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Case Records: Maintenance, Review, Retention, Storage, Retrieval and Scheduled Disposal Section /#	Ana Dutcher Quality Assurance Manager	3/14/2012	3/31/2022	Page 1 of 9

Approved By: Mohamad Khraizat	Title: Health Operations Manager
Signature: 	Date: 3/31/22

I. POLICY

It is the policy of ACCESS Community Health and Research Center (ACCESS CHRC) that case records shall be maintained for all clients who are the responsibility of ACCESS. Case records shall be maintained according to the standards presented by the funding source and the standards of protection, completeness, accuracy, legitimacy, timeliness and clinical pertinence to assure availability of reliable documentation of service provided and client response.

It is also the policy of ACCESS that records of the persons served shall be retained and stored in a safe and confidential manner that allows for efficient retrieval, for at least the legally mandated period of time and disposed in the appropriate manner according to the confidential nature of the record.

II. PURPOSE

To provide guidance regarding the ongoing maintenance, review, retention, storage, retrieval and disposal of records, in the appropriate manner. The purpose of this policy is to:

- Define the responsibility for ACCESS staff to maintain client record
- To validate funding of services through case documentation
- To assure the existence of a reliable source for Quality Improvement and Utilization related data.

III. APPLICATION:

This is a policy that applies to ACCESS employees, interns and volunteers who provide support and treatment on behalf of the agency.

Retrieval and Scheduled Disposal

IV. PROCEDURES

- A. ACCESS will maintain in English, Electronic Medical Records necessary to fully disclose and document the extent of services provided to clients.
 - a. The primary clinical case record may consist of electronic documentation, paper documentation or a hybrid thereof. ACCESS is responsible for assuring that there is an organized, current, clear, complete and accurate medical record for every patient

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- B. The clinical record is confidential and is protected from unauthorized disclosure by law. The use and disclosure of confidential medical record information is regulated by HIPAA, the State of Michigan Mental Health Code and state and federal laws. The record will also maintain an accounting of disclosures as required by the HIPAA and HITECH Act.
- a. Forms to authorize release of information have been developed to ensure that they:
 - i. Comply with applicable laws.
 - ii. Identify, at a minimum:
 1. The name of the person about whom information is to be released.
 2. The content to be released.
 3. To whom the information is to be released.
 4. The purpose for which the information is to be released.
 5. The date on which the release is signed.
 6. The date, event, or condition upon which the authorization expires.
 7. Information as to how and when the authorization can be revoked.
 8. The signature of the person who is legally authorized to sign the release.
 - iii. The form is maintained in the EMR and it includes all of the items listed above regarding information released. A scanned packet of the information released is also maintained in the EMR.
 1. A Consent to Share Behavioral Health Information has been developed by the state and is used when releasing information to client, family members or other collateral contacts
 2. A Release of Information/Coordination of Care form is used to coordinate care with the clients' PCP or other medical professionals
- C. The individual record includes:
- a. The date of admission
 - b. Information about the individual's personal representative, conservator, guardian, or representative payee, if any of these have been appointed, including the name, address, and telephone number
 - c. Information about the person to contact in the event of an emergency, including the name, address, and telephone number
 - d. The name of the person currently coordinating the services of the person served
 - e. Iron Mountain is the location of any other records
 - f. Information about the individual's primary care physician, including the name, address, and telephone number, when available
 - g. Financial agreement with the person served (Ability to Pay/Financial Acceptance Agreement)
 - h. Healthcare reimbursement information, if applicable
 - i. The person's:

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- i. Health history
 - ii. Current medications
 - iii. Preadmission screening, when conducted
 - iv. Documentation of orientation
 - v. Assessments
 - vi. Person-centered plan, including reviews
 - vii. Transition plan
 - j. Progress notes to be documented
 - k. A Transition/Discharge summary
 - l. Correspondence pertinent to the person served – All correspondence is saved in the EMR
 - m. Orientation
 - n. Consent for treatment
 - o. Authorization for release of information
 - p. Documentation of internal or external referrals
- D. The maintenance of the record includes but is not limited to privacy and confidentiality issues, program oversight, responsibility designation, legal and protective measures to foster data integrity, record reconstruction and safeguards to prevent unauthorized access, and address the following:
- a. Similar information will be found in the same place for all case records
 - b. Abbreviations will not be used in the record unless it's a professional standard
 - c. It is ACCESS' expectation that all progress note documentation be submitted into the clinical record within 72 hours
 - d. All paper records are held by Iron Mountain, stored and protected from damage such as from fire or breach of confidentiality
 - e. Corrections may be made in case records by requests to a supervisor. The supervisor is allowed to make the correction, or they can delegate the correction back to the staff.
 - f. The name of the person signing the entry is clearly identified as "electronically signed by:" and the signature is also documented
 - g. Accurate dating of reports or entries
 - h. Accuracy of information and use authenticating signatures.
 - i. Blank spaces may not be left between entries and when they exist, a line must be drawn through
 - j. ACCESS will only release information produced by ACCESS staff. Any contained within the record that belongs to another entity, will not be released
- E. If duplicate information or reports from the main record of a person served exist, or if working files are maintained, such materials:
- a. Are not substituted for the main record.

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- b. Are considered secondary documents, with the main record of the person served receiving first priority.
- F. Archiving: If the portions of the record need to be archived, the current treatment documents are scanned in the active record in the EMR, specifically the assessments completed in preparation for the current plan of service/ treatment and all documentation entered toward the implementation, review and revision of that plan.
- G. Contents: The record shall contain, at a minimum, complete client identifying information including information on services provided by other community agencies. It must contain documentation of all treatment, including, at a minimum, intake, assessments, treatment plans, status and monitoring reports, progress notes, medical orders, prescriptions and termination reports/discharge summaries. All entries must be authenticated with dated signatures and credentials of the person making the entry.
- H. Record Storage: Records must be stored and monitored in a way as to protect the confidentiality of the information and to protect them from fire and other hazards. The provider must develop an indexing system and method for monitoring the location of records when they are removed from the primary storage area and must assure by policy that records may not remain out of the storage area after closing hours.
- I. "Primary" Record: When the provider offers services at a location other than the primary clinic site and, therefore, more than one version of a record is created, one of the records must be identified as the "primary" record and must contain all the information. The record located in the program or residential site must contain enough information to assure appropriate and quality care at the program site.
- J. Retention: Case records must be retained for 20 years following the last service rendered to the individual client or following the client's eighteenth birthday.
- K. Peer Review: Care provided by qualified professionals shall be reviewed by peer professionals to assure that care is being provided according to professional standards of practice and results should affect provider standards of care. This is particularly required for psychiatric services.
- L. Utilization Review: ACCESS will conduct ongoing reviews to assure appropriateness of care according to a written plan and using a written level of care criteria. Results shall be addressed for individual cases and shall be reported in the aggregate as part of the provider's Quality Improvement Plan.
- M. There shall be on-going reviews of case records to ensure they contain current, accurate and complete information.
 - a. Case record reviews shall be conducted according to the ACCESS at least quarterly as directed by contracts, using written criteria to assure consistency.
 - i. When records are selected for review, the person responsible for providing the service/treatment is not:
 - 1. Solely responsible for the selection of his/her records to be reviewed
 - 2. A reviewer of his/her records
 - ii. The quarterly review is performed:

