

**\*\*\*DRAFT - NOT FOR FILING\*\*\***

**3793:2-1-06 Client records.**

- (A) The purpose of this rule is to state the minimum client records requirements for certification/licensure as an alcohol and drug addiction treatment program.
- (B) The provisions of this rule are applicable to all of the following Ohio alcohol and drug addiction treatment programs, public and private, regardless of whether they receive any public funds that originate and/or pass through the Ohio department of alcohol and drug addiction services, in accordance with division (A) of section 3793.06 of the Revised Code.
  - (1) Alcohol and drug addiction outpatient treatment programs.
  - (2) Alcohol and drug addiction residential treatment programs.
  - (3) Opioid agonist programs.
  - (4) Alcohol and drug addiction ambulatory detoxification programs.
- (C) The provisions of this rule are not applicable to the following programs:
  - (1) Alcohol and drug prevention programs.
  - (2) Alcohol and drug addiction sub-acute detoxification and acute hospital detoxification programs.
  - (3) Criminal justice therapeutic community programs.
  - (4) Treatment alternatives to street crime programs.
  - (5) Driver intervention programs.
- (D) Each program shall have written policies and/or procedures for maintaining a uniform client records system that include, at a minimum, the following:
  - (1) Confidentiality of client records that includes, at a minimum, the following statements:
    - (a) Program staff shall not convey to a person outside of the program that a client attends or receives services from the program or disclose any information identifying a client as an alcohol or other drug services client unless the client consents in writing for the release of information, the disclosure is allowed by a court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purposes.
    - (b) Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a client either at the program or against any person who works for the program.
    - (c) Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.
  - (2) Access to client records:
    - (a) By clients.
    - (b) By staff.

**\*\*\*DRAFT - NOT FOR FILING\*\*\***

(c) By individuals other than clients or staff.

(3) Release of client information.

(4) Components of client records and time lines, when applicable, for completing each component.

(5) Storage of client records that requires client records be maintained in accordance with 42 C.F.R. part 2, confidentiality of alcohol and drug abuse client records.

(6) Destruction of client records to include the requirement that records be maintained for at least seven years after clients have been discharged from the program. Client records shall be destroyed to maintain client confidentiality as required by state and federal law.

(E) Programs shall maintain documentation for services provided.

(F) Components of client records shall include, but not be limited to, the following:

(1) Identification of client (name of client and/or client identification number).

(2) Assessment.

(3) Consent for alcohol and other drug treatment services.

(4) Client fee agreement.

(5) Documentation to reflect that the client was given a copy of the following:

(a) Program rules or expectations of clients.

(b) Client rights and grievance procedures.

(c) Written summary of the federal laws and regulations that indicate the confidentiality of client records is protected as required by 42 CFR Part B, paragraph 2.22.

(6) Diagnosis.

(7) Treatment plans.

(8) Case management plans of care.

(9) Progress notes.

(10) Disclosure of client information forms, when applicable.

(11) Termination summary/discharge plan.

(G) Disclosure of client information forms shall include the following information as required by 42 C.F.R. part 2:

(1) Name of the program making the disclosure.

(2) Name or title of the individual or the name of the organization to which the disclosure is to be made.

(3) Name of the client.

**\*\*\*DRAFT - NOT FOR FILING\*\*\***

- (4) Purpose of the disclosure.
  - (5) Type and amount of information to be disclosed.
  - (6) Signature of the client or person authorized to give consent.
  - (7) Date client or other authorized person signed the form.
  - (8) Statement that the consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.
  - (9) The date, event or condition upon which the consent will expire, unless revoked before that specified time.
- (H) Each disclosure made with the client's written consent must be consistent with 42 C.F.R. part 2, by including the following written statement: "This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."
- (I) A diagnosis shall be made by a clinician who can diagnose substance-related disorders as authorized by the Ohio Revised Code, and shall be recorded in each client's record upon completion of assessment. Supporting documentation in the client record shall include:
- (1) Identification of the client.
  - (2) Diagnosis.
  - (3) Signs and symptoms justifying the diagnosis.
  - (4) Date the diagnosis was made.
  - (5) Original signature and credentials of the clinician making the diagnosis.
- (J) A program may accept a diagnosis made within ninety days of the admission date of a client by a clinician who can diagnose substance-related disorders as authorized by the Ohio Revised Code.
- (K) The individualized treatment plan and case management plan of care may be integrated into a single plan as long as the single plan meets the criteria of paragraphs (L) and (M) of this rule.
- (L) An individualized treatment plan (ITP) shall be written for each client within seven days of completion of the assessment or at the time of the first face-to-face contact following assessment. Individualized treatment plans shall be based on assessment and include, at a minimum, the following:
- (1) Client identification (name and/or identification number).
  - (2) Level of care to which client is admitted.
  - (3) Problem(s) to be addressed including but not limited to diagnosis or diagnoses and other primary problems based upon clinician recommendations.

