VI. CLIENT CASE RECORDS

Revised 8/18/2014

Creation and Organization of Client Records

POLICY

There shall be a case record for each client admitted to Meta House [DHS 75.03(8)(a)] [DHS 83.42(1)]. The designated guardian of the case records is the Medical Records Coordinator. The Medical Records Coordinator is charged with ensuring that the format of the case record is consistent and facilitates information retrieval.

PROCEDURE

1. The Medical Records Coordinator is responsible for overall maintenance and security of Meta House client case records [DHS 75.03(8)(b)].

2. The appropriate program File Folder Set-Up Checklist will be followed to maintain the consistency of the case record and facilitate information retrieval.

3. A case record is initially developed by the Orientation Counselor and sent to the appropriate program before the client is formally admitted to Meta House. The Orientation Counselor is responsible for placing the following completed forms into the case record:
    a. Intake Data Sheet; [DHS 83.42(1)(a) & (b)].
    b. Informed Consent [DHS 75.03(8)(e)(1)];
    c. Grievance Procedure;
    d. Client Rights [DHS 75.03(8)(e)(3)];
    e. Releases of Information;
    f. Admission Agreement [DHS 75.03(8)(e)(2)] [DHS 83.42(1)(f);
    g. ASAM PPC or WIUPC [DHS 75.03(8)(e)(5)];
    h. Acknowledgement of Receipt of Notice of Privacy Practices [DHS 75.03(8)(e)(3)];
    i. Evacuation Assessment (Residential only)
    j. Client Responsibilities
    k. Agreement to Inspection
    l. Other background information that the staff has obtained.

4. After intake, the Medical Records Coordinator will be responsible for assuring that the following are included in all client charts on an ongoing basis:

a. Results of communicable disease screening* [DHS 83.28(4);

b. Documentation of any sensory (hearing or vision) impairment of the client rendering them unable to detect or respond to a fire emergency [DHS 83.42(1)(L)] and [DHS 83.48(7)(a) & (b)].*

c. Any DHS−approved resident-specific waiver, variance or approval. [DHS 83.42(1)(n)];*

d. Copy of any court order or other document authorizing another person to speak or act on behalf of the client, or other legal documents as required which affect the care and treatment of a client. [DHS 83.42(1)(s)];*

e. Assessments, including those required under DHS 83.35(1).* [DHS 75.03(8)(e)(4)] [DHS 83.42(1)(c) & (h)];

f. Diagnosis [DHS 75.03(8)(e)(4)];

g. Results of subsequent ASAM PPC [DHS 75.03(8)(e)(5)];

h. Results of any testing [DHS 75.03(8)(e)(4)]:

i. Treatment plan [DHS 75.03(8)(e)(6)] [DHS 83.42(1)(i)];

j. Documentation of all services provided [DHS 83.42(1)(t)];

k. Current personal physician, if any [DHS 83.42(1)(d)];*

l. Medication records [DHS 75.03(8)(e)(7)] [DHS 83.42(1)(p)] [DHS 83.42(1)(r)];*

m. Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37 (1) (h) 1. [DHS 83.42(1)(q)];*

n. Medication orders [DHS 75.03(8)(e)(8)] [DHS 83.42(1)(o)];*

o. Documentation of significant incidents and illnesses, including the dates, times and circumstances [DHS 83.42(1)(g)];*

p. Reports from referral sources [DHS 75.03(8)(e)(9)];

q. Records of referral by Meta House; [DHS 75.03(8)(e)(10)];

r. Staffing notes; [DHS 75.03(8)(e)(11 & 16)];

s. Correspondence ([DHS 75.03(8)(e)(12)];

t. Consents for Release of Information [DHS 75.03(8)(e)(13)] ;

u. Progress notes [DHS 75.03(8)(e)(14)] [DHS 83.42(1)(j)];

v. Client satisfaction survey [DHS 83.42(1)(i)];*

w. Results of the annual resident evacuation evaluation [DHS 83.42(1)(k)];*

x. Documentation of transfer from one level of care to another [DHS 75.03(8)(e)(17)];

y. Discharge Documentation [DHS 75.03(8)(e)(18)] [DHS 83.42(1)(m)].

*Residential Treatment program only.

5. Case records shall be maintained by Meta House for a period of 7 years from the date of termination of services [DHS 75.03(8)(h)] [DHS 83.13(2)b)].

Storage and Maintenance of Client Records

POLICY:

Meta House's primary patient case record is electronic accessed via the Epitomax electronic health records system; however, a minimal paper case record will be maintained when needed for forms not available in Epitomax or records not easily scanned into the system. Epitomax is implemented as a hosted system, so that electronic patient case records are stored offsite on HIPAA compliant servers with encrypted communication and a regular backup system. When not in use, active and archived paper patient case records will be maintained in locked file cabinets, in locked rooms. All active case material will be returned to its designated location at the end of the business day [DHS 75.03(8)(c)] [DHS 83.42(2)]. Responding to requests for Medical Records will be the responsibility of the Medical Records Coordinator. The release of Medical records will only occur with a specific written consent that fulfills all the requirements of 42 CFR Part 2, HIPAA and Wisconsin state law. A record of all medical records requests will be maintained by the Medical Records Coordinator.

