ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 09/23

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

- ☐ SCCCMHA Board
- ☒ SCCCMHA Providers & 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 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 encounter in any care delivery setting and including various health-related, demographic and service information 10.1.12 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B. Historical Case Record: The official case record which contains all the case record documentation no longer in effect, but required to be maintained under Michigan Department of Health and Human Services (MDHHS) retention guidelines.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 SCCCMHA 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 CMH's EHR will be forwarded for scan/upload into OASIS.

C. The Scanned Document Guide (located in ADP) will be kept up to date (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 per agency needs, state or federal requirements, or accreditation recommendations.

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

V. PROCEDURES:

SCCCMHA

Primary Case Holder (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 any hard copy documents that are created outside of OASIS (e.g., guardianship papers, correspondence, etc.) that should be added to the electronic record to the Records/Scanning Staff to be scanned/uploaded into OASIS. Staff should refer to the Scan Document Guide (available on ADP) to ascertain 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 per their contract requirements are completed correctly and forwarded to CMH to be scanned/uploaded into the EHR in a timely manner.

Requesting Archived Records for Review

Program/Agency

A. Emails Administration staff a request for a record search.

QIDM Staff

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

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Program/Agency

A. Deletes the PDF when finished with review.

VI. REFERENCES:

None Available

VII. EXHIBITS:

None Available

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.