**Acknowledgement of Receipt**

Acknowledgement of receipt of information is an important step in the process of notifying consumers and LRPs of their rights, privacy practices, how to access services during a crisis, and other important information. This can be accomplished in a variety of ways:

* Develop a handbook with all relevant information contained within and give the handbook to the consumer/LRP at the first meeting. Review the information with the consumer/LRP and obtain a signed and dated acknowledgment that they have received it.
* Develop different documents for each informational area, e.g. Notice of Privacy Practices, Notification of Rights, etc. and have the consumer/LRP sign and date their acknowledgement of receipt at the bottom of each document. Give copies to the consumer/LRP and maintain originals in their record.
* Develop different documents for each informational area and have an acknowledgement page where the consumer/LRP can place their initials beside the name of each document, acknowledging receipt, and then sign/date at the bottom.

It is important that you periodically check for updates in requirements and update your paperwork accordingly. When you revise information given to the consumer/LRP it is important either because of a change in your practice or a change in policies and regulations that you make sure all consumers you serve are notified of the updates and acknowledge receipt of the updated information.

Throughout this packet you will see forms that require the signature of a consumer/LRP. It is important to determine whose signature is required. For consumers receiving service who are over 18 and do not have a guardian, they must sign and date all documentation. If someone over the age of 18 has a guardian, if it is appropriate, they *should* sign paper work, but the guardian *must* sign the paperwork and guardianship papers must be obtained. For children, their parents must sign the paperwork, and in the case of substance abuse treatment and adolescent must also sign the paperwork. It is always best practice, when appropriate to have the service recipient sign the paperwork in addition to a guardian. If a child is in DSS custody or has a guardian that is not a parent, then the guardian must sign paperwork and guardianship papers must be obtained. Sometimes guardianship paperwork is difficult to obtain, you must document you attempts to obtain guardianship papers.

You will also notice that there is a requirement that signatures are dated by the person signing. This is how it is validated that forms, plans, etc. were signed by the person on a particular date.

Practice Letterhead

Consumer Name: Date of Birth:

Medicaid Number: Medical Record #:

By initialing below, I certify that I have reviewed and/or received a copy of the following documents:

Consumer Rights

Notice of Privacy Practices

Financial Agreement

Service Plan

Consumer or Legally Responsible Person Signature Relationship to Consumer Date

Witness Signature Date

**Guidelines for Developing**

**Policy and Procedure on the Protection and Storage of Records**

***\*\*The information herein is meant to serve as a resource and framework for you to develop your own policies/procedures. The information in this section cannot serve as your policies/procedures.***

Providers must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information in both paper and electronic formats.

**Providers must adhere to all federal and state laws, rules, regulations, and policies that protect and ensure the confidentiality, privacy, and security of service records.** Where there are multiple sources of requirements, it is the provider’s responsibility to follow the most stringent requirements, including the code of ethics of their professional licensure.

Policies and procedures should address various aspects of health information management including, but not limited to, how information will be **recorded, stored, retrieved, maintained and disseminated**, as well as to how such information will be **protected against loss, theft, destruction, unauthorized access, and natural disasters**.

Prior to the development of policies and procedures, it is recommended that a risk assessment be done to assess the vulnerability of the environment in which the records are stored. The ensuing policies and procedures must identify the safeguards that have been implemented to ameliorate any potential loss or compromise of the integrity of pertinent clinical/service and non-clinical information.

Policies/procedures should include at a minimum the following:

* How records are safeguarded against loss, tampering, defacement, use, or disclosure by unauthorized persons, but are readily accessible to authorized users at all times.
* How confidential information stored in portable computers is protected. It should address:
  + - Who has access to the laptop/portable computer
    - How information is securely purged from the laptop/portable computer
    - How information contained on the laptop/portable computer is backed up
    - How laptop/portable computer, disks and thumb drive are securely transported
    - How the information that is stored on a portable device is encrypted
    - Password protection of the device.
* If the provider agency utilizes faxing, then policies and procedures must reflect how the information being faxed will be protected, including verifying the fax number with the receiving party and checking to ensure that the fax was received.