PROCEDURE:

1) Electronic Records

a) Meta House network passwords must be strong enough to reasonably ensure proper security.

- All passwords must contain three of the following characteristics:
  - Uppercase characters (A through Z)
  - Lowercase characters (a through z)
  - Base 10 digits (0 through 9)
  - Non-alphabetic characters (example: !, $, %)
- Passwords must also meet the following complexity requirements.
  - Not contain the users account name or parts of the users full name that exceed two consecutive characters
  - Be at least 9 characters long

b) All users will be automatically prompted to change their Meta House network passwords every 180 days.

c) Users may not share their login information (user name and password) with anyone, including other Meta House staff.

d) Passwords used to access the Meta House network or websites that contain client PHI[1] may not be written down or stored anywhere that they could be seen by anyone, including Meta House staff.

e) When leaving their workstation, users must lock their screen or log out of their computer. (Locking can be done quickly by pressing the windows key and the letter L at the same time.)

f) All workstations will lock automatically if not inactive for 10 minutes.

g) If anyone is logged into a computer that is used by other people, they must log out of the computer when they leave the workstation so that other users may log in to use the computer without being locked out. If users are locked out of a computer because another user did not log out properly, they should contact IT staff for help to unlock the computer rather than obtaining another user's password to unlock the computer.

h) When accessing websites that contain client PHI, passwords should never be saved in the browser, even though the browser may prompt users to do so. If users save login information in error, they should contact IT staff to help them remove it.

i) Staff may only have remote access to their computer via LogMeIn, Epitomax, or other website containing client PHI if approved by their supervisor. The IT department will maintain a list for each user with remote access specifying which systems they are able to access. Appendix XX specifies the staff positions that are appropriate for remote access, and Appendix XX specifies the users who currently have remote access via LogMeIn.

j) Any computer used for remote access to client PHI must be current on operating system security updates (e.g., Windows updates), have virus protection installed, and the software and virus definitions kept up to date.

k) Remote access of client PHI may not occur over a public or unsecured WiFi network (e.g., at a coffee shop, airport, etc.) or at a public workstation (e.g., the library).

l) All mobile phones or tablets used to access Meta House email will be equipped with a mobile device policy that will require a password on your device and automatically lock the device after no more than seven minutes of inactivity.

m) When a staff member, intern, volunteer, or anyone else with access to the Meta House network or websites containing client PHI (see footnote above) leaves Meta House or changes positions so that access is no longer required, their supervisor or the HR department will inform the IT department, who will disable the individual's access to all such systems.

n) The network servers will be stored in a locked room that is only accessible to IT staff.

2) Electronic Storage of PHI

[1] These include Epitomax, Dynacare, CMHC, ServicePoint, the Forward Health portal, and any other websites that contain client PHI.

a) Files containing client PHI should only be saved in folders specifically designated for client PHI. Currently, these are the Census folder, the HIPAA Compliant Records folder, or the Evaluation folder (for program evaluation data). Such files should never be saved on a user's desktop, their personal folder (U: drive), General Office (O: drive), or any other location on the network.

b) When staff are using Meta House laptops, no client PHI should be left on the laptop at the time it is signed back in to the IT department.

c) Backup data from the network will be stored offsite either on media encrypted by a password or in a location only accessible by Meta House IT staff (e.g., a locked safe).

d) Other than backup data, client PHI (including client names and social security numbers) may not be saved on any portable media, including flash/thumb drives and CD's.

e) When users are remotely accessing the system, any client PHI saved to their computer must be deleted immediately after use. If any PHI is saved to a remote computer, the computer must be password protected with a password of reasonable strength (see guidelines above) and the password/user name may not be shared with any other member of the household.

f) Client PHI must be cleared off of any workstation, laptop, mobile phone, or other device before it is disposed of or the device must be disposed of by organizations that can certify destruction of all data.

g) Client PHI may not be uploaded to file storage websites without appropriate security and encryption, such as Dropbox or Google Docs.

3) Emailing PHI

a) Electronic transmission of PHI to anyone outside of Meta House (i.e., any email address that does not end in *metahouse.org*) is only permitted via secure, encrypted email. Currently, such email will be sent using a SendInc.com account, either via the website or through the Outlook add-in.

b) All emails containing PHI must include a notification that the information is private and confidential and that redisclosure or other unauthorized use of the information is not permitted.

