

SAN MATEO COUNTY HEALTH SYSTEM
BEHAVIORAL HEALTH AND RECOVERY SERVICES

DATE: January 7, 2000

BHRS POLICY: 00-04

SUBJECT: Medical Records Management

AUTHORITY: 45CFR Section 160 (HIPAA Privacy Regulations); 42CFR Part 2; CA B&P Code 2620.7; 22 CCR 79351; Health and Safety Code 123145; County Policy

AMENDED: 2/25/03, 10/10/08 and 3/14/12

PURPOSE: To establish a broad policy governing medical records management and, where needed, to create related procedures concerning oversight, storage, and destruction of behavioral health medical records.

Other behavioral health policies address the protection and/or disclosure of the content of the medical record and are not altered or excepted by this policy. These associated policies include, but are not limited to:

96-14	Subpoenas to Release Records
98-12	Provider Certification
00-06	Client Access to Behavioral Health Record
03-01	Confidentiality/Privacy of Protected Health Information
03-02	Privacy Practices, Notice of
03-04	Disclosure of PHI – Minimum Necessary
03-06	Disclosures of Protected Health Information with Client Authorization
03-07	Disclosures of Protected Health Information – Request for an Accounting
03-08	Restrictions on Use or Disclosure of Protected Health Information
03-09	Amendment of Protected Health Information

Additionally, policy direction found within the Behavioral Health Documentation Manual (which describes the content of the behavioral health record) or the AOD (Alcohol and Other Drugs) Providers' Manual or Documentation Manual is not altered or excepted by this policy.

DEFINITIONS

Custodian of Records – The individual responsible for monitoring medical records confidentiality and retention guidelines for an institution. Other direct clinical or managerial duties may be assigned to or delegated by this individual, as the organization requires.

Designated Record Set –Medical and billing records including enrollment, payment, claims, adjudication and case or medical management maintained by or for a health care provider concerning clients; or used, in part, to make decisions about clients. All information within the designated record set is protected health information.

Destruction/Expunging of a Medical Record – For purposes of this policy, this means the permanent removal of the record (paper, microfiche or electronic) from active use with no possibility of reconstructing the information contained in the record *except* that an electronic record of admissions and closings will be maintained.

Behavioral Health Record or Behavioral Health Chart -Here, the term record or chart means any item, collection or grouping of information within the designated record set that is maintained, collected, used or disseminated by or for San Mateo County Behavioral Health Services (BHRS). The record or chart may be in paper format, an electronic medical record, microfiched, or scanned and stored electronically or on disk.

Protected Health Information (PHI) - Information relating to a person's health, the care received and payment for services, including demographic information.

POLICY

1. Custodian of Records – The Quality Manager is hereby designated the Custodian of Records for San Mateo County Behavioral Health Services. As noted in this policy, certain records management functions are delegated to Management Information Services (MIS) and/or to the Patient Services Office Manager.
2. Behavioral Health Chart – Since the implementation of the electronic medical record (Avatar), mental health clinical and administrative material is now accessible on-line, regardless of team or program opening. A more limited set of information with more restricted access is created and maintained electronically for a client in Alcohol or Other Drug Services. However, any client open to BHRS may continue to have PHI stored in several locations. (Examples include the historic paper chart(s) that may be in a treating clinic or in storage.)

The *single behavioral health record* for the individual consists of all materials that are part of the designated record set, even when these are physically separated from other chart components.

3. Effective 1/5/2012, BHRS affirmed that electronic clinical record keeping is the practice standard of BHRS.

- a. With only a few exceptions, personal health information (PHI) shall not be maintained in a paper chart or in portions of a paper chart (e.g. “working charts).
- b. Documents and forms shall not be maintained outside of the electronic medical record (AVATAR).
- c. Every effort shall be made to obtain client/guardian signatures on consents and treatment plans using an electronic signature pad.
- d. When it is necessary to use a paper form to document client care, the form must be scanned into the electronic record and then shredded after 90 days.
- e. If notes or a worksheet are used during the completion of an assessment or other clinical activity, this document must be shredded after data entry into AVATAR is completed.

