SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY

NUMBER: BA004

NAME: MEDICAL RECORD POLICY

INITIAL APPROVAL DATE:	03/14/1996	BY: Administrative Committee
(LAST) REVISION DATE:	07/20/2024	BY: EAA
(LAST) REVIEW DATE:	08/15/2024	BY: Policy Committee
DISCONTINUED DATE:	NA	REPLACED BY: NA

I. PURPOSE

The purpose of the Medical Record is to accurately and adequately document an individual's history, including past and present treatment, with emphasis on events affecting the current episode of care.

The Medical Record houses the information that describes all aspects of care, i.e., demographic information, diagnoses, medication lists and problem lists. It serves as a communication link among caregivers and provides clinical decision support, as well as electronically transmitting prescriptions to the pharmacy. Documentation in the Medical Record also serves to protect the legal interests of the individual we serve, the service provider and the Agency and to substantiate reimbursement claims.

II. APPLICATION

Populations: **ALL**
Programs: **Direct - ALL**
Contracted - ALL

III. DEFINITIONS

A. Protected Health Information (PHI): Individually identifiable health information (1) (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media or (iii) transmitted or maintained in any other form or medium. (2) Excludes individually identifiable health information in (2)(i) education records covered by the Family Educational Right and Privacy Act, as amended 20 USC 1232g; and (ii) records described at 20 USC 1232g(a)(4)(B)(iv).

B. Medical Record: The medical record of each individual served by Sanilac County Community Mental Health may be in one or both of the following formats:
   1. Electronic Health Record: Also known as EHR, shall refer to the protected health information (PHI) of individuals served by Sanilac County Community Mental Health and be the original document maintained in electronic format stored in computer files, in the EHR software system and on the servers of the Agency. This would be any PHI generated on and after October 1, 2007.
   2. Paper Record: Paper record shall refer to the protected health information (PHI) of individuals served by Sanilac County Community Mental Health that was the original document maintained in paper format and paper files prior to October 1, 2012.

C. Individual: Individual shall mean any individual who has received services from Sanilac County Community Mental Health.

IV. OWNERSHIP

The Medical Record is considered the physical property of the Agency. The information contained therein is the property of the individual receiving services and may be released only as set forth in the Agency's Policy RR005 Confidentiality and Disclosure of Information and BC043 Release of Information for Substance Abuse Disorder. The CEO or his designee is the holder of the record.

An individual has a right of access to inspect and obtain a copy of their Protected Health Information (PHI) with few exceptions. Only authorized persons can release PHI.

V. ORGANIZATION OF ELECTRONIC HEALTH RECORD (EHR)

The EHR is divided into 9 major sections:

Administrative/Financial
Access/Admissions
Legal/Consents
Court Services
Letters
Other
Search All Scanned Documents
Services
Assessments
Health Services

VI. INFORMATION CONTAINED IN A MEDICAL RECORD

Each individual entering into services is assigned a unique consumer identifier (case number) by the EHR. A complete record of identifying information is to be kept on each medical record including full name, address and telephone number, marital status, sex, race, date of birth, the names and addresses of the individual's next of kin or legal guardian, social security number, all applicable insurance information (with copy of card(s)). The Medical Record should also include consumer characteristics such as living arrangement of the individual, employment status, correction status, payment source(s), income information, and any other demographic information required by the state. The Medical Record should contain the name, address and telephone number of the primary physician for coordination of care.

The medical record shall identify a care manager/therapist for each individual.

The record contains the electronic version of a completed Consent for Mental Health Services that is needed for the use or disclosure of PHI to carry out treatment, payment or health care operation. The record also contains the electronic version of a completed Consent to Exchange Health Information - MDHHS 5515 form that is needed for the use or disclosure of PHI for any other reason that is covered by a Consent form. The forms must specify the information being released, to whom it will be released, the conditions for which the Consent/Authorization will be valid, the expiration date of the Consent/Authorization, and the date and signature of the individual served/guardian. Treatment may be conditioned on receiving a signed consent form; this failure must be documented. Any revoking of a Consent/Authorization form must be in writing. Clinical Records Personnel shall indicate specifically what information has been released (e.g., psychological dated 11/02/91) and include this information in the cover letter when forwarding. Per Public Act 559 of 2016, which went into effect April 10, 2017, written consent is not always required, these exceptions must be verified prior to release of information.

