnic background.

(f) Hearing status.

(g) Language of preference.

(h) Home address.

(i) Current telephone number.

(j) Next of kin or person to be contacted in case of emergency.

(k) Marital status.

(l) Social Security number.

(m) Referral source.

(n) Reason for referral.

(o) Presenting problem(s).

(p) Admission type (new, readmission).

(q) Date of admission to the program/service.

(r) Substance Use Only - date of treatment initiation (first day of service within level of care).

(s) Family history.

(t) Educational history.

(u) Mental Illness Only: Educational/Employment/ vocational goals and/or aspirations, as appropriate.

(v) Relevant medical background.

(w) Employment/vocational history.

(x) Psychological/psychiatric treatment history.

(y) Military status.

(z) Legal history.

(aa) Alcohol/drug use history.

(bb) Mental status examination. If receiving Mental Illness Targeted Case Management only, this is not required.

(cc) History of trauma.

(dd) Thoughts and behavior related to suicide.

(ee) Thoughts and behavior related to aggression.

(ff) Initial diagnostic formulation.

(gg) Identification of initial services, referrals and/or recommendations for subsequent treatment and/or assessment.

(hh) Referral to other medical, professional, or community services as indicated.

(ii) Special supports for recipients who have mobility challenges, hearing or vision loss, and/or limited English Proficiency.

(jj) Screening tool(s), as appropriate.

(kk) Intake/Assessment tool(s).

(ll) A written authorization for disclosure covering each instance in which information concerning the identity of diagnosis, prognosis, treatment, or case management of the recipient is disclosed. Each authorization for disclosure shall contain all the following information:

1. The name of the agency that is to make the disclosure.

2. The name or title of the person to whom, or organization to which, disclosure is to be made.

3. The full name of the recipient.

4. The specific purpose or need for the disclosure.

5. The extent and/or nature of information to be disclosed.

6. A statement that the authorization is subject to revocation by the recipient or recipient's lawful representative at any time except to the extent that action has been taken in reliance thereon and in accordance with 42 CFR Part 2 and HIPPA.

7. A specification of the date (no more than 2 years as long as the original purpose/need still exists), event, or condition upon which the authorization will expire without express revocation.

8. The date on which the authorization is signed.

9. The signature of the recipient (or lawful representative, if applicable).

(i) There should be 2 witnesses to the recipient's signature if the recipient signs with a mark (e.g. signs with an "X").

(ii) If authorization is given by telecommunication, it shall be documented in recipient record. When authorization is given by telecommunication, the recipient's actual signature is obtained at the earliest opportunity. Signature can be obtained electronically or in person.

(iii) If the recipient is under the age of consent or adjudicated incompetent, the parent/lawful representative must sign the written authorization.

10. Documentation that authorization was obtained through interpretation or translation when the recipient is deaf or limited English proficient.

(mm) A consent for follow up form which authorizes contact for up to one year after case closure.

(7) There shall be in the record of each recipient who is deaf or has limited English proficiency an approved ADMH Office of Deaf Services notification of free language assistance form which includes the following:

(a) Signatures of the recipient and witnessed by a staff person fluent in the recipient's preferred language or an

interpreter completed at intake/assessment and annually thereafter. Signatures shall be obtained by the following procedures:

1. For deaf recipients, this form shall be witnessed by a staff person from the Office of Deaf Services or approved by the Office of Deaf Services.

2. For hearing persons with limited English proficiency the following shall apply:

(i) When agency staff fluent in the language of preference of the recipient is utilized, the agency staff shall sign this form.

(ii) When a face-to-face interpreter is utilized, the interpreter shall sign this form.

(iii) When telephonic interpreter services are utilized, the name of telephonic service, interpreter's identification number and name of interpreter and credentials, if given, shall be documented on this form.

(8) For each event/service interpreter(s) are utilized, the interpreter's name and credentials shall be documented in the recipient's record.

(a) If telephonic interpreter services are utilized, the name of telephonic service and interpreter's identification number are documented in recipient record.

(9) Individual Service/Treatment Planning Process. Each entity shall develop, maintain, and document implementation of written policies and procedures defining the recipient's service/treatment planning process that shall include, at a minimum, the following components:

(a) Mental Illness Only: An initial individualized service/treatment plan shall be completed by the fifth face to face outpatient service, within ten working days after admission into all day programs or residential programs, or within other time limits that may be specified under programs specific requirements.

(b) Substance Use Only: An initial individualized service/treatment plan shall be completed by the tenth calendar

day after admission into an outpatient program or completed by the fifth calendar day after admission to a residential program.

