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Owner:	*Starlit Smith: Quality Management Administrator*
Policy Area:	*Quality Improvement*
References:	

CASE RECORDS MAINTENANCE AND REVIEW

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) that Network Providers, including Substance Abuse provider agencies, establish a process to ensure case records are maintained for all beneficiaries who are the responsibility of DWIHN. Case records shall be maintained according to these standards for protection, completeness, accuracy, legibility, timeliness and clinical pertinence to assure availability of reliable documentation of services provided and beneficiary response.

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PURPOSE

The purpose of this policy is to:

1. To establish and define the responsibilities for the DWIHN and contract service providers in the maintenance of case records consistent with contractual guidelines, state and federal laws and regulations.
2. To ensure a medical record will be maintained for every individual who is receiving or has received behavioral health services from contractual providers of DWIHN.
3. To validate funding of services through case record documentation.
4. To improve quality of care along with managing risk.
5. To assure the existence of a reliable source for Quality Improvement and Utilization related data.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Access Center, Network Providers, Crisis services vendor and Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI, SED,SUD and Autism
3. This policy impacts the following **contracts/service lines** : MI-HEALTH LINK, Medicaid, SUD, Autism, Grants and General Fund

KEYWORDS

1. Case Record Review

2. Clinical Pertinence
3. Health Information Technology for Economic and Clinical Health (HITECH) Act
4. Individual Plan of Service/Person-Centered Plan/Family-Centered Plan (IPOS/PCP)
5. Medical Record
6. Mental Health Professional (MHP) (MCL 330.1100b(14)
7. Record Keeping
8. Service Provider
9. Utilization Management
10. Utilization Review

STANDARDS

1. Network Providers, including Substance Use provider agencies, must maintain in English and in a legible manner, records necessary to fully disclose and document the extent of services provided to members.
2. The primary clinical case record is held by the clinically responsible provider which may consist of electronic documentation, paper documentation or a hybrid thereof. The clinically responsible provider is responsible for assuring that there is a complete and accurate medical record for every member. This will be addressed during impaneling, re-impaneling, readiness reviews and quality reviews.
    a. At the request of a Federal, State or DWIHN representative, access to a complete medical record must be made available immediately. Access to the record shall be produced within 30 minutes of the request.
    b. Providers must also ensure that sufficient staff are properly trained to ensure the medical record information is available during all operating hours.
    c. Backup and retrieval systems must be in place and operational in case of power outages and failures.
3. 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 DWIHN policies, HIPAA, the State of Michigan Mental Health Code 42 CFR Part II, state and federal laws, rules and Recipient Rights. The provider agrees to maintain an accounting of disclosures as required by the HIPAA and HITECH Act.
4. Network Providers shall develop policies for case record organization and maintenance that includes but is not limited to privacy and confidentiality, 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. Material must be affixed in a binder, electronic record or case file folder and arranged so that information can be found quickly and easily.
    b. Abbreviations that have been approved for use in case records by the provider administration and clarification that no other abbreviations may be used.
    c. Time frames specifying when reports and documents must be entered in the record. It is the DWIHN's expectation that all progress note documentation be submitted into the clinical record within 24 business hours.

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d. Description of how case records will be stored and protected from damage such as fire or breach of confidentiality, i.e., records must be returned to their secure storage location at the close of business each day. It is required that all providers implement a process that complies with DWIHN's Record Retention and HIPAA policies.

e. Description of how corrections may be made in case records by drawing a single line through the entry to be corrected, entering the correction, initialing and dating the entry. "White-out" may not be used.

f. All entries must be legible and provisions for alternative methods for record entry when individuals are not able to write legibly. The name of the person signing the entry must be clearly identified if the signature is not legible.

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. Process for notifying DWIHN and members of managing case records in the event the provider goes out of business. Providers must have a policy/process that complies with attachments: A & B of the Network Monitoring and Management policy.

k. Provisions for release of information contained within the record and protection of second-party materials.

5. Archiving: If the provider archives portions of the record, the current treatment documents must remain in the active record, 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.