Consent for Mental Health Services forms are completed at time of intake and at least annually thereafter. If significant changes in programming occur before that time, a new consent form is obtained.

A statement, signed by the individual served, indicating that he/she received a summary of rights as a

recipient, the date and by whom they were provided is maintained in the record.

Travel charts used by clinicians should only contain copies of the individual's information with the same standards used to safeguard all PHI. The electronic version of all original documentation created by Sanilac CMH shall be in the individual's electronic health record (EHR).

VII. DOCUMENTATION

Clinicians should exercise the highest standards of professional and personal responsibility in writing for the record. It should always be kept in mind that the record serves a specific purpose for other authorized staff members; that it may be subject to subpoena; and that it is the only concrete documentation of the service delivered by the individual worker and the Agency. Accordingly, personal prejudices, biases, and judgmental statements are out of place in the Medical Record. Slang and any derogatory terms should be avoided. Good judgment should be used in determining how much detail is necessary for treatment purposes in recording information potentially harmful to the individual we serve or others. Names of other persons involved in incriminating situations should be omitted where possible. Names of other individual's receiving services should also be omitted from the record in most instances.

All direct services to an individual must be documented, such as specific findings and results of diagnostic or therapeutic procedures, test methodology, record of prescribed treatments, tests, therapies, and drugs. Services consist of, but are not limited to, screenings, prevention, treatment, and care coordination. The record should also contain strength, dosage and quantity of drugs prescribed. The individual's diagnosis, symptoms, and condition should be included along with any consultation reports. The record also needs to include the prescribing or referring physician's information.

Progress notes must include the date of service, the name of the individual receiving the service, type of service, description of interaction, start and stop time and must be signed and dated by the person providing the service, including appropriate licensure credentials. Documents created through the electronic record system are signed by electronic signature. The e-signature is controlled through an internal computer security system and constitutes the staff person's legal signature. All progress notes must be generated through the computer system.

Clinical documentation shall follow the guidelines established in clinical policy BC1030 Clinical Documentation Guidelines. For SIPs and Residential services, documentation must be completed within 24 hours and filed in the home record. The documentation must be submitted to Sanilac CMH the month following the month of service. If documentation guidelines are not able to be met, staff must notify their supervisor of the reason, in advance, and provide a plan of correction.

VIII. SAFEGUARDS

Please refer to Policy BA023 - Safeguarding Records of Individuals Served.

IX. ABBREVIATIONS

Only abbreviations listed in procedure DC1017 - Approved Abbreviations are to be used in documentation. All other entries must be written in their entirety.

X. LEGIBILITY

The usefulness of the record depends in large part on the legibility of the entries. Agency staff are to use care in making entries in the record to assure legibility.

XI. DATA MANAGEMENT

The EHR is the system utilized to capture all client and service data. The data includes, but is not limited to, demographic information, vital signs, medications prescribed, treatment documentation, diagnoses, referrals, assessment and diagnostic findings, authorizations, crisis and discharge plans.

Service data will include the consumer's unique identifier, the clinic's unique identifier, staff name and credentials, date of service, start and stop time of service, service provided, units of service provided, and diagnosis. The EHR has edits embedded into the system to reduce errors. The EHR has a large report module that offers many standard reports that allow us to track and monitor activity for all Agency consumers. Sanilac CMH EHR contains staff information which is used to validate an appropriate licensed staff performs a service, to bill out services to third party payers, and to encounter services to the State.

Sanilac CMH is also responsible for collecting all necessary data elements from DCOs and other contractors in order to complete all required reporting. MDHHS 5515 consents will be completed to ensure appropriate sharing of information.

The EMR is used to create and pull reports to show such things as consumer and quality data, encounters, consumer outcomes; reporting metrics for the State, region, SAMHSA, CCBHC and CARF; service usage as a whole and by funder; and staffing ratios. OASIS is used to track services and staffing information including, but not limited to, the following information: consumer characteristics; staffing; access to services; use of services, screening, prevention, and treatment; care coordination; other process of care; costs; and consumer outcomes.