**\*\*\*DRAFT - NOT FOR FILING\*\*\***

- (4) Measurable goals that address client's needs.
  - (5) Measurable treatment objectives with time frame for achievement of each objective.
  - (6) Frequency, duration and types of treatment services as described in rule 3793:2-1-08 of the Administrative Code.
  - (7) Original signature of the client.
  - (8) Date, original signature and credentials of the person who completed the plan and is qualified to provide alcohol and drug addiction services in accordance with rule 3793:2-1-08 of the Administrative Code.
- (M) A case management plan of care (CMP) shall be written for each client that receives case management services. The CMP shall be completed prior to a client receiving case management services and shall include, at a minimum:
- (1) Comprehensive assessment and periodic reassessment of individual needs. The case management assessment, which can be the same as or derived from the assessment service defined in rule 3793:2-1-08 of the Administrative Code as long as the components described in this rule are also met, shall include:
    - (a) Taking or reviewing a client's history.
    - (b) Identification of the needs of the individual.
    - (c) As necessary, gathering information from other sources. Other sources may include, but are not limited to, family members, medical providers, other behavioral health providers, the criminal or juvenile justice systems, child welfare, social workers and educators.
    - (d) The first CMP reassessment, whether it is stand alone or integrated with the ITP, shall be conducted at least ninety days from the completion of the initial CMP and at least once every ninety days following each reassessment.
  - (2) Development and periodic revision of the CMP shall be based on the case management assessment that includes the following:
    - (a) Goals and actions to address the medical, social, educational and other services needed by the client.
    - (b) Activities that ensure active participation by the client in developing case management goals.
    - (c) Course of action to respond to the assessed case management needs of the client.
  - (3) Referral and related activities to assist the client to obtain needed services, including but not limited to, activities that help link the client with medical, social and educational providers or other programs and services in order to meet identified needs and goals in the CMP.
  - (4) Monitoring and follow-up activities in order to determine if the following conditions have been met:
    - (a) Services are being furnished in accordance with the CMP.
    - (b) Services in the CMP are adequate.
    - (c) Changes in the needs and status of the client.

