ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 05/24

CHAPTER Information Management		**CHAPTER** 08	**SECTION** 003	**SUBJECT** 0005
SECTION Electronic Health Record System	**SUBJECT** Electronic Health Record Management			
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I. APPLICATION:

ST. CLAIR COUNTY CMH
☐ SCCCMH Board
☒ SCCCMH Providers and Subcontractors
☒ Direct-Operated Programs
☒ Community Agency Contractors
☒ Residential Programs
☐ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall ensure to establish responsibility and standards for the management and use of the electronic health record (EHR).

III. DEFINITIONS:

A. Electronic Health Record (EHR): A longitudinal electronic record of an individual's health information generated by one or more encounters in a care delivery setting which includes demographics, service plan, progress notes, medications, vital signs, past history, etc. The information is maintained in a form able to be processed by a computer that is stored and transmitted securely, and is accessible by multiple authorized users. The EHR has the ability to generate a complete record of a clinical encounter, as well as supporting other care-related activities directly or indirectly via interface – including evidence-based decision support, quality management and outcomes reporting. Its primary purpose is the support of continuing, efficient and quality integrated health care, and it contains information that is retrospective, concurrent and prospective. An EHR replaces the paper medical record as the primary source of case record information.

B. OASIS: Optimal Alliance Software Information System – is the certified electronic health record utilized by Lapeer, Sanilac and St. Clair CMHs and contract providers.

C. 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 U.S.C. 1232g; and (ii) records described at 20 U.S.C. 1232g (a)(4)(B)(iv).

IV. STANDARDS:

A. EHR – Generally

1. A health record will be maintained for every individual who is receiving or has received mental health services.

2. The Case Record (Health Record) is a collection of documents concerning an individual who receives mental health and integrated health care. It is created and maintained by each CMH in accordance with policies and Michigan Department of Health and Human Services (MDHHS) rules and regulations, made by a person who has knowledge of the acts, events, opinions, or diagnoses relating to the individual and made at or around the time indicated in the documentation.

3. Each CMH will have an identified person or department who is custodian of the Electronic Health Record.

4. The electronic health record will be organized according to OASIS Chart Links. External and non-OASIS developed forms will be scanned/uploaded into OASIS within 24-48 hours.

    A. Protected health care or treatment based documents from external providers will be scanned/uploaded into the record.

    B. Some CMH related forms not available in OASIS will be scanned/uploaded into OASIS following the recommended scanning procedure at a centralized location.

5. Each CMH will be responsible for maintaining a complete electronic case record, including following policies and procedures to safeguard the data integrity, security and privacy of the EHR.

B. EHR – Data Integrity

1. Users are expected to follow standards and expectations for documentation in the electronic health record that supports accurate, complete and timely data entry according to Exhibit A.

2. All staff who create, handle, view or modify personal health information that is part of the clinical record have a responsibility to ensure that the information is as accurate as possible and belongs in the record. In addition, if documents or information appears to be missing, it is the responsibility of the primary case holder to attempt to obtain this information or provide documentation of its absence (ex. Individual chooses not to provide primary care information or provide health history).

3. Staff that are responsible for billing, claims, obtaining or maintaining any of the billing records shall ensure that the information is complete, entered in a timely manner, communicated to the appropriate individuals and appropriately secured according to OASIS security administrative procedures.

4. The utilization of standardized clinical forms enhances care, ensures a person-centered plan and recovery process, reduces redundant collections of clinical information, enhances individual outcomes and measurement of data, and ensures ease of accessibility of information. Confirming that all staff make use of the clinical forms in OASIS reduces the risk that information is not collected uniformly, reduces the amount of paperwork, results in more objective data collection and enhances system-wide accountability.

5. Every effort will be made to ensure that existing "paper" forms be transferred to electronic versions in OASIS as applicable. This reduces the needs for scanning/uploading and provides consistent usage of the forms. As paper forms are reviewed, an OASIS version is created. The OASIS versions are approved at the OASIS and Data Management Committee and then tested prior to implementation into the production mode of OASIS. This process continues to enhance the accessibility and usability of the electronic health record.