Reporting is completed based on the intervals dictated by the entity requiring the information, such as the EQI is completed every 4 months and submitted to the State, encounter and claim data is submitted every two weeks to Region 10, and performance indicators are submitted quarterly and submitted to Region 10 and the State.

XII. QUALITY IMPROVEMENT

Continuous quality improvement is essential for the Agency's growth. Sanilac CMH completes a data-driven Quality Improvement (QI) plan annually which contains the goals and objectives that the whole Agency will be working on throughout the year. The goals are based on many factors such as program need, survey results, staff and consumer input, State and Federal mandates, grant funding, and stakeholder feedback. The plan documents include the reason/rationale for each goal and the measurement/objectives to reach the goal. The clinical departments look at the needs of the population it serves and reflect the scope, complexity, and past performance of the services and operations, improvements to behavioral and physical outcomes. The plan is to address priorities for improvement in quality of care and safety and improvement in the Agency's performance. The administrative departments look at ways to improve the support they provide to the clinical departments and to enhance programs. Status updates are provided on an ongoing basis to the Quality Improvement Committee by the staff that oversees the goal which includes the effectiveness of the plan. The Board must approve the annual plan. The Board is provided a status update report mid-year and a final report at the end of the fiscal year.

XIII. ERROR CORRECTIONS

As the medical record is considered a legal document, extreme care should be exercised when making an entry. Error correction is a particularly important aspect of documentation.

Errors in the medical record on the computer system must be corrected according to the error correction or addendum process outlined herein.

Error Correction Process:

If an error was made in entering the activity information, such as activity code, time or location, follow the error correction process for our software system.

If an error was made in entering the actual progress note, a change signed document must be completed. This might be used if a misspelling is discovered, etc. However, if there is a major change such as addition to the note, the preferred method is to create an addendum through the system so

that your record is complete.

If a serious error occurs, such as entering the wrong individual's note in another's record and the note and activity must be removed, contact the Data Management staff to have the note deleted with an explanation for the request.

Data error reports are pulled by Data Management staff throughout the month. Daily pulls are done for:

- Face-to-Face SAL w/Indirect code
- SAL less than 2 minutes
- SAL greater than 8 hours
- Overlapping SAL's for staff
- Non-Face-to-Face SAL w/direct code
- Primary DX is SUD
- Missing SUD status, and
- Invalid SA diagnosis.

Monthly pulls are done for:

- IPOS overdue
- Missing primary location
- Missing primary staff
- Missing CAFAS errors, and
- Missing/incomplete NOMS.

All other data error reports and unsigned notes reports are pulled weekly.

Emails are sent to the staff person who has the error with a request for correction of that error and given a deadline of one week. If the error is not corrected, a second email is then sent after the deadline to the staff person and their supervisor with a new one-week deadline. If the error is still not fixed, a third email is sent after the new deadline to the staff person, their supervisor, and the program director.

XIV. REQUEST FOR AMENDMENT TO RECORD

Requests to amend PHI must be made by the individual and/or legal guardian. The response must be timely and in a standardized manner for all requests received from an individual and/or legal guardian to amend their record. All requests from individuals and/or their guardian for amendments of health records that are received will be documented.

The request for amendment should be denied if Sanilac CMH did not create the information, the staff who created the information is no longer employed with the Agency, the information is not part of the individual record, or if the information in the record is accurate and complete.

A. Procedure

1. The CIO, or designated staff, will keep track of requests for amendment.

2. The primary clinical staff/caseholder will review the individual's written request, which must clearly detail what is to be amended in the EHR and why.

3. The primary clinical staff/caseholder will make a recommendation as to if the request for amendment should be honored or denied. The CIO, or designated staff, will make the final determination. If approved, staff inform the individual and/or legal guardian that the amendment was accepted and made, and a copy of the amended information is provided to anyone who has received the information subject to that amendment. If the request is denied,

staff, with the consultation of their Supervisor, provides to the individual and/or legal guardian, a letter which includes an explanation of the reason for denial and the individual's right to submit a written statement disagreeing with the denial. The individual is also provided with information on how to submit a complaint.

