APA-1
Revised 4/2018

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control 580 Department or Agency **Alabama Department of Mental Health**
Rule No. 580-2-9-.06
Rule Title: **Consumer Records**
_____ New _____ Amend **X** 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 ______________________

(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: **580-2-9-.06 Consumer Records**

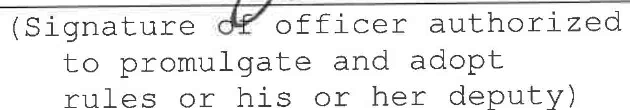
INTENDED ACTION: **Repeal**

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)

REPEALED

580-2-9-.06 ~~Consumer Records.~~

~~(1) The provider shall implement written policies and procedures approved by the Board that prohibit creation after the fact, alteration, or falsification of original administrative or clinical documentation in order to make it appear that the documentation is original, factual, or occurred at some time other than it actually did to give the appearance of on-going compliance with these standards or other applicable regulations.~~

~~(2) A single case file must be established for each consumer 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.~~

~~(3) If the consumer is involved in more than one program, ready access to consumer information necessary for the safety of the consumer, obtaining emergency medical attention and coordination of services across programs shall be assured.~~

~~(4) The provider must describe in writing and maintain a system that provides for the control/location of all case files.~~

~~(5) The provider must establish a system to secure consumer records from unauthorized access.~~

~~(6) The job descriptions document that a specific staff member is responsible for the storage and protection of consumer records in each location where records are stored.~~

~~(7) All entries and forms completed by the service provider in the consumer record shall be dated and signed with name and credentials/position. The entries shall be made in ink and be legible or be done electronically.~~

~~(8) Corrections are made in a manner that clearly identifies what is being corrected, by whom, and the date of correction. White-out is not permitted.~~

(9) Following the completion of Intake and assignment for treatment, the following information, if available, shall be recorded in the consumer record:

(a) Consumer identifying data including:

1. Case number.

2. Consumer name.

3. Date of birth.

4. Sex.

5. Race/ethnic background.

6. Hearing status.

7. Language of preference.

8. Home address.

9. Home telephone number.

10. Next of kin or person to be contacted in case of emergency.

11. Marital status.

12. Social Security number.

13. Referral source.

14. Reason for referral.

15. Date of admission to the program.

16. Admission type (new, readmission).

17. Special supports for consumers who have mobility challenges, hearing or vision loss, and/or limited English Proficiency.

(b) Documentation of the Intake must include information, as appropriate, from among the following:

1. Family history.

~~2. Educational history.~~

~~3. Relevant medical background.~~

~~4. Employment/vocational history.~~

~~5. Psychological/psychiatric treatment history.~~

~~6. Military history.~~

~~7. Legal history.~~

~~8. Alcohol/drug abuse history.~~

~~9. Mental status examination.~~

~~10. History of trauma.~~

~~11. Thoughts and behavior related to suicide.~~

~~12. Thoughts and behavior related to aggression.~~

~~(c) Assignment of a diagnosis (latest DSM version) substantiated by an adequate diagnostic database and, when indicated, a report of a medical examination. The diagnosis must be signed by a licensed physician, a licensed psychologist, a licensed professional counselor, a certified registered nurse practitioner, or licensed physician's assistant. A consumer unknown to the provider must be seen face-to-face by a licensed physician, certified registered nurse practitioner, or licensed physician's assistant prior to writing a prescription for psychotropic medication, except in the case of a documented emergency.~~

~~(d) A description/summarization of the significant problem(s) that the consumer is experiencing, including those that are to be treated and those that impact upon treatment.~~

~~(e) A description of how linguistic support services will be provided to consumers who are deaf or have limited English proficiency including a signed waiver of free language assistance if the consumer who is deaf or who has limited English Proficiency has refused interpreting or translating services. If a family member is used to interpret, such should be documented in the consumer record. No one under the age of 18 can be used as interpreters.~~

~~(f) A written treatment plan that includes elements defined in (g) below completed by the fifth (5th) face-to-face outpatient service ,within ten (10) working days after admission in all day programs and residential programs, or within other time limits that may be specified under program specific requirements.~~

~~(g) A treatment plan that:~~

~~1. Represents a person-centered, recovery-oriented treatment planning process through which consumers 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 view), to identify short-term outcomes that will assist in achieving the recovery goal (treatment goals), and to specify objectives and related services and supports necessary to overcome barriers to achieving the outcomes (necessary services and supports).~~