* If email is used to communicate confidential information, a policy regarding how the confidential information will be secured and protected shall be developed by the agency. Unless the provider agency has the capability to encrypt email, the emailing of confidential information should be the least preferred method of transmitting information and be used only when the information is password-protected.
* If an electronic medical record is utilized or if confidential information is stored or developed on electronic devises, the following policies, at a minimum, shall be developed:
* A policy which defines who has access to what information,
* A policy which specifies that only authorized users have access to service recipient information and that identifies measures such as passwords, audit trails [a detailed record of who viewed, modified, entered, or deleted data, and when, etc.], to help ensure that only identified users have access to the minimum amount of service recipient information necessary to complete their job function. .
* All entities that maintain electronic records should develop an electronic records policy, please use resources below for assistance.
* Confidential information shall also be protected, disseminated or disclosed as follows:
* Information in service records for consumer s who receive mental health and developmental disabilities services shall be disseminated in accordance with G.S. § 122C-51 through G.S. § 122C-56 and the Confidentiality Rules codified in 10A NCAC 26B.
* Information in service records for those consumer s who receive substance abuse services shall be disseminated in accordance with 42 CFR, Part 2
* Information relative to consumer s with AIDS or related conditions shall only be disclosed in accordance with the communicable disease laws as specified in G.S. § 130A-143.
* Secondary records, which contain information wherein a specific consumer or consumers can be personally identified, shall be protected with the same diligence as the original service record.
* Service records shall only be transported by consumer s designated by the agency:
* When original service records are removed from the facility premises, efforts shall be made to ensure that the records are packaged safely and securely. When service records are transported by motor vehicle, service records shall be secured in a locked compartment [e.g. locked car, locked trunk, or locked briefcase].
* Procedures should include detailed instructions as to what the consumer must do in the event that confidential information is lost or stolen.
* Policy should include circumstance that necessitate the transportation of records and who is authorized to transport those records, per APSM 45-1.
* Service records should be stored and maintained in a manner consistent with the principles of privacy and security. Policy and procedure should include:
* How records are protected from theft, unapproved use, and damage or destruction.
* What safeguards are in place to mitigate harm by fire, water, and natural disasters?
* How records are destroyed in a manner that safeguards confidentiality and privacy.
* How service records are safeguarded and also available to be used.

Providers should implement policies and procedures to mitigate any potential risks and document the risk analysis, the resulting policies and procedures, as well as their implementation. The entire records storage system should be reassessed on a regular basis to ensure that all current risks and changes have been addressed.

* In general terms, the proper handling of medical records, as well as other protected health information, is facilitated by a process including the following activities on the part of the provider:
* Assess current security, risks, and gaps
* Develop an implementation plan
* Implement solutions
* Document solutions
* Reassess periodically
* Records, including paper and digital storage media and hardware, are vulnerable to a variety of physical threats - internal and external forces - that can damage or destroy their readability. Community service providers should analyze their records storage processes for risks such as fire, flood, theft, etc. Some of these physical threats include:
* Instability over time due to deterioration of material
* Improper storage [temperature, humidity, dust, light];
* Overuse;
* Natural disaster;
* Infrastructure failure: plumbing, electrical, climate control
* Inadequate hardware maintenance
* Malfunction of hardware
* Human error and improper handing
* Sabotage, including theft and vandalism.

There are some good resources listed below and you are encouraged to utilize these resources to build a robust policy and procedure on the protection and storage of records.

* APSM 45-2 Records Management and Documentation Manuals: <http://www.ncdhhs.gov/document/apsm-45-2-records-management-and-documentation-manual> Pages 2-7 through 2-10 speak specifically to the protection and storage of medical records
* Privacy: <http://www.hhs.gov/hipaa/for-professionals/privacy/index.html>
* Security: <http://www.hhs.gov/hipaa/for-professionals/security/>
* The Centers for Medicare and Medicaid Services [CMS], which is the federal agency that administers Medicare, Medicaid, and State Children’s Health Insurance Program, has published *The Health Insurance Portability & Accountability Act of 1996 [HIPAA] Security Information Series*, which is a group of educational papers with a section titled, "Security Standards for the Protection of Electronic Protected Health Information." Security of Electronic Records: <https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html?redirect=/hipaageninfo/>
* NC DHHS HIPAA web site: <https://www2.ncdhhs.gov/DMA/hipaa/>
* 45 CFR § 164.530: <https://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/pdf/CFR-2010-title45-vol1-sec164-530.pdf>
* 45 CFR § 164.312: <https://www.gpo.gov/fdsys/pkg/CFR-2007-title45-vol1/pdf/CFR-2007-title45-vol1-sec164-312.pdf>
* APSM 45-1, updated 1/1/2005: <https://www.ncdhhs.gov/document/apsm-45-1-confidentiality-rules>
* Sample Electronic Records and Imaging policy <http://archives.ncdcr.gov/Portals/3/PDF/guidelines/model_erec_policy.pdf?ver=2016-03-21-112010-703>
* Digital Records Policy and Procedure <http://archives.ncdcr.gov/For-Government/Digital-Records/Digital-Records-Policies-and-Guidelines>
* APSM 10-5, Records Retention and Disposition Schedule DMH/DD/SAS Provider Agency <https://ncdhhs.s3.amazonaws.com/s3fs-public/Rec-Retention-and-Disp-Sched_dmh-dd-sas_provagency_APSM-10-5_10-26-11.pdf>

**Notice of Privacy Practices for Protected Health Information**

The HIPAA Privacy Rule gives consumers a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus consumers on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights. Health care providers are required to provide the Notice of Privacy Practice no later than the date of first visit and make a good faith effort to obtain the individual’s written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.