C. EHR – Changes (amendments, corrections, deletions, disclaimers)

1. Requests to amend the EHR per the Michigan Mental Health Code (MHC) section 330.1749 Statement Correcting or Amending Information: "A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record. The recipient, guardian, or parent of a minor recipient shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become part of the record."

2. Form #0917 Request for Amendment of Protected Health Information is to be completed and submitted by the recipient, guardian or parent of a minor recipient will be added to the Electronic Health Record (EHR).

3. The request for amendment should be denied if: the CMH did not create the information, the staff who created the information is no longer employed by Sanilac, St. Clair or Lapeer CMH, the information is not part of the individual record, or if the information in the record is currently accurate and complete.

4. The records are to be amended at the discretion of each CMH designated administrative authority.

5. Any corrections of erroneous entries in OASIS must be made in accordance with the requirements defined by this administrative procedure. Entries to the electronic health record will be maintained and inaccurate information will be accessible and changes to the information traceable.

6. A document is considered valid in OASIS once it is signed by the staff (and signed by supervisor) documenting the provision of the service. Signing a document serves as authentication and adds the document as official documentation in the electronic health record.

7. Signed documents cannot be deleted from the record. If a change is needed or required in regards to an incorrect date, time of service, location code or individual, the corresponding CMH data staff must be contacted for assistance. Staff must change own record if changes are requested. Signed documents can be deleted by data staff by request from creator of the document. However, a record of this change is kept.

8. No changes can be made to a signed electronic document without approval; however amendments are allowed to be made to the Individual Plan of Service (IPOS). A change signed document request can be made if additions or corrections are needed to a signed OASIS document.

9. Form #1039 Notice of Disclaimer will be scanned into any records that demonstrate inadequate, inaccurate or missing case records documentation.

10. Documents created before 10/1/12 in a paper format but scanned into OASIS may contain corrections made by ink including a line drawn through the portion that was changed with the word “error” or “correction” beside the deleted section. The correction should include a date and staff signature of the staff who made the correction. The corrected statement may be rewritten or typed.

V. PROCEDURES:

A. EHR - Generally

Records Staff

1. Will be responsible to scan/upload records into OASIS as designated by the Scan Document Guide. All current individuals’ cases are a fully electronic record. Historical records (which includes some closed cases) may be accessed by PDF.

Staff

2. Will receive accessibility to OASIS based on their need to complete individual job functions. Only authorized staff with a “need to know” are allowed access to view an individual’s electronic health record. CMH and CMH providers are responsible for developing and adhering to a process which outlines staff authorization to electronic health records based on assignments and

supervision responsibility. Staff access will be monitored on a regular basis and access will be adjusted to reflect any job function changes.

Administration

3. CMH will assign a specific staff or a department within their organization who is responsible for oversight of the electronic record. This includes assisting with controlling the proper access to the records, ensuring completeness and integrity of the content of the record and the security standards established in the Health Insurance Portability and Accountability Act of 1996, as well as the Michigan Mental Health Code.

B. EHR – Integrity

Staff/Supervisors

1. Enter information and data in OASIS after interaction with the individual or non-face to face activity is completed. When efficient, data shall be entered directly rather than entered on paper forms and then transferred to the system.

2. Will be allowed to perform the above tasks related to information in OASIS if they are users authorized to enter, alter or remove data who are trained in the appropriate standards and procedures.

C. EHR – Changes

Administration

1. Designates staff or a department to keep track of record management.

Clinical Staff/Primary Case Holder

1. Reviews the individual's written request on form #0917 Request for Amendment of Protected Health Information, which clearly details what is to be amended in their electronic health record and why.

2. Determines if the request for amendment is to be honored or denied. If approved, staff informs 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. Determines if the request for amendment 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.