~~2. Identifies needed safety interventions based on history of harm to self or others.~~

~~3. Uses a strength-based approach to treatment planning by identifying consumer and environmental positive attributes that can be used to support achievement of goals and objectives.~~

~~4. Identifies psychiatric, psychological, environmental, and skills deficits that are barriers to achieving specific measurable outcomes.~~

~~5. Identifies treatment and supports that are needed to address barriers to achieving desired therapeutic goals, including supports for consumers who have mobility challenges, hearing or vision loss, and/or limited English proficiency.~~

~~6. Is approved in writing by a licensed physician, certified nurse practitioner, licensed physician's assistant, licensed psychologist, licensed certified social worker, a licensed marriage and family therapist, a registered nurse with a master's degree in psychiatric nursing, or a licensed professional counselor.~~

~~(h) Each consumer and significant other (with the consumer's consent) are invited to actively participate in the~~

formulation and modification of the individual treatment plan. The treatment planning process includes the consumer's signature/mark on the treatment plan to document the consumer's participation in developing or revising the plan, unless clinically contra-indicated. If the consumer agrees to involve significant others in the treatment planning process, a HIPAA compliant authorization for release of information for that party(ies) is (are) signed by the consumer.

(i) Written assessments of the consumer's progress in relation to the treatment plan must be documented at the intervals described below:

1. For each outpatient contact.

2. For residential and Rehabilitative Day Program consumers every two weeks.

3. For partial hospitalization, each service delivered should be documented every day.

4. For Intensive Day Treatment and Child and Adolescent Day Treatment on a weekly basis written or co-signed by the program coordinator/primary therapist. A daily attendance record listing the activities scheduled and attended for each consumer will be maintained in each consumer's record.

5. For Rehabilitative Day Programs every 2 weeks written by a program staff member and co-signed by the program coordinator/case responsible staff member with equivalent credentials. A daily attendance record listing the activities scheduled and attended for each consumer will be maintained in each consumer's record.

6. Progress notes must include the following:

(i) Date.

(ii) Amount of time.

(iii) Setting/location.

(iv) Signature.

(v) Description of services/interventions provided.

(vi) Consumer's response to services/interventions.

(vii) Number of consumers present for group therapy/counseling.

7. In all programs and settings whenever Individual, Family, or Group Therapy/Counseling are provided, such services shall be provided and documented consistent with all requirements for such services described in 580-2-9-.09 (4)(c),(d), and(e). Group Therapy/Counseling progress notes must support that a process-oriented service involving group dynamics was provided. Group Therapy/Counseling for adults may not exceed 15 consumers present or 10 for children and adolescents.

(j) Residential and all day program treatment plans that are reviewed and updated at 3 month intervals or earlier if needed.

(k) Outpatient consumer treatment plans that are reviewed and updated every twelve 12 months.

(l) A medication chart containing a profile of all medication reported by the consumer at intake and an ongoing account of all medications. The chart must contain all of the following information:

1. Both psychotropic and non-psychotropic medications.

2. Both medications prescribed by the providers and by other practitioners.

3. Non-prescription medications.

4. For each category (provider-prescribed, other-prescribed, non-prescription) either a listing of medication or the notation of "none".

5. Periodic updates at the frequency defined by the provider's written policy.

(m) For medications prescribed by the provider: The name, strength and dosage of the drugs, the date prescribed, the date refilled, number of refills permitted, and the prescribing physician's name.

~~(n) The provider will have a system for tracking due dates for injections administered by the provider and scheduling consumers accordingly.~~

~~(o) At discharge or 180 days after receipt of last service, documentation completed within 15 days specifying the status of the case.~~

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

~~1. The name of the program 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 consumer.~~

~~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 consumer or his agent at any time except to the extent that action has been taken in reliance thereon. In the case of those individuals whose release from confinement, probation or parole is conditioned upon his/her participation in a treatment program, the authorization may not be revoked.~~

~~7. A specification of the date (no more than 2 years away 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 consumer (or agent if applicable). There should be 2 witnesses to the consumer's signature if the consumer signs with a mark (e.g. signs with an "X") or if authorization if given by telephone. When~~

~~authorization is given by telephone, the consumer's actual signature is obtained at the earliest opportunity.~~

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

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

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.
Repealed: Filed October 19, 2022.