6. Contents: Case record documentation must be compliant with payer specific requirements i.e., the Michigan Medicaid Manual, CMS, Medicare or third party payer requirements. The record shall contain, at a minimum, complete member identifying information including information on services provided by other community agencies. It must contain documentation of all treatment including, at a minimum, intake assessments, demographic information, treatment plans, 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.

7. 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.

8. "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.

9. Retention: Case records must be retained for ten years following the last service rendered to the person served or following the person's eighteenth birthday. This requirement also extends to any subcontracted providers.

10. Case Record Reviews: There shall be on-going reviews of case records to ensure they contain current, accurate and complete information. Case record reviews shall be conducted according to the DWIHN's written monitoring plan to assure consistency. The plan describes the scope of the review, how the review

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is performed, sample size and selection of records, frequency of reviews, assurances of confidentiality, how the findings will be protected, and reported, how problems will be corrected. Aggregate results of case record reviews shall be incorporated into the provider's Quality Improvement Plan and opportunities to improve identified.

11. Records will be released from the provider organization in accordance with the provisions of DWIHN policies, the Michigan Mental Health Code, HIPAA, 42 CFR Part II, state and federal laws, rules and regulations.
12. Utilization Review: The provider shall 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.
13. 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.
14. Integration of Care: It is the DWIHN's expectation that clinical information will follow the member 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. All providers are required to obtain a Release of Information according to DWIHN policy, HIPAA, 42 CFR Part II, the Mental Health Code; however, treatment may not be withheld from a person served due to the lack of a signed release.
15. Confidentiality: Case records must be protected as defined by, 42 CFR Part II, HIPAA, the Mental Health Code and DWIHN policy on Confidentiality. They may be accessed only as stipulated in DWIHN policy and relevant laws, rules and regulations. Research projects must be approved by the DWIHN prior to having access to member record information.
16. Electronic Medical Record (EMR) Guidelines:
    a. All Protected Health Information (PHI) from an outside facility will be scanned into the provider's Electronic Medical Record (EMR) according to the provider scanning procedures. Once the record has been scanned into the EMR, it is the official record and the paper record can be destroyed using the approved protocol.
    b. A provider utilizing an EMR must ensure confidentiality, integrity and availability of its electronic health information. The provider must also protect against reasonably anticipated threats, hazards or misuse of electronic health information
    c. Providers utilizing an EMR agree to abide by all requirements of the HIPAA Security Rule and its progeny.
    d. Providers utilizing an EMR health record shall have all appropriate administrative, physical and technical safeguards in place for the protection of protected health information.
    e. Providers utilizing an electronic health record shall document compliance with all Security Rule implementation specifications, both required and addressable.
    f. All providers shall perform regular risk analysis for their operations as the privacy and security of health information whether in paper or electronic form. See Exhibit A: Guidance on Risk Analysis Requirements Under the HIPAA Security Rule.
    g. Providers:

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1. May maintain individual medical records with electronic signatures in a computerized environment as long as the provider has a written policy describing the clinical record and authentication policy in force. These include, but are 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. Implementing, at a minimum, the following procedures may alleviate objections to the use of electronic signatures in medical records.
2. Delineate those categories of personnel who are authorized to access, modify and authenticate medical records using electronic signatures/computer entry.
3. Use a unique ID number, code, password or some other measure (such as a fingerprint/voice activation code) to identify each authorized user of an electronic signature. This ID number, code or password should be confidential and known only to the user and complex enough so that others cannot employ it.
4. Keep a signed statement authorizing that the user's electronic signature can only be applied to specific types or sections of the record they have authored. System managers must have the ability to revoke this authorization at any time.
5. Establish a system to place responsibility for verifying the accuracy of dictated information. A statement regarding this responsibility could be incorporated into the authorization for use of the electronic signature.
6. Include a method for "flagging" records with blanks, incomplete information and/or questions prior to their authentication. Records must be reviewed prior to signing. For systems in which the electronic signature is assigned at the time of transcription, there must be the ability for staff to verify the record is accurate and the signature has been properly recorded before it is considered complete.
7. Ensure that a security system is established that prohibits changes to a record after it has been authenticated.
8. Establish and enforce penalties for anyone who discloses their ID number, code or password to others or for anyone using an ID number, code or password without authorization.

