LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 10/22/2012
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CHAPTER Information Management	**CHAPTER** 07	**SECTION** 002	**SUBJECT** 05
SECTION Data Management	**DESCRIPTION** Electronic Health Record: Optimal Alliance Software Information System OASIS		
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APPLICATION:

☒CMH Staff	☐Board Members	☐Provider Network	☒Employment Services Providers
☐Employment Services Provider Agencies	☒Independent Contractors	☒Students	☒Interns
☒Volunteers			

POLICY:

It shall be the policy of Lapeer County Community Mental Health (LCCMH) to establish responsibility and standards for the maintenance and use of the electronic health record (EHR), Optimal Alliance Software Information System (OASIS).

STANDARDS:

A. The case record (health record) is a collection of documents concerning an individual that receives mental health and integrated health care. It is created and maintained by LCCMH in accordance with policies and MDHHS rules and regulations, made by a person who has knowledge of the acts, events, opinions, or diagnoses relating to the person served and made at or around the time indicated in the documentation.

B. A health record will be maintained for every person who is receiving or has received mental health services.

C. The health record (both electronic and paper format) is confidential and is protected from unauthorized disclosure by law. The use and disclosure of confidential health record information is set forth in the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices and in the Protected Health Information – Health Information Privacy Policy (04.003.40). All protected health information in the electronic record (OASIS) will be stored in a manner that ensures the record's accessibility, completeness and logical arrangement or ability to be retrieved in a logical manner. Secure storage of protected health information safeguards against loss, defacement, and tampering as well as unauthorized use or disclosure.

D. Currently the LCCMH maintains a hybrid record consisting of both Electronic (OASIS) and - historical paper files.

E. The electronic health record will be organized according to OASIS Chart Links. External and non-OASIS developed forms will be scanned into OASIS within 24 - 48 hours.

- Protected health care or treatment based documents from external providers will be scanned into the record.
- Some LCCMH related forms not available in OASIS will be scanned into OASIS following the scanning procedure at a centralized location.

F. Historical paper records and the EHR are to be maintained in consistency with the Region 10 PIHP, the Michigan Department of Health and Human Services (MDHHS), CARF and state and federal laws and regulations.

G. Staff will complete clinical documentation as indicated by form instructions, in alignment with Medicaid guidelines, the Michigan Mental Health Code, and the Administrative Rules.

H. Documents completed or scanned into OASIS must follow the policies that determine case record timelines as determined by LCCMH, MDHHS and accreditation requirements. All documentation should be entered into the OASIS Software within 24 hours of the appointment.

I. LCCMH will maintain accurate and confidential records that are secured against loss, tampering and from unauthorized use.

J. LCCMH Information Technology (IT), Billing, and Data Management Supervisor is the custodian of the Electronic Health Record.

K. LCCMH will be responsible for maintaining a complete electronic case record, including following policies and procedures to safeguard the data integrity, security and privacy of the EHR.

L. The confidentiality, integrity and availability of electronic protected health information in OASIS is maintained in a secure, experienced and confidential manner, and adheres to professional standards, rules and regulations of applicable governmental organizations, such as Michigan Department of Health and Human Services.

M. LCCMH will maintain accurate and updated user accounts in OASIS and ensure all OASIS accounts are removed or disabled upon employee termination, reassignment or any occasion where access is no longer required. User accounts require strong secure unique logins and regular changes to each user's password. A strong password contains capital letters, numbers and is at least eight characters long. If the wrong password is entered (at least 3 times) this will disable the account. Also, if not accessed after a certain time frame, the account will also become disabled and will need to be reset by data staff.

N. OASIS access will only be allowed on LCCMH computing equipment; affiliate or contract agency owned and managed equipment.

O. LCCMH assigned staff will review security access reports to identify misuse of OASIS accounts or other security related incidents. Security incident processes are in place, according to HIPAA standards to provide overall security and risk assessment.

P. LCCMH will participate in a regional management process of OASIS (OASIS - Data Management Committee) to develop improvements, rectify problems and provide oversight.

Q. All security incidents that impact or have the potential to impact confidentiality, integrity or the availability of OASIS data must be reported to the IT, Billing, and Data Management Supervisor.

R. The Regional Chairperson of the OASIS Data Management Committee will mediate all issues between affiliates and PCE Systems.

PROCEDURES:

Medical Records Clerks

A. Will maintain scanning of records into OASIS. A paper record existing prior to October 1, 2012 will be maintained as long as the individual is open and for up to one year after the upgrade of OASIS on 10/1/2012. Once the "do not purge" documents have been scanned into OASIS, the remainder of the existing paper chart will be placed into storage. For individuals that have cases opened on 10/1/2012 or after, a fully electronic chart will be maintained.

Staff

B. Will receive accessibility to OASIS based on their need to complete individual job functions. Only authorized staff with a "need to know" are allowed access to view an individual's electronic health record. LCCMH and providers are responsible for developing and adhering to a process which outlines staff authorization to electronic health records based on assignments and supervision responsibility. Staff access will be monitored on a regular basis and access will be adjusted to reflect any job function changes.

Administration

C. Responsibility for oversite of the electronic health record is assigned to the IT, Billing, and Data Management Supervisor. This includes assisting with controlling the proper access to the records, ensuring completeness and integrity of the content of the record and the security standards established in the Health Insurance Portability and Accountability Act of 1996, as well as the Michigan Mental Health Code.

DEFINITIONS:

A. Current Case Record - The official case record which contains all documents currently in effect; the most current Individual Plan of Service (IPOS) forward to date (plus historical documents not to be removed).

B. Electronic Health Record (EHR) - A longitudinal electronic record of an individual's health information generated by one or more encounters in a care delivery setting which includes demographics, service plan, progress notes, medications, vital signs, past history, etc. The information is maintained in a form able to be processed by a computer that is stored and transmitted securely, and is accessible by multiple authorized users. The EHR has the ability to generate a complete record of a clinical encounter, as well as supporting other care-related activities directly or indirectly via interface – including evidence-based decision support, quality management, and outcomes reporting. Its primary purpose is the support of continuing, efficient and quality integrated health care, and it contains information that is retrospective, concurrent and prospective. An EHR replaces the paper medical record as the primary source of case record information.

C. OASIS: Optimal Alliance Software Information System – is the certified electronic health record utilized by LCCMH and contract providers.

D. Security of Electronic Health Record (EHR) – Protections, policies and processes for preventing either intentional or unintentional issues resulting from an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with OASIS and the protected health information contained within.

REFERENCES:

- HIPAA Privacy Rule, 45 CFR Part 164 (164.501)
- Mental Health Code, Act 258 of 1974, 330.114 (section 141)
- American Recovery and Reinvestment Act of 2009
- LCCMH Policy 04.003.40 Health Information Privacy

SK:mgr