4. The CIO, or designated staff, will review the individual's letter of disagreement, if submitted. The CIO, or designated staff, will prepare a written response to the statement of disagreement and provide a copy to the individual that includes: the information that the individual and/or legal guardian wanted amended, the individual's request for amendment, the denial of the request, the individual's statement of disagreement and the written rebuttal including the name and title of the staff responsible for receiving and processing the amendment requests.

5. Documents in the individual's EHR record the processing of the request for amendment and outcome. Supporting documentation will be submitted for scanning into the individual's EHR.

6. Copies of the correspondence with the individual and/or legal guardian will be scanned into the individual's EHR in the correspondence section.

XV. RECORD RETENTION

Medical Records are maintained in the following media types:

A. Microfilm – Past microfilmed jackets are kept in a special microfilm cabinet. No further microfilming of records will be done. Duplicate rolls of the microfilm are currently kept in the case of a lost or damaged microfilm jacket which may need to be recreated. The microfilmed jackets have the following color codes in effect that correspond to the case numbers:

   400's – Yellow
   800's – Black
   300's – Red
   200's – Blue
   100's – Green.

B. Scanned to CD by Paper Vision – CD's containing the scanned images are in the possession of the Agency IT Department and have been placed into the appropriate directory on the Agency server. Rights to access the appropriate directory on the server will be determined and granted by the IT Department. A copy of each CD is kept in the server room and locked in the fireproof safe.

C. Scanned to OASIS – Documents from previously held paper medical records have been scanned into the Agency EHR known as OASIS.

D. Purging of Records – It is the practice of Sanilac CMH to **NOT** purge/destroy any of the EHR formats identified above.

XVI. REQUESTS FOR COPIES OF RECORDS

The following individuals or agencies may request copies of information held by Sanilac CMH:

A. State, county or local government agencies may request client records when accompanied by an appropriate release or as mandated by law.
B. Individuals, who have in the past or are currently receiving services, or their legal representative (guardian, POA or parent) may request copies of their case record.
C. State, county or local government agencies, as well as any citizen, can request public information covered under the Freedom of Information Act (FOIA), as outlined in Sanilac CMH Policy BA079.
D. Requests will be processed as follows:

a. Social Security requests for information required to determine an individual's application for SS benefits will be charged at the current rate allowed by Social Security and with no additional cost to the individual.
b. Requests for copies of the following information by individuals receiving services, their legal representative, and State, county or local agencies will be provided at no charge for:
    i. Most current Individual Plan of Service, including amendments
    ii. Most current assessments
    iii. Provided the records are copied to a CD.
c. Individuals receiving services and/or their legal representatives will not be charged a fee for copies of information Sanilac CMH is required by law to provide (i.e., Individual Plan of Service, plan amendments, etc.)
d. Contractual staff, home providers or agencies will not be charged for copies of clinical records required to provide services to individuals referred for services.
e. Requests by individuals and/or their legal representatives for paper copies of their records shall be processed as follows:
    i. Paper copies totaling 20 pages or less will have no charge.
    ii. Paper copies totaling 21 pages or more will be charged at the following rate:

2011 Base Year Cost/hour	$25.00
Cost/Copy	$00.02

f. All other requests for public information will be provided and charged for as outlined in the Freedom of Information Act (FOIA), as outlined in Sanilac CMH Policy BA079.

XVII. OTHER USE

The Sanilac CMH EHR currently known as OASIS is also utilized to conduct activities such as population health management, quality improvement, reducing disparities and for research and outreach. Additionally, the Agency utilizes MDHHS systems such as CareConnect 360 and the Waiver Support Application (WSA) to coordinate care for those served.

XVIII. ENFORCEMENT

All Supervisors and Officers will be expected and are responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination from employment, professional discipline, or criminal prosecution in accordance with the provisions outlined in Employee Conduct and Discipline Policy (BA044).

XIX. REFERENCES

BC149 - Clinical Documentation Guidelines Policy
BA009 - Microfilming and Scanning Policy
BA023 - Safeguarding Records of Individuals Served
DC1017 - Approved Abbreviations Procedure
BA044 – Employee Conduct and Discipline Policy
RR005 – Confidentiality and Disclosure of Information