4. Management of Open Charts

- a. The management of open or closed paper charts stored in regional clinics/sites is under the general supervision of the Patient Services Office Manager.
- b. Charts shall be stored in the treatment site in compliance with state and federal regulation. All regional clinics shall have separate lockable chart rooms until such time as no paper charts remain in the individual clinic. In any situation where material containing identifiable client information is not maintained in a distinct chart room, procedures to assure confidentiality of PHI, including locked storage, shall be followed.
- c. In rare circumstances, the Custodian of Records may approve alternative written site-specific procedures.

5. Additional Client Information

MIS (Management of Information System) shall maintain an online database consisting of client identification, episode and service records, financial/billing records and other statistical information, including but not limited to that mandated through the California Department of Mental Health (Dept Health Care Services) system called California Statistical Information (CSI). When a client’s chart/electronic record is determined eligible for destruction, all information about that client shall be expunged from the electronic database, with the exception of limited demographic information for identification purposes and a record of episodes opened and closed.

6. Management of Closed Charts

- a. In the electronic medical record, closing a chart is a clinical and administrative function that requires no handling of paper.
- b. Administrative support staff shall verify whether the case remains open elsewhere within County BHRS. If so, any old volumes of paper chart(s) remaining in a BHRS site shall be sent to the open treatment site, and stored there until the case is completely closed and protocols for longer-term storage take effect.
- c. Closed paper charts (with no open provider) shall be maintained in each local clinic site for a brief period of time period specified by MIS and the Patient Services Office Manager. The administrative supervisor at a local site is responsible for timely retrieval of a closed chart still at that site, upon appropriate request. Following this period, closed charts shall be sent to a storage location identified by the Health Department for long-term records management.
- d. MIS has the responsibility for tracking closed paper charts, once they leave the location where the client was treated. MIS shall ensure rapid retrieval of specific requested material or of the entire chart by forwarding requests to the storage facility in a timely manner. Further, MIS shall report any delays in receiving charts from the storage facility to the Custodian of Records.

7. Chart Destruction (Paper)

- a. Background: In 1981, the San Mateo County Board of Supervisors authorized by resolution the destruction of client charts for adults that have been inactive for ten or more years; inactive charts of minors could be destroyed at ten or more years after the minor reached age eighteen. (Note: California regulations more liberally allow destruction of an adult chart seven years after the date of discharge. For youths, California regulations prescribe that an inactive chart shall be kept for at least one year after the minor has reached the age of eighteen, but in no case for less than seven years.)
- b. Charts may be authorized for destruction following County of San Mateo standards for retention and destruction as noted above.**
- c. One time or gradual destruction of charts following electronic storage of information shall be in accordance with all policies and procedures concerning protection of PHI.
- d. Records identified for destruction shall be catalogued on a Records Disposition Request Form (supplied by the chart storage provider). The charts identified on the form shall be reviewed by the Custodian of Records. Once approved, the chart storage provider shall be notified that these records may be destroyed, using procedures identified and approved in its contract with San Mateo County Health Department

- e. The chart maintenance/storage provider shall confirm in writing the date of destruction of the indicated charts.
- f. A copy of the destruction request and confirmation of destruction of records shall be maintained by MIS.

8. Electronic Medical Record Implementation and Destruction of Scanned Material

At the time of implementation of the electronic medical record, paper charts had been maintained for all clients with open cases. A selection of critical information, including recent assessments, treatment plans, medication notes, laboratory data, and recent progress notes was scanned into the electronic medical record.

A client may return to treatment whose paper chart was closed before any historic material was scanned into the EMR (Electronic Medical Record). The paper chart should be requested for clinical review. Relevant material should be scanned into the EMR.

As cases close, management of the paper chart will follow the procedure identified in section (4) above. Earlier destruction of the paper chart may occur only in circumstances where all material has been scanned and is available electronically. This determination shall be made by the custodian of records.

Approved: _____
Signature on File
 Stephen Kaplan, Director
 Behavioral Health and Recovery Services

Approved: _____
Signature on File
 Keith Clausen, Custodian of Records
 Behavioral Health and Recovery Services

Reviewed: _____