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1. By personnel who are trained and qualified
2. On a representative sample of persons served.
3. That includes:
 - a. Current records
 - b. Closed records
4. In accordance with the established review process
- iii. It addresses, as evidenced by the record of the person served:
 1. The quality of service delivery
 2. Appropriateness of services
 3. Patterns of service utilization
 4. Model fidelity, when an evidence-based practice is identified
- iv. The records review addresses whether:
 1. The persons served were:
 - a. Provided with an appropriate orientation.
 - b. Actively involved in making informed choices regarding the services they received.
 2. Confidential information was released according to applicable laws/regulations.
 3. The assessments of the persons served were thorough, complete, and timely.
 4. Risk factors:
 - a. Were adequately assessed.
 - b. Resulted in safety plans, when appropriate.
 5. The goals and service/treatment objectives of the persons served were:
 - a. Based on:
 - b. The results of the assessments.
 - c. The input of the person served.
 - d. Revised when indicated.
 6. The actual services were related to the goals and objectives in the person's plan.
 7. The actual services reflect:
 - a. Appropriate level of care
 - b. Reasonable duration
 8. The person-centered plan was reviewed and updated in accordance with the organization's policy.
 9. When applicable, the following have been completed:
 - a. Transition plan/Discharge summary
 10. Services were documented in accordance with the organization's policy.

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- b. The plan describes the scope of the review, how the review is performed, sample size and selection of records, frequency of reviews, authority and responsibility of personnel conducting the reviews, assurances of confidentiality, how the findings will be protected, how the findings will be reported, how problems will be corrected.
- c. Aggregate results of case record reviews shall be incorporated into the provider's Quality Improvement Plan and opportunities to improve identified
 - i. The information collected from its established review process is:
 - 1. Used to improve the quality of its services through performance improvement activities
 - 2. Used to identify personnel training needs
 - 3. Reported to personnel
- N. Integration of Care: It is the contract holders' expectation that clinical information will follow the client through the system of care and be made readily available at the point of service. Based on Michigan Attorney General Opinion # 5709 (5/20/1980), DWIHN and its subcontractors are considered one entity for the purpose of sharing confidential case records. Treatment may not be withheld from a client due to the lack of a signed release.
- O. Confidentiality: Case records must be protected as defined by HIPAA, the Mental Health Code and ACCESS' policy on Confidentiality. They may be accessed only as stipulated in this policy. Research projects must be approved by the ACCESS Research Advisory and Human Subjects Review Committees prior to having access to client record information.
- P. ACCESS shall have written documentation, including a record retention schedule, (se Attachment) that demonstrates compliance with the following standards
 - a. Records including clinical, financial, administrative, and treatment/services/supports shall be maintained in a legible manner, through hard copy or electronic storage/imaging, to fully disclose and document the quality, quantity, appropriateness and timeliness of services provided to persons receiving or requesting community mental health services.
 - b. Records will be retained in their original form or on material that will maintain its integrity over the required time (which includes electronic storage/imaging). The storage of all material records shall be in a secured, waterproof and fire-resistant location that is protected from access by unauthorized individuals.
 - c. Confidentiality of information in a person's record and confidential personnel information shall be maintained in the process of record storage and disposal. Consumer and confidential personnel information shall be safeguarded against loss, premature destruction, or unauthorized use.
 - d. Certain records may need to be retained beyond the minimum retention period due to:
 - i. Statute of limitations for those records,
 - ii. The Age of Majority (emancipated minor) or legally incapacitated person,

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- iii. Records involved in litigation, government lawsuit, other legal action, inspection, or an imminent (received knowledge of a threat) lawsuit,
 - iv. Pending or ongoing audit
 - v. As otherwise compelled by law
 - e. Records retained due to litigation, government lawsuit, other legal action, inspection, an imminent lawsuit, or a pending or ongoing audit, must be retained until completion of the action and resolution of all issues which arise from it. A log must be maintained to monitor the retention of these records.
 - f. Records shall be stored in such a manner to allow efficient retrieval and appropriate destruction based upon type of record as noted on ACCESS' record retention and disposal schedule.
 - g. Employees and contractors shall be trained on their entity's retention of records schedule and in the proper storage, retrieval, disposal and destruction of records.
 - h. If an employee or contractor receives notice of potential litigation, investigation or audit, this information must be reported to ACCESS' Human Resources office, as well as to ACCESS' legal counsel and Executive Director.
 - i. Records shall be stored (e.g., in boxes or cabinets, etc.) in an appropriate manner and with labels that allow for efficient access, retrieval and appropriate disposal.
- Q. Inactive records in on-site or off-site storage are recorded on a master index, which is maintained by the designated employee or contractor in charge of records maintenance
- R. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations require that records that demonstrate compliance with HIPAA must be retained for a minimum of six years
- S. Disposal and Destruction of Records:
- a. In accordance with the retention and disposal schedule, on a regular basis, when the need arises, records are to be identified for disposal. Under no circumstances shall un-shredded paper containing PHI be placed in a trash can, recycle bin or otherwise disposed of in a manner that would expose PHI. The following shall be included in ACCESS' record destruction and disposal process:
 - a. Prior to destruction, verify (through the log that monitors this information) that no selected record is involved in any current or potential litigation, investigation or audit
 - b. Records with confidential information are to be destroyed in a manner that ensures that confidential information cannot be retrieved or reconstructed
 - c. Paper that contains PHI shall be shredded or destroyed in another means as approved by ACCESS' Privacy Officer or ACCESS' Quality Assurance Manager
 - d. A master index of destroyed clinical records will be created for documentary purposes. The master index will note the date, method, and etc. of destruction



