Title: Case Records Policy

Prepared By: Clinical Director

Purpose:

To define the guidelines for documentation placed in the consumer's case records.

Scope:

This policy applies to all employees and contractual providers of Huron Behavioral Health (HBH). This policy also applies to all consumer case records.

Information:

N/A

Policy:

1. A case record shall be maintained for each person or family served by HBH. Records are retained electronically using an Electronic Medical Record (EMR) system. Case records contain Protected Health Information (PHI) and Electronic Protected Health Information (EPHI) and contain confidential and sensitive personal and health information. Confidentiality and disclosure requirements apply to all consumer records (paper and electronic). (See also "Confidentiality and Disclosure of Information Procedure" RR.2.07).
2. Access to the case records is limited to:
   a. Authorized agency personnel on a "need to know" basis (see also ORI.1.14 "Minimum Necessary for Internal Disclosure Policy")
   b. Others outside of the organization whose access is permitted or required by law (see also RR.2.07 "Confidentiality and Disclosure of Information Procedure").
   c. The individual served and, as appropriate, the parent, or legal guardian of the individual served.
3. Minimum contents of the case record are:
   - Biographical, Demographic, or other personal identifying information
   - Reason for referral/request for services
   - Assessments
   - Person-Centered Plans (PCP)
   - Signed Consent forms and Information Release forms
   - Description of services provided
   - Routine documentation of on-going treatment/service activities
   - Copies of medication orders (if applicable)
   - Fee Assessment documentation
   - Recommendations for ongoing and/or future service needs and referrals made
   - Assignment of other care or follow-up responsibility (if needed and as appropriate)
   - Closing Summary (if applicable)
4. Other information may be contained in the case file if appropriate and necessary for the care and treatment of the individual. Those documents may include, but are not limited to:
   - Psychological evaluations
   - Psychiatric evaluations/assessments
   - Medical, toxicological, diagnostic records
   - Court documents, court orders, guardianship papers, legal documents, advance directives, etc.

- Information about services provided from other organizations or service providers
- Other information essential for service delivery

5. Entries into case records are only made by authorized staff and are to be:
   - Specific
   - Factual
   - Pertinent to the nature of the service and the needs and preferences of the persons served
   - Entered within twenty-four (24) hours of the service provided
6. Case record entries are made by authorized personnel only and, when required, are reviewed, signed, and dated by the supervisor, clinical director, and/or psychiatrist, as appropriate (see also "Basic Rules for Documenting Service Records" QI.2.19).
7. All entries in the case record must be:
   - Complete
   - Signed
   - Credentialed
   - Dated
   - Legible (if hand-written)

Definitions/Acronyms:

COA – Council on Accreditation
EMR – Electronic Medical Record
EPHI – Electronic Protected Health Information
HBH – Huron Behavioral Health
PCP – Person Centered Plan
PHI – Protected Health Information

Forms:

N/A

Records:

Case records are retained in accordance with the "HBH Record retention and Storage Policy" (QI.1.23).

Reference(s) and/or Legal Authority

COA standards
ORI.1.14 Minimum Necessary Rules for Internal Disclosures Policy
QI.1.23 HBH Record Retention and Storage Policy
QI.2.19 Basic Rules for Documenting Service Records Procedure
RR.2.07 Confidentiality and Disclosure of Information Procedure

Change History:

Change Letter	Date of Change(s)	Changes
A	02/10/09	Reviewed and revised to comply with COA 8th Edition Standards and present practices – removed COA chapter-specific reference (G9), added reference "EPHI" & "PHI", added second sentence in #1, and "Records" section added references to RR.2.07 (Confidentiality & Disclosure Procedure) 2 places and ORI.1.14 (Minimum Necessary Policy) 2 places, added #7, added 2nd bullet in #5, added "and guardianship…" to 3rd bullet in #5.
B	07/16/13	Reviewed and revised to comply with 8th edition COA standards – removed "Gallery" (2 places) "Records" & "Policy" sections, #4 5th bullet added "release of information forms", minor wording/grammar changes without changing content, #8 removed example with first initial and full last name, #5 added "Psychiatric Assessments", #2 combine ""a" & "b" into "a".
C	02/02/16	Combined old numbers 8 & 9 into new #7 and bulletized, in #2 re-ordered a-c, 2nd bullet #4 added "evaluations", made numerous small grammatical corrections/changes throughout document without changing sentence content.
D	07/10/17	Made several minor wording/grammatical changes/corrections throughout document without changing sentence content.