(c) The service/treatment plan shall include the following:

1. Identification of clinical issues that will be the focus of treatment.

2. Specific services necessary to meet recipient's needs.

3. Referrals as appropriate for needed services not provided directly by the agency.

4. Identification of expected outcomes toward which the recipient and treatment provider will be working to impact upon the specific clinical issues.

5. Upon completion of a communication assessment, identify any language supports necessary to implement service/treatment plan for recipients who are deaf, hard of hearing and/or Limited English Proficiency.

6. Identification of needed safety interventions based on history of harm to self or others.

7. All treatment goals and objectives shall be measurable.

8. Mental Illness Only:

(i) Represents a person-centered recovery-oriented treatment planning process through which recipients are assisted to articulate their vision and hope for how their lives will be changed for the better within three to five years (long term recovery vision) and to identify short-term outcomes that will assist in achieving the recovery goal (treatment goals).

(ii) Uses strength-based approach to treatment planning by identifying recipient and environmental positive attributes that can be used to support achievement of goals and objectives.

(iii) Identifies psychiatric, psychological, environmental, and skills deficits that are barriers to achieving desired outcomes.

(iv) Identifies treatment supports that are needed to address barriers to achieving desired therapeutic goal.

(d) The plan shall be developed in partnership with the recipient and/or lawful representative, as appropriate, based upon the recipient's goals.

(e) The recipient will sign/mark the service/treatment plan to document the recipient's participation in developing and/or revising the plan. If the recipient is under the age of consent or adjudicated incompetent, the parent/lawful representative must sign the service/treatment plan.

(f) The agency shall specify the processes used to ensure that the recipient:

1. Will be an active participant in the treatment/service planning process.

2. Is provided the opportunity to involve family members or significant others of his/her choice in formulation, review, and update of the service/treatment plan.

(g) The treatment/service plan must be approved in writing or electronically by any of the following:

1. Physician, physician assistant, a Certified Nurse Practitioner, or a registered nurse with a master's degree in psychiatric nursing. Shall be licensed under Alabama law and practicing within the guidelines of their licensure boards,

2. Licensed psychologist, licensed professional counselor, licensed master's social worker, licensed independent clinical social worker, licensed marriage and family therapist. Shall be licensed under Alabama law and practicing within the guidelines of their licensure boards,

3. Substance Use Only: QSAP I.

(h) Mental Illness Only: After completion of the initial treatment plan, staff shall review and update the recipient's treatment plan:

1. Once every three months for all residential and day programs or earlier if needed.

2. Outpatient treatment plans every twelve months or within other time limits that may be specified under program specific requirements to determine the recipient's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment.

3. Providers must document this review in the recipient's record by noting on the treatment plan or a treatment plan review form that the treatment plan has been reviewed and updated or continued without change.

(i) Substance Use Only: After completion of the initial treatment plan, staff shall review and update the recipient's treatment plan as specified in level of care.

(j) Treatment/service plan shall be maintained as a working document throughout the recipient's treatment and/or care process with modifications to the treatment/service plan based on the recipient's progress, the lack of progress, recipient preferences, or other documented clinical issues.

(k) Document in recipient's record that recipient was offered a copy of treatment/service plan. If copy is refused, document reason for refusal.

(10) Substance Use Only: Continuing Care Plan. Each recipient shall develop a continuing care plan as a part of their service planning process that begins at the initiation of services/treatment. The continuing care plan shall support the recipient's recovery efforts after discharge from treatment and be based on recipient's individual needs and available resources.

(a) A copy of the continuing care plan shall be filed in the recipient's case record.

(b) Continuing care plan shall be signed by recipient and qualified substance abuse professional who assisted recipient in the development of plan.

(11) Clinical Documentation. Documentation in the recipient's record for each session, service, or activity shall include:

(a) The identification of the specific services rendered.

(b) The date and the amount of time that the services were rendered to include the time started and time ended.

(c) The signature and credentials of the staff person who rendered the service(s) or as specified within service/program requirements.

1. Printed name of staff person who rendered the service(s) shall be below or next to signature.

2. Shall be appropriately authenticated in the electronic system for electronic records.

(d) The identification of the setting in which the service(s) were rendered.

(e) A written assessment of the recipient's progress, or lack thereof, related to each of the identified clinical issues discussed.

(f) All entries must be legible and complete.

(g) Documentation of recipient's signatures shall be entered on a sign-in sheet, service receipt, or any other record, to include electronic, that can be used to indicate the recipient's signature and the date of service for services received. Recipient's signature is only required one time per day that services are provided.