4) **Paper Records.**

a) Active charts for Riverwest North are located on the fourth floor in the designated records area. Active charts for Riverwest South are located in the designated medical records room. Active charts for Outpatient services and Housing are located in the Medical Records room at Riverwest East. Active charts for clients transferred to Maryland are maintained at Riverwest.

b) Under no circumstances are client records to be left unattended.

c) Charting is to take place in the designated records rooms. Charts are to remain in the records rooms. A staff member may remove assessment instruments and treatment or service plans in order to meet privately with a client. A completed chart index card must be left indicating what was removed from the chart and who has checked it out. Anything that is checked out must be returned to the appropriate medical record at the end of the business day.

d) Only the Medical Records Coordinator or a Program Manager may approve the removal of the entire chart from its designated location.

e) Filing cabinets and doors must be kept locked when staff persons are not physically present in designated chart areas. If a staff person is working on a medical record in their office and leaves the office, the material must be locked in a file cabinet or desk, or the door must be locked.

f) Requests for archived charts or transfer of charts must be approved by the Medical Records Coordinator, Medical Records Assistant, the Outpatient and Residential Services Managers or the Director of Social Services. A completed chart index card must be left in the chart's place in the cabinet to indicate who is using an archived chart.

g) Transporting client charts (or content from charts) is permissible only between Meta House sites and only for approved activities (e.g., to transport from residential facilities to evaluators, auditors; to deliver new charts from intake to residential facilities, to deliver archived charts to the Riverwest East medical records room). When transporting protected information, staff is PROHIBITED from leaving the information in the vehicle when they leave the vehicle, unless they lock it in the trunk or a locked container.

h) Opaque bags will be used to transport charts between facilities to indicate that the material is confidential.

i) Upon discharge the case record will remain in the cabinet until the discharge staffing is complete. The Medical Records Coordinator and/or Assistant will remove the chart to be archived upon the completion of the typed discharge summary.

j) The Medical Records Coordinator will designate the location of the keys to current client files in cooperation with the Program Managers.

k) The Medical Records Coordinator will maintain responsibility for the keys and the archived charts for the Riverwest Complex located in the basement of the Riverwest South Building and the archived charts located in the Riverwest East medical records room and utility room.

XIII. PROGRESS NOTES

Revised 8/18/2014

POLICY

A progress note will be entered in the client chart in a timely manner for every instance of every service provided to or contact with the client and for every contact with a collateral source (i.e., anyone from which information may be obtained regarding the client, which may include a family member, clinical records, a friend, a co-worker, a child welfare worker, a probation and parole agent or a health care provider) by a professional staff member who delivered the service or made the contact [DHS 75.03(15)(a)].

PROCEDURE

1. Progress notes will be entered electronically via the electronic health records system.
2. All progress notes will be entered into the client chart by the end of the day on which the service was delivered. The only exception is for staff who work on evenings or weekends and are not at the office at the end of the work day. Such individuals may insert the progress notes in the chart at the beginning of the next day they are in the office.
3. Progress notes are entered into a client's medical record in a chronological manner [DHS 75.03(15)(b)(1)].
4. Progress notes document a client's progress toward their treatment plan and responses to treatment.
5. Progress notes will be entered using the appropriate progress note form.
    - For clinical AODA and child & family services, a DAP format will be used.
    - For all other eligible services, a blank progress note will be used.
6. When the DAP format is used, the note should follow these guidelines:

    D (DATA). This is a descriptive account of exactly what took place at the time of service. It should be written with descriptive words that indicate simply what was said, done, provided, describes who, what, when and how. Writers should not report their thoughts, impressions or opinions.

    A (ASSESSMENT). This is the writer's impression, assessment, and /or sensory response to the specific DATA indicated above. The writer documents what was witnessed and the impact this may have on the continued treatment planning for the individual. Descriptive terms, adjectives and adverbs are helpful to portray the impression resulting from the data.

    P (PLAN). Once the exact event or service has been recorded in the DATA statement and assessed in the ASSESSMENT portion, it is necessary to close the note with a PLAN for

continued treatment. Depending on the nature of the observance or service that is documented, the writer may offer a plan for immediate action or a plan for on-going treatment intervention and action. The Plan section of the note should include a statement about whether there is another appointment and when (i.e., the next scheduled date of contact for either group or individual).

7. The person making the entry must sign the progress note electronically using their credentials for the electronic health records system. Signing the progress note marks the note with the date it was signed as well as marking the note as completed, which does not allow the narrative to be modified in any way [DHS 75.03(15)(c)].
8. If any changes or additions to the progress note are required after it is signed, they should be added as an amendment in the electronic health record.
9. If a service is entered for a client in error in the electronic record, the client's status should be changed to Incorrect Entry so that the correct information may be added.
10. The electronic health record system maintains an audit trail of all changes made to a client's record, allowing a list to be generated of all updates made to the client record.
11. The person making the entry will note only services personally rendered to the client, events that the staff person was physically present with the client and/or personal contact with collateral agencies on behalf of the client. Notes on "hearsay" are not acceptable.
12. Staff shall make efforts to obtain reports and other case records for a client receiving concurrent services from an outside source. The reports and other case records shall be made part of the client's case record [DHS 75.03(15)(d)].