ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 09/24

CHAPTER		**CHAPTER**	**SECTION**	**SUBJECT**
Service Delivery		03	002	0005
SECTION	**SUBJECT**			
Records	Case Record Format and Removal Process			
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I. APPLICATION:

- ☐ SCCCMH Board
- ☒ SCCCMH Providers & Subcontractors
- ☒ Direct-Operated Programs
- ☒ Community Agency Contractors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health (SCCCMH) shall ensure that all case records are maintained in an electronic format.

III. DEFINITIONS:

A. EHR (Electronic Health Record): The official case record which contains a collection of patient electronic health information generated by one or more encounters in any care delivery setting and including various health-related, demographic, and service information from 10/01/2012 forward.

B. Historical Case Record: The official case record which contains all the case record documentation no longer in effect but required to be maintained under Michigan Department of Health and Human Services (MDHHS) retention guidelines. There should be one separate historical file for each Individual Plan of Service (IPOS) year. Historical files are currently maintained in an electronic format.

IV. STANDARDS:

A. As SCCCMH moves towards a fully electronic health record in OASIS, some case record forms are completed electronically, some forms are available in hard copy only, and some forms are available in both formats.

B. Group home documents required to be included in SCCCMH's EHR will be forwarded for scan/upload into OASIS.

C. The Scanned Document Guide (located in ADP) will be kept updated by Quality Improvement Data Management (QIDM) staff and appropriate staff will be notified when changes occur, such as when new forms are added, deleted, or modified due to agency needs, state or federal requirements, or accreditation recommendations.

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D. Staff must remain aware of the most current case record requirements and complete clinical documentation in alignment with Medicaid guidelines and the Michigan Mental Health Code.

V. PROCEDURES:

SCCCMH

Primary Caseholder (including contract agencies)/ Clinical Staff / Administrative Staff

A. Completes documents within OASIS Electronic Health Record (EHR) as required.

B. Forwards any hard copy documents (e.g., signature pages, releases, etc.) to Records/Scanning Staff to be scanned/uploaded into OASIS.

C. Forwards to Records/Scanning Staff for scan/upload any hard copy documents that are created outside of OASIS (e.g., guardianship papers, correspondence, etc.) and that should be added to the EHR. Staff should refer to the Scan Document Guide (available on ADP) to determine which forms are included in the EHR and where they are located.

Records/Scanning Staff

A. Scans/uploads documents that have been forwarded within 48 hours of receipt of document. Documents are to be scanned/uploaded into the correct consumer record in the correct location per the Scan Document Guide.

B. Holds scanned documents (pdf version) for a minimum of 14 days after scanning into EHR before document is deleted.

Contract Agency Providers

A. Ensures **all** required case record documentation according to their contract requirements is completed correctly and forwarded to SCCCMH in a timely manner to be scanned/uploaded into the EHR.

Requesting Archived Records for Review

Program/Agency

A. Requests a record search by Administration staff.

QIDM Staff

A. Conducts a search and locates requested archived record(s). Sends the requested file(s) via secure messaging in OASIS to the requester.

Program/Agency

A. Deletes the .pdf file when finished with review.

VI. REFERENCES:

N/A

VII. EXHIBITS:

N/A

VIII. REVISION HISTORY:

Dates issued 11/88, 02/91, 08/93, 01/95, 01/98, 07/04, 01/07, 01/12, 09/13, 09/14, 09/15, 09/16, 11/17, 01/18, 01/19, 11/20, 09/21, 09/22, 9/23.