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QUALITY ASSURANCE/IMPROVEMENT

The DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives. The DWIHN's direct contractor's quality improvement program must include measures for both the monitoring of and the continuous improvement of the program or process described in this policy.

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs DWIHN's direct contractors must include measures monitoring that include DWIHN's standardized monitoring tools. Reference the attached exhibit: **2018-2019 Network Monitoring Plan and attachments**

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, direct contractors, and subcontractors are bound by all applicable local, state and federal laws,

rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Mental Health Code, P. 258 of 1974, Sections 330.1746 and 330.1748.
2. HIPAA Security Guide
3. DWIHN Record Retention Storage Retrieval and Scheduled Disposal Policy
4. Michigan Attorney General Opinion #5709, (5/20/1980)
5. Medicaid Clinic Service Manual, Chapter III.

RELATED POLICIES

1. **Customer Service Medical Retention Retrieval Procedure**
2. Detroit Wayne Integrated Health Network Network Monitoring Plan FY 2018-2019
3. Network Monitoring and Management
4. Record Retention Storage Retrieval and Scheduled Disposal Policy

RELATED DEPARTMENTS

1. Administration
2. Children's Initiatives
3. Claims Management
4. Clinical Practice Improvement
5. Compliance
6. Customer Service
7. Information Technology
8. Integrated Health Care
9. Legal
10. Managed Care Operations
11. Quality Improvement
12. Recipient Rights
13. Residential
14. Substance Use Disorders

CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

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Attachments:

2018-2019 Case Record Monitoring Plan.pdf

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	11/2019

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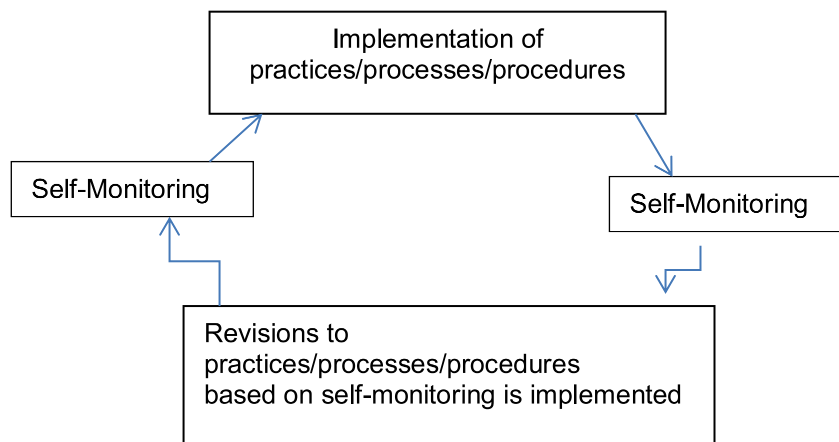
Detroit-Wayne Mental Health Authority
Monitoring Plan

The Detroit Wayne Mental Health Authority (DWMHA) developed standardized self-monitoring tools for use by contracted service providers. Implementation of this self-monitoring practice is a component of the continuous Quality Improvement (QI) process. The continuous QI process is designed to provide an organized, documented process for improving behavioral health care by identifying problems, implementing and monitoring corrective action and studying its effectiveness. The overall goal is to assure all eligible Wayne County residents are receiving the medically necessary and appropriate services for mental health issues, substance disorders and/or developmental disabilities. In addition, these services must conform to accepted standards of care while achieving the members' desired outcomes.

The goal of the self-monitoring plan is to support a continuous QI process. This involves ongoing monitoring efforts to improve services through constant evaluation and change, thus resulting in a process/procedure that creates program refinements.

The CQI process is iterative.



Four main principles of quality improvement include:

1. *Focus on the individual*: Services should be designed to meet the needs and expectations of members. An important measure of quality is the extent to which customer needs and expectations are met.

2. *Understanding work and system processes:* Providers need to understand the service system and its key processes in order to improve them. Using process-

engineering tools provides simple visual images of these processes and systems.

