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 clinical 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 individual 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 consists of 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 "Minimum Necessary for Internal Disclosure Policy" ORI.1.14)
    b. Others outside of the organization whose access is permitted or required by law (see also "Confidentiality and Disclosure of Information Procedure" RR.2.07" and "Minimum Necessary Protocols for External Disclosure of PHI Policy" ORI.1.13).
    c. The individual served and, as appropriate, the parent, or legal guardian of the individual served.
3. Minimum contents of the case record include:
    - Biographical, Demographic, historical, or other personal identifying information
    - Reason for referral/request for services
    - Assessments
    - Individual Plans of Service (IPOS)/Person-Centered Plans (PCP)
    - Signed Consent forms and Information Release forms
    - Description of services provided
    - Routine documentation of on-going treatment/service activities (such as progress notes, periodic reviews, etc.)
    - 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 (if needed and as appropriate)
    - Closing Summary and Aftercare Plan (if applicable)
4. Other information may be contained in the case record as 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, crisis plans
- Information about services provided from other organizations or service providers
- Other information essential for service delivery

5. Entries in the case records shall only be 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) business hours of the service provided
6. Case record entries are to be made by authorized personnel only. And, when required, they 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 (when hand-written)

Definitions/Acronyms:

COA – Council on Accreditation
EMR – Electronic Medical Record
EPHI – Electronic Protected Health Information
HBH – Huron Behavioral Health
IPOS – Individual Plan Of Service
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) and "Organizational Record Retention and Disposal Policy" (ORI.1.35).

Reference(s) and/or Legal Authority

COA standards
ORI.1.13 Minimum Necessary Protocols for External Disclosure of PHI Policy
ORI.1.14 Minimum Necessary Rules for Internal Disclosures Policy
ORI.1.35 HBH Record Retention and Storage 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.
E	03/27/19	In "Scope" section changed "contractual providers" to "contractual clinical providers", in "Policy" section 2.b. added ORI.1.13. in #3 4th bullet added "Individual Plans of Service (IPOS)", in 7th bullet added "such as progress notes, periodic reviews, etc.)", in last bullet added "and Aftercare Plan" & #5 last bullet changed "24 hours" to "24 business hours", in "Acronyms" section added "IPOS", in "Records" section added ORI.1.35, in "References" section added ORI.1.13 & ORI.1.35, made several minor wording/grammatical changes/corrections throughout document without changing sentence content.