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- e. The master index of destroyed clinical records will be retained permanently. (If the Agency is no longer in existence, the index will be kept by the successor organization.)
- f. If destruction services are contracted, the contract must meet the requirements of HIPAA privacy regulations

VI. QUALITY ASSURANCE/ IMPROVEMENT

Methods of destroying confidential paper records include:

- a. Shredding
- b. Burning (incineration)
- c. Pulping
- d. Pulverizing.

If shredding has been determined by ACCESS' Privacy Officer or ACCESS' Quality Assurance Manager to be the only approved method by which PHI shall be disposed and a shredder is not available at the time the paper containing PHI needs to be destroyed, the paper must be kept in a secure environment, e.g., locked room, file cabinet, secure storage container, desk, etc., until a shredder is available

This policy shall be monitored by an ongoing internal audit process by the Compliance Section.

VII. COMPLIANCE WITH ALL APPLICABLE LAWS

ACCESS, its affiliates, service providers, and other contracted and subcontracted employees are bound by all applicable local, state and federal laws, rules, regulations, all Federal waiver requirements, and state and county contractual requirements, policies and administrative directives in effect, or as amended.

VIII. LEGAL AUTHORITY AND REFERENCES

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; Health Information Technology for Economic and Clinical Act (HITECH), Public Law 111-5; Department of Health and Human Services (HHS), Standards for Privacy of Individually Identifiable Health Information, Final Rule, 67 Federal Register 157, August 14, 2002; HHS, Security and Electronic Signature Standards, Final Rule, 68 Federal Register 8334, 2/20/03.

Revised Judiciary Act of 1961, P.A. 236 of 1961 as amended, MCL 600.5851.

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Michigan Status of Minors & Child Support Act, P.A. 293 of 1968 as amended, MCL 722.4.

State of Michigan, Administrative Code.

State of Michigan, Department of Management and Budget Office Services Division, State Records Management Services and Records Center. Retention and Disposal Schedule for Department of Mental Health, Community Mental Health Board 7.17.91.

Agency/MDCH Managed Specialty Supports and Services Contract.

County of Wayne, HIPAA Policies and Procedures Manual.

State of Michigan, Records Management Manual for Local Governments, 7/27/10.

State Bar of Michigan, Health Care Law Section, Health Care Records Retention Manual 2009.

Medical Records Retention Guide (Michael Spak & Jonathan P. Tomes, eds., Veterans Press, 3rd ed. 2011).

Michigan Mental Health Code, P.A. 258 of 1974, Sections 330.1746 and 330.1748. Medicaid Clinic Service Manual, Chapter III.

HIPAA Security Guide

Record Retention Storage Retrieval and Scheduled Disposal Michigan Attorney General Opinion #5709, (5/20/1980)

IX. EXHIBITS

DWIHN Record Retention Storage Retrieval and Scheduled Disposal - Exhibit A (2) Guidance on Risk Analysis Requirements under the HIPAA Security Rule