3. *Teamwork*: Because work is accomplished through processes and systems in which different people fulfill different functions, it is essential to involve stakeholders in the improvement process. This brings their insights to the understanding of changes that need to be made and to the effective implementation of the appropriate process. It also ensures ownership of the improvement processes and systems.

4. *Focus on the use of data*: Data is needed to analyze processes, identify problems and measure performance. Changes can then be tested and the resulting data analyzed to verify that the changes have actually led to improvements.

Monitoring and contractual responsibilities:
DWMHA contracts with Service Providers responsible for managing and delivering a full array of supports and services to adults with mental illness, individuals with developmental disabilities, children with serious emotional disturbances and persons with substance use disorders. In addition, DWMHA maintains a three-way contract with five Integrated Care Organizations and Community Mental Health (CMS) to serve both Medicaid and Medicare (dual-eligible) individuals.

Delegation:
Delegation is a formal process by which a Prepaid Inpatient Health Plan (PIHP) gives another organization the authority to perform certain functions on its behalf, such as, but not limited to, customer services, utilization management or quality improvement. Although DWMHA can delegate the authority to perform a function, the ultimate responsibility, for assuring the quality and appropriateness of care rests with DWMHA. DWMHA must ensure all contractual obligations between the Michigan Department of Health and Human Services (MDHHS) and all other regulatory bodies are met. It is DWMHA's responsibility to ensure that providers deliver the provision of Medicaid services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the Center for Medicare and Medicaid (CMS) Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, the Michigan Medicaid Provider Manual and Mental Health-Substance Abuse requirements.

This monitoring plan is geared to improve quality, measure our performance in the delivery of service and ensure compliance with required standards. The plan requires the involvement, skills, expertise and input from the service providers, and DWMHA staff. This approach is a partnership between the DWMHA, the providers, professionals and individuals serviced.

Goals, Objectives and Strategies:

Improving the quality and consistency of services is an important part of improving the provision of services to Wayne County members. The goals of DWMHA are to ensure providers maintain high standards and offer reliable supports and services within all programs. And ensure that services are integrated across the entire organization to ensure a whole-person approach to treatment.
To accomplish this goal, DWMHA needs to achieve the following three objectives.

Objective 1: Continuously improve the overall standards of clinical care.
Objective 2: Reduce unacceptable variation in clinical practice.
Objective 3: Ensure the best use of resources so that members receive the greatest benefits.

Strategies to meet the above objectives require that supports and services be:
- Appropriate to the member needs
- Effective by utilizing the best practices based on available clinical evidence
- Efficient and cost effective to maximize mental health gains for the maximum number of members.

Implementation of a Multilevel Approach:

This multi-level monitoring approach begins at the service provider level and cascades up to the DWMHA Quality Improvement Team.

Standardized Tools:
Standardized monitoring tools were developed to promote inter-rater reliability, sound and cost-effective self-regulation and data driven outcomes. Mental health professionals will be able to assess the care they provide against established standards.

Standardized tools are necessary to ensure:
- Actions and/or process requirements are not open to different interpretations
- The process is made easier to understand
- Non-value added steps are eliminated
- An increase in effectiveness and efficiency
- The process can be benchmarked to determine if it is proficient or that new performance goals are needed
- DWMHA staff can collect evidence relying on process conformity to increase validity and reliability in findings.

Review Process:

Providers receive a DWMHA-generated random sample of cases to be reviewed. Providers with greater than $250,000 in revenue receive 35 case records to review. Providers with less than $250,000 are grouped together and then 35 cases are

sampled. Providers complete their reviews using the **Clinical Record Review Tool** identified for that specific quarter in MH-WIN. The case record findings are to be aggregated by the providers using the Combined Record Review process in MHWIN which can provide immediate feedback on the provider's overall performance. On-going review will identify trends, areas for improvement and corrective action plans as needed.

Level I: The beginning of the process occurs at the provider level with the clinician delivering the service and documenting it in the clinical record. Staff is expected to self-regulate their clinical activities under the direction of the supervisor.