Please visit the following website for sample Notice(s) of Privacy Practice that you can use as a guide when developing one for your practice:

<https://www.healthit.gov/providers-professionals/model-notices-privacy-practices>

**Clinical Information**

The scope of this packet does not include requirements surrounding clinical documentation, however, DMA Clinical Coverage Policy 8C is a great resource for you. Below are requirements for clinical documentation taken directly from Clinical Coverage Policy 8C:

**7.3.3.2 CCA (Comprehensive Clinical Assessment) Format**

The format of a CCA is determined by the individual provider, based on the clinical presentation. Although a CCA does not have a designated format, the assessment (or collective assessments) used must include ALL of the following elements:

a. description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;

b. chronological general health and behavioral health history (including both mental health and substance abuse) of the beneficiary’s symptoms, treatment, and treatment response;

c. current medications (for both physical and psychiatric treatment);

d. a review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area;

e evidence of beneficiary and legally responsible person’s (if applicable) participation in the assessment;

f. analysis and interpretation of the assessment information with an appropriate case formulation;

g. diagnoses from the DSM-5, including mental health, substance use disorders, or intellectual/developmental disabilities, as well as physical health conditions and functional impairment; and

h. recommendations for additional assessments, services, support, or treatment based on the results of the CCA.

i. The CCA must be signed and dated by the licensed professional completing the assessment

**7.3.4 Individualized Plan**

An individualized plan of care, service plan, treatment plan, or PCP, hereinafter referred to as “plan,” consistent with and supportive of the service provided and within professional standards of practice, is required within 15 business days of the first face-to-face beneficiary contact. This plan is based on the assessment, and is developed in partnership with the beneficiary or legally responsible person, or both. When services are provided prior to the establishment and implementation of the plan, strategies to address the beneficiary's presenting problem shall be documented. The plan shall be an identifiable document in the service record.

The plan shall include at a minimum:

a. beneficiary outcomes that are anticipated to be achieved by provision of the service and a projected date of achievement;

b. strategies;

c. staff responsible;

d. a schedule for review of the plan (in consultation with the beneficiary or legally responsible person or both) as needed but at least annually to review goals and strategies to promote effective treatment;

e. basis for evaluation or assessment of outcome achievement; and

f. written consent or agreement by the beneficiary or legally responsible person, or a written statement by the provider stating why such consent could not be obtained.

The treatment plan must be updated as required, but a new plan is required at least annually.

All treatment plans are to be developed in partnership with the beneficiary or legally responsible person, and all updated or new plans require the beneficiary or legally responsible person's signature, and the licensed professional's signature. The licensed professional's signature on the updated or new plan may also serve as the service order.

**7.3.5 Service Notes and Progress Notes**

There must be a progress note for each treatment encounter that documents the following information:

a. Date of service;

b. Name of the service provided (e.g., Outpatient Therapy – Individual);

c. Type of contact (face-to-face, phone call, collateral); non-face-to-face services are not covered and not reimbursable. Services provided in accordance with clinical coverage policy 1H, *Telemedicine and Telepsychiatry*, are considered as face-to-face services. Refer to http://www.ncdhhs.gov/dma/mp/)

d. Purpose of the contact (tied to the specific goals in the plan);

e. Description of the treatment or interventions performed. Treatment and interventions must include active engagement of the beneficiary and relate to the goals and strategies outlined on the beneficiary’s plan;

f. Effectiveness of the intervention(s) and the beneficiary’s response or progress toward goal(s);

g. The duration of the service (e.g., length of the assessment or treatment in minutes;

h. Signature, with credentials, degree, and licensure of clinician who provided the service. A handwritten note requires a handwritten signature; however, the credentials, degree, and licensure may be typed, printed, or stamped; and

i. Service notes must be written in such a way that there is substance, efficacy, and value. Interventions, treatment, and supports must all address the goal(s) listed in the plan. They must be written in a meaningful way so that the notes collectively outline the beneficiary’s response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.

**Note:** The exception to the above service note policy is the documentation required for medical providers offering medication management and billing E/M codes. In this case, the medical provider must document the chosen E/M code with all of the necessary elements as outlined in the current edition of the American Medical Association's Current Procedural Terminology (CPT) manual.

**7.2.2 Coordination of Care**

The provider shall communicate and coordinate care with other professionals providing care to the beneficiary. The provider shall document coordination of care activities. The following are examples of coordination of care activities.

a. Written progress or summary reports;

b. Telephone communication;

c. Treatment planning processes. An individualized plan of care, service plan, treatment plan, or Person-Centered Plan (PCP), consistent with and supportive of the service provided and within professional standards of practice, is required according to **Subsection 7.3.4** below. When the beneficiary is receiving multiple behavioral health services in addition to the services in this policy, a PCP must be developed with the beneficiary, and outpatient behavioral health services are to be incorporated into the beneficiary’s PCP;

d. Coordination of care with the beneficiary’s CCNC/CA care manager (if applicable) and primary care or CCNC/CA physician;

e. Coordination of care with PIHP (not applicable for NCHC beneficiaries

**7.4 24-Hour Coverage for Behavioral Health Crises**

Enrolled providers shall provide, or have a written agreement with another entity, for access to 24-hour coverage for behavioral health emergency services. Enrolled providers shall arrange for coverage in the event that they are not available to respond to a beneficiary in crisis. This coverage shall include the ability for the beneficiary to speak with the licensed clinician on call either face-to-face or telephonically.