1. The following services do not require recipient signatures:

(i) Any ADMH approved non-face to face services that are provided remotely or indirectly .

(ii) Crisis Intervention and mental health care coordination.

(iii) Mental Illness only: Assertive Community Treatment (ACT), Program for Assertive Community Treatment (PACT), Child and Adolescent In-Home, High Intensity Care Coordination (HICC), Low Intensity Care Coordination (LICC), pre-hospitalization screening, psychoeducation.

(h) Documentation shall not be repetitive.

(i) Documentation of services provided shall not be preprinted or predated. After each service provided in a group setting, progress notes shall:

1. Identify the number of participants, the topic, and a general description of the session. This information may be copied for each participant.

2. Each recipient shall have individualized documentation relative to the recipient's specific interaction in the group and how it relates to their treatment/service plan.

(j) Documentation of services received by recipient and recipient's progress shall match the goals on the recipient's treatment/service plan and the plan shall match the needs of the recipient. The interventions shall be appropriate to meet the goals. There shall be clear continuity in the recipient record.

(k) Documentation must provide enough detail and explanation to justify the service.

(l) Substance Use Only: Documentation must be completed and placed in recipient record within two (2) business days of service being provided.

(m) Mental Illness Only: Documentation must be completed and placed in recipient record after completion of services as outlined below:

1. For each outpatient contact within two (2) business days.

2. For residential programs, a written assessment of the recipient's progress, or lack thereof, related to each of the identified clinical issues discussed shall be documented for every two (2) weeks and placed in record within two (2) business days.

3. For partial hospitalization, each service delivered shall be documented every day and placed in record within two (2) business days.

4. For Intensive Day Treatment and Child and Adolescent Day Treatment on a weekly basis a progress note written or co-signed by the program coordinator/case responsible staff member with equivalent credentials and placed in record within two (2) business days.

5. For Rehabilitative Day Programs every two (2) weeks a progress note written or co-signed by the program coordinator/case responsible staff member with equivalent credentials and placed in record within two (2) business days.

(12) All medication information shall be documented within the recipient record. If recipient reports no medication(s), documentation shall indicate no medications. The medication information shall contain all the following information:

(a) A list of all medication(s) reported by the recipient at intake/assessment.

(b) All medications, to include but not limited to psychotropic, and non-psychotropic, prescribed by the provider and by other practitioners.

(c) Non-prescription medications.

(d) For all medications prescribed by the agency, documentation shall include:

1. The name of medication.

2. Strength and dosage of the medication.

3. The date prescribed.

4. Number of refills permitted.

5. The prescriber's name.

(e) The provider shall have a system for tracking due dates for injections administered by the provider and scheduling recipients accordingly.

(f) Mental Illness Only: Medications shall be updated at least annually.

(g) Substance Use Disorder Only: Medications shall be reviewed at each Case Review.

(13) Transfer. Documentation of transfer to a separate program/level of care within same agency shall be clearly documented as a transfer that shall include the following:

(a) Information related to the transfer within the agency to different level of care/program.

(b) Document that transfer was discussed with recipient or recipient's lawful representative.

(c) If not discussed with recipient, documentation shall include reason why transfer was not discussed with recipient or recipient's lawful representative.

(14) Discharge. Documentation of the discharge shall:

(a) Be entered into each recipient's record and shall include a description of the reasons for discharge, regardless of discharge type.

(b) The summary shall include:

1. A summary of goals for continuing care after discharge.

2. An evaluation of the recipient's progress toward goals established in the service/treatment plan and participation in the program.

3. The discharge summary shall be signed by the recipient, when possible, the primary counselor, and for Substance Use Disorder only, the clinical director or designee.

4. A copy of the discharge summary shall be provided to the recipient upon discharge, when possible.

5. Mental Illness Only: In the event of loss of contact or death, an administrative discharge shall be completed. A summary is not required and only the reason for discharge shall be documented.

(c) Mental Illness Only: Be entered into each recipient's record within fifteen (15) days after discharge or up to one hundred eighty (180) days after receipt of last service specifying the status of the case.

(d) Substance Use Disorder Only: Be entered into each recipient's record within five (5) days after discharge or thirty (30) days after receipt of last service.

(e) Substance Use Disorder Only: Notify the recipient's referral source of recipient's discharge with written informed consent of the recipient. Agency shall follow all federal regulations and laws regarding confidentiality and privacy i.e., 42 CFR Part 2 and HIPPA and shall document notification in recipient's record.

Author: Division of Mental Health and Substance Abuse Services,
DMH Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: Filed: October 19, 2022.