Level II: The service provider's Quality Improvement staff is responsible for evaluating their program's use of self-monitoring tools. Identify areas for improvement and initiate the appropriate interventions to correct the problem(s).

Level III: The DWMHA Performance Monitoring staff will be responsible for validating the information submitted by the providers. On a monthly basis DWMHA Performance Monitoring staff will generate aggregated reports of their assigned providers.

Steps of the Review Process:

Step I: Clinician, Clinical Supervisor and or Quality Improvement Supervisor:

Clinicians will deliver the services, document the findings in the case record, review case record documentation based on clinical record requirements and consult with the supervisor in areas of concern.

Training and technical assistance can be provided through a number of venues: peer reviews, increased supervision, technical assistance, in-service training, and practice-specific conferences. To ensure skills are updated the service provider organization should create an organizational learning culture that encourages staff to continually update their skills through such arenas as; University courses, DWMHA community events, trainings and conferences and other educational forums. All completed trainings must be submitted into Detroit Wayne Connect for monitoring purposes.

Step II: Provider Quality Improvement Supervisor:

The service provider's Quality Improvement (QI) staff is responsible for evaluating provider compliance using self-monitoring tools and other interventions they deem appropriate.

On a monthly basis it is strongly recommended that providers analyze data on completed case reviews by completing a combined report in MHWIN. The findings should be reviewed with the supervisor(s) who will then review with staff and if needed, will implement corrective action.

Each quarter all providers will review at 100% of the randomly selected case records provided by DWMHA. At the end of each quarter, the QI supervisor will complete an Aggregate report of the randomly selected Case Record Review tools.
The findings shall be used to assess program compliance and plan continuous quality improvement activities. The QI supervisor will aggregate the scores from the standardized review tool to assess trends, areas of weaknesses and strengths. The results will be shared with supervisors, clinical staff as part of the continuous quality improvement process. It is the responsibility of the QI supervisor and staff to implement a plan to achieve and maintain no less than 95% compliance.

At the provider level, the reviewers are able to determine the employee or supervisor's level of understanding, skill set and strengths. If problems are found, the QI supervisor should take the lead to provide direction, guidance and technical assistance. It is imperative that problem areas are addressed and corrected. Evidence of these corrections should be demonstrated in the clinical record progress notes and/or a revised IPOS, as appropriate.

Step III: DWMHA

On a monthly basis, the Performance Monitoring staff will review and validate the provider Case Record Reviews and Combined Reports in MH-WIN. The Performance Monitoring staff will submit:

a. Monthly reports to the Performance Monitoring Administrator on the on the 3rd Wednesday of each month. Monthly reports shall include but not limited to the following:
    i. Updates on the outcomes of the Provider Plans of Correction.
    ii. Results of continuous monitoring from desk audits, internal Agency reporting that impact a provider's performance and on-site reviews.

b. Quarterly reports identifying the overall performance from the standardized reviews will be completed by the Quality Administrator and shared with-in the provider network, reporting will outline the following:
    i. A brief summary outlining the overall provider performance. The summary is to include significant findings: improvements/deficiencies and plans of correction for providers below the 95% compliance threshold.

   ii. Recommendations for technical assistance that DWMHA can offer to the providers as a group to ensure compliance to the standards of care to continue to be a "high performing PIHP".
   iii. Recommendations for the Provider to perform a root-cause-analysis.

c. Annually Performance Monitoring staff is responsible for completing site reviews for assigned Direct Contract Provider.
   i. Site reviews entail:
      1. An Administrative site review
      2. Randomly selected sample of their contracted programs will be reviewed.
         a. Special attention will be given to providers on plans of correction from previous reviews by DWMHA staff or from external reviews i.e. MDHHS.

<u>Culture of Excellence focus through inter-departmental communication and involvement:</u>

DWMHA Performance monitoring staff will work in conjunction with staff from other units in monitoring identified standards. These units will include but are not limited to the following:

1. Contract Management
2. Office of Recipient Rights
3. Customer Services
4. Clinical Practice Improvement
5. Children's Initiative
6. Information Technology

Coordinating with the various units will improve DWMHA's ability to monitor the overall health and welfare for the individuals' we serve.