SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

Date of Issue: 4/19/17 **Section Number 606**
Date Revised:

Policy 606 – OBMAT Patient Records

The SHCMHC OBMAT program shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system shall comply with all federal and state reporting requirements relevant to medications approved for use in treatment of substance use disorder.

All patient records shall be maintained for a minimum of five years from the time that the documented treatment is provided. In the event a patient is a juvenile, the records shall be kept for a minimum of five years from the time the patient reaches the age of 18.

All patient records shall be kept confidential in accordance with all applicable federal and state requirements.

All patient records shall be updated in a timely manner.

Information in the patient medical records shall be entered by designated program staff and approved by the program physician. Entries shall be legible and organized in an effective manner, allowing materials to be easily retrieved.

The SHCMHC OBMAT program policies and procedures will help to ensure security of all records including electronic records.

Individual patient records shall contain:

- Identifying and basic demographic data and the results of the screening process.
- Documentation of program compliance with the program's policy regarding prevention of multiple admissions.
- An initial assessment report.
- A narrative biopsychosocial history.
- All physical and biopsychosocial assessments.

The SHCMHC OBMAT program will work to ensure that the medical records will include the following:

- Results of the physical assessment.
- Family medical history.
- Review of systems

- Laboratory reports, including results of required toxicology screens.
- Results obtained from the Controlled Substances Monitoring Program database.
- Progress notes.
- Documentation of current dose and other dosage data.
- Any other information deemed pertinent.
- Dated case entries of all significant contacts with patients, including a record of each counseling session in chronological order.
- Dates and results of case conferences for patients.
- The individualized treatment strategies, and any amendments, reviews or changes to the plan.
- Documentation that the services listed in the treatment plan are available and have been provided or offered.
- Coordination of care agreements signed by the patient, program physician and primary counselor.
- Documentation that the SHCMHC OBMAT program made a good faith effort to review whether the patient is enrolled in any other OBMAT program.
- A record of correspondence with the patient, family members and other individuals and a record of each referral for services and its results.
- A record of correspondence with other healthcare providers of the patient if applicable.
- Documentation that the patient was provided with a copy of the program's rules and regulations.
- A copy of the patient's rights and responsibilities.
- A copy of the detoxification treatment plan option if applicable.
- A copy of the patient's individualized treatment plan.
- A copy of the patient's goals and documentation that each of these items was discussed with the patient.
- Consent forms.
- Releases of information.
- Prescription documentation.
- Travel (how the patient gets to appointments).
- Employment
- A closing summary, including reasons for discharge and any referral. In the case of death, the cause of death, if known, shall be documented.

Documentation of Patient Contact

SHCMHC will ensure that proper documentation of significant contact with each patient will be noted in the patient record and include a description of:

- The reason for or nature of the contact.
- The patient's current condition.
- Significant events occurring since prior contact.

- The assessment of patient status.
- A plan for action or further treatment.

Each entry should be completed by the next business day, but no longer than three business days following the contact and shall be clearly dated and initialed or signed by the staff person involved.

If SHCMHC closes or discontinues the OBMAT program, services will be arranged for continued management of all patient records utilizing the following procedure:

> The Administrator or designee of the SHCMHC OBMAT program shall notify the secretary in writing of the address where records will be stored and specify the individual who will be managing records and that individual's contact information.

The Administrator or designee of the SHCMHC OBMAT program shall arrange for the storage of each record through one or more of the following measures:

> The record will be maintained electronically for ten (10) years.

The Administrator or designee of the SHCMHC OBMAT program shall continue to manage the records and give written assurance to the secretary that it will respond to authorized requests for copies of patient records within ten (10) working days.

The Administrator or designee of the SHCMHC OBMAT program shall transfer records of patients who have given written consent to another OBMAT program if necessary.

The Administrator or designee of the SHCMHC OBMAT program shall enter into an agreement with another OBMAT program to store and manage the patient records if necessary.

Controlled Substances Monitoring Program Database

The SHCMHC OBMAT program shall comply with policies and procedures developed by the designated state oversight agency and the West Virginia Board of Pharmacy to access the Controlled Substances Monitoring Program database maintained by the West Virginia Board of Pharmacy. Other states may be checked as deemed necessary. This will be outlined in the consent form.

The SHCMHC OBMAT practitioner or designee will access the database in accordance with the requirements of West Virginia Code § 16-5Y-5(j).

The SHCMHC OBMAT practitioner or designee shall access the Controlled Substances Monitoring Program database in order to ensure that the patient is not seeking prescription medication from multiple sources. The results obtained from the database shall be maintained with the patient records.