



# HURON BEHAVIORAL HEALTH OPERATIONAL POLICY

Policy #: **QI.1.29**  
Issue Date: 02/04/05

Rev. Date: 11/19/24  
Page: 1 of 3

## Title: Case Records Policy

Prepared By: Clinical Director

**NOTE: This Document Copy is Uncontrolled and Valid on this date only: December 23, 2024. For Controlled copy, view shared directory I:\ drive**

### Purpose:

To define the guidelines for documentation placed in the consumer's case record in the Electronic Medical Record (EMR) system.

### Scope:

This policy applies to all employees (including full-time and part-time employees), contract clinical providers, volunteers, students, and/or interns of Huron Behavioral Health (HBH) and all consumers served by HBH.

### 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 consist 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 (with the appropriate signed release of information and consent forms) 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, and other personal identifying information
  - Reason for referral/request for services
  - Assessments
  - Individual Plans of Service (IPOS) and addendums to the IPOS
  - Signed Consent forms and Information Release forms
  - Description of services provided
  - Routine documentation for on-going treatment/services (e.g., progress notes, periodic reviews, etc.)
  - 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

## Title Case Record Policy

Prepared By: Clinical Director

Procedure #: QI.1.29  
Issue Date: 02/04/05  
Rev. Date: 11/19/24  
Page: 2 of 3

NOTE: This Document Copy is **Uncontrolled and Valid on this date only: December 23, 2024.** For Controlled copy, view shared directory I:\drive

- Psychiatric evaluations
  - Clinical assessments
  - Medical, toxicological, diagnostic records, including, when applicable, special treatment procedures, allergies, or adverse treatment responses
  - Court documents, court orders, guardianship papers, legal documents, psychiatric advance directives, crisis plans
  - Information about services provided from other organizations or service providers
  - Other information essential to the delivery of services
5. Entries in the case records shall only be made by authorized staff and are to be:
- Specific and detailed
  - Factual, accurate, and complete
  - Professional and non-judgmental
  - Pertinent to the nature of the service and the needs and preferences of the persons served
  - Timely (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  
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](#)

# Title Case Record Policy

Prepared By: Clinical Director

Procedure #: **QI.1.29**  
Issue Date: **02/04/05**  
Rev. Date: **11/19/24**  
Page: **3 of 3**

NOTE: This Document Copy is **Uncontrolled and Valid on this date only: December 23, 2024.** For Controlled copy, view shared directory I:\drive

## [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 8 <sup>th</sup> Edition Standards and present practices – removed COA chapter-specific reference (G9), added reference “EPI” & “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 2 <sup>nd</sup> bullet in #5, added “and guardianship...” to 3 <sup>rd</sup> bullet in #5.
B	07/16/13	Reviewed and revised to comply with 8 <sup>th</sup> edition COA standards – removed “Gallery” (2 places) “Records” & “Policy” sections, #4 5 <sup>th</sup> 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, 2 <sup>nd</sup> 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 4 <sup>th</sup> bullet added “Individual Plans of Service (IPOS)”, in 7 <sup>th</sup> 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.
F	02/02/21	Made several minor wording/grammatical changes/corrections throughout policy without changing sentence content.
G	04/01/21	In “Policy” section #4 fourth bullet added “including, when applicable, special treatment procedures, allergies, or adverse treatment responses”.
H	02/08/23	In “Policy” section 2.b added (with the appropriate signed release of information and consent forms)”, made several minor wording/grammatical changes/corrections throughout policy without changing sentence content.
I	11/19/24	In “Policy” section #4 5 <sup>th</sup> bullet added “psychiatric”, in #5 1 <sup>st</sup> bullet added “and detailed”, in 2 <sup>nd</sup> bullet added “accurate, and complete”, added 3 <sup>rd</sup> bullet, in 5 <sup>th</sup> bullet added “Timely”, in “Acronyms” section removed “PCP”.