**\*\*\*DRAFT - NOT FOR FILING\*\*\***

- (N) Programs shall have written policies and procedures that specify criteria and time frames for reviewing and updating an ITP, which take into account the client's changing clinical needs and response to treatment. If the ITP and CMP are integrated, then the integrated plan must be reviewed and updated in accordance with paragraph (M)(1)(d) of this rule.
- (O) Progress notes shall be written to reflect the implementation and evaluation of ITPs for clients admitted to programs. Progress notes are required to include sufficient content to justify the client's continuing need for services. Each service listed in rule 3793:2-1-08 of the Administrative Code delivered to the client, with the exception of urinalysis, shall be documented as defined in this rule in the client's record with either a service level, daily or weekly progress note. Results of urinalysis testing shall be placed in the client's file per paragraph (R)(1)(g) of rule 3793:2-1-08 of the Administrative Code.
- (1) Progress notes shall indicate progress the client is making towards achieving the goals and objectives that are identified in the individualized treatment plan.
- (P) Service level progress notes shall include, at a minimum, the following:
- (1) Client identification (name and/or identification number).
  - (2) Date of service contact or service delivery.
  - (3) Length of time of service contact or service delivery (calculated by the number of hours, minutes and/or start and ending time of service delivery).
  - (4) Type of service (for example, case management, individual counseling, group counseling, crisis intervention, etc.).
  - (5) Summary of what occurred during the service contact or service delivery.
  - (6) Date, original signature and credentials (registration, certification and/or license) of the staff member providing the service.
- (Q) If provided, the following modalities and/or activities shall be documented in each client's record: occupational therapy, recreational therapy, activity therapies, parenting skills training, alcoholism and drug addiction client education, expressive therapies (art, drama, poetry, music, movement) and nutrition education.
- (1) If provided, a progress note is not required for parenting skills training, alcoholism and drug addiction client-education, urinalysis and nutrition education; however, documentation verifying the client's attendance is necessary.
  - (2) If provided, a progress note is required for occupational therapy, recreational therapy, activity therapy, expressive therapy and nutrition counseling.
- (R) Daily or weekly progress notes shall include, at a minimum, the following and may include checklists:
- (1) Client identification (name and/or identification number);
  - (2) For daily progress notes, the calendar day the progress note is applicable to;
  - (3) For weekly progress notes, the weekly period the progress note is applicable to. (must be a continuous 7 day period);

**\*\*\*DRAFT - NOT FOR FILING\*\*\***

- (4) An overall summary of the client's treatment progress during the note period.
  - (5) Date, original signature and credential (registration, certification and/or license) of the staff member writing the daily or weekly progress note. The staff member must be qualified, in accordance with rule 3793:2-1-08 of the Administrative Code, to provide all of the services documented in the daily or weekly service log.
- (S) Client records utilizing daily or weekly progress notes pursuant to paragraph (P) of this rule must contain a service log that includes, at a minimum, the following which may include checklists:
- (1) Date of service for each service provided during the day or week.
  - (2) Type of services (for example, case management, individual counseling, group counseling, crisis intervention, etc.) provided during the day or week.
  - (3) Length of time of each service contact or service delivery (calculated by the number of hours, minutes and/or start and ending time of each service delivery).
  - (4) The signature and license of each clinician who provided services during the day or week.
- (T) A termination summary shall be prepared within thirty calendar days after treatment has been terminated in accordance with the client's individualized treatment plan. For purposes of this rule, treatment has been terminated when no treatment services have been provided or upon documentation of last communication or attempted communication with the client. Services must be documented in the client's chart in order to establish the timeline governing the preparation of the termination summary. Termination summaries/discharges summaries shall include, at a minimum, the following:
- (1) Client identification (name and/or identification number).
  - (2) Date of admission.
  - (3) Date of discharge.
  - (4) Diagnosis.
  - (5) The degree of severity at admission and at discharge for the following dimensions shall be based on the Ohio department of alcohol and drug addiction services' protocols for levels of care (youth and adult) for publicly-funded clients. For non-publicly-funded clients, the degree of severity at admission and discharge shall be based on the Ohio department of alcohol and drug addiction services' protocols for levels of care or other objective placement criteria:
    - (a) Intoxication and withdrawal.
    - (b) Biomedical conditions and complications.
    - (c) Emotional/behavioral/cognitive conditions and complications.
    - (d) Treatment acceptance/resistance.
    - (e) Relapse potential.
    - (f) Recovery environment.

**\*\*\*DRAFT - NOT FOR FILING\*\*\***

- (g) Family or care giver functioning (for youth).
- (6) Level of care and service(s) provided during course of treatment.
- (7) Client's response to treatment.
- (8) Recommendations and/or referrals for additional alcohol and drug addiction treatment or other services.
- (9) Date, original signature and credentials of a person qualified to provide counseling services in accordance with rule 3793:2-1-08 of the Administrative Code.
- (U) If a program maintains electronic health records (EHRs) it must be a system or module that is certified in accordance with the Public Health Service Act (PHSA) Title XXX and also comply with section 3701.75 of the Revised Code.
- (V) If a program discontinues operations or is taken over or acquired by another entity, it shall comply with 42 C.F.R., part 2, subsection 2.19 which governs the disposition of records by discontinued programs.