3. Reviews individual's letter of disagreement, if submitted. CMH prepares a written response to statement of disagreement and provides 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 CMH's denial of the request, the individual's statement of disagreement and the CMH's written rebuttal including the name and title of the staff responsible for receiving and processing the amendment requests.

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

5. Ensure that copies of correspondence with the individual and/or legal guardian is scanned into the individual's electronic health record in the correspondence section.

Staff

6. Reviews and Identifies information in OASIS that need changes or corrections.

7. Deletes an unsigned document in OASIS using the delete option if the document was created in error or needs to be reentered.

8. Determines if a correction/addition is needed to the IPOS. Staff must make an amendment to the document or a change request. An amendment is used to provide additional information in conjunction with an original entry. With this type of correction, a previous note has been made and the amendment provides additional information to address a specific situation or incident. The author must provide a reason for the amendment. A new document is prepared and signed clearly identifying the document as an amendment.

9. Updates documents in OASIS annually, quarterly or as needed.

Staff/Supervisor

10. Completes a Notice of Disclaimer (form #1039 in Forms Index) denoting what portion of the individuals record is not up-to-date, is missing, is inaccurate, or was not maintained. The documentation of incomplete records is necessary for auditing and the integrity of the electronic health record. This Notice of Disclaimer will be submitted for scanning into the electronic health record.

VI. REFERENCES:

A. HIPPA Privacy Rule, 45 CFR Part 164 (164.501)

B. Mental Health Code, Act 258 of 1974, 330.114 (section 141)

C. American Recovery and Reinvestment Act of 2009

D. #0917 Request for Amendment of Protected Health Information

E. #1039 Notice of Disclaimer

VII. EXHIBITS:

A. Standards and Expectations for Documentation in the EHR

IX. REVISION HISTORY:

Dates issued 11/20, 09/21, 09/22, 09/23.

EXHIBIT A

STANDARDS AND EXPECTIONS FOR DOCUMENTATION IN THE EHR

1. The accuracy, comprehensiveness and timeliness of data in OASIS shall meet the requirements of the Michigan Department of Health and Human Services (MDHHS), External Quality Review (EQR), Commission on Accreditation of Rehabilitation Facilities (CARF), and any other necessary regulatory or accrediting organizations. Commission on Accreditation of Rehabilitation Facilities

2. Data and Quality Improvement assigned staff monitor the accuracy, completeness and timeliness of the data in OASIS.

3. All documentation will comply with the standards of administrative and clinical record keeping as specified in the Medicaid Provider Manual, MDHHS Administrative Rules, Michigan Mental Health Code and other polices and guidelines set forth by the Region 10 PIHP.

4. Service ActivityLogs (SALS) for direct operated programs shall be signed in accordance with CMH clinical documentation timelines, and should be reviewed by supervisors for accuracy as needed and by billing personnel through auditing reports.

5. Claims should be entered or imported as denoted by the designated process and should pass through system edits as part of the claims processing cycle.

6. All data entries are dated by month, day and year. Many entries in the individual chart contain the author's identification by name and credentials. The author identification may be handwritten signature (if document is scanned) or by a unique electronic identifier/signature. It is expected that all documentation is signed by the author at time of completion.

7. All data entries in OASIS, involving authorized services that require specific times, will indicate actual beginning and ending times of the service provided. Exceptions may include per diem services or equipment, etc.

8. Individual Plans of Service (IPOS) are not effective (valid) until individual/guardian has provided a signature or in rare circumstances, the guardian has given verbal consent. Therefore, documentation must be completed prior to effective date.

9. Delayed entries are acceptable within a reasonable time period after the service, for the purposes of clarification, error correction, the addition of information not initially available, on holidays or weekends, or if certain unusual circumstances prevented the generation of the document at the time of service.

10. Although it may be appropriate to print out information from OASIS for limited reference purposes or to supply the individual with information, routine printing of OASIS documents for reviewing information or documenting data is not recommended.