POLICY TITLE: Medical Records Maintenance		PAGE 1 OF 7
	CHILD AND FAMILY SERVICES AGENCY **Approved by: Debra Porchia-Usher** Interim Agency Director **Date: October 4, 2010**	**REVISION HISTORY:**
LATEST REVISION: October 4, 2010	**EFFECTIVE DATE:** October 4, 2010	

I. AUTHORITY	The Director of the Child and Family Services Agency (CFSA) adopts this policy to be consistent with the Agency's mission and applicable federal and District of Columbia laws and regulations, including DC Official Code § 4-1303.06 and the Health Insurance Portability and Accountability Act (HIPAA), and the *LaShawn* Implementation and Exit Plan (December 17, 2010).
II. APPLICABILITY	All Agency employees, contract agency staff and contracted personnel.
III. RATIONALE	The careful maintenance of medical records is critical to the safety and well-being of the children in care. It is essential to maintain these records in an organized format and to have them easily accessible to the assigned social workers, their supervisors, and the Office of Clinical Practice (OCP), including OCP's Clinical and Health Services Administration (CHSA) and the Healthy Horizons Assessment Center (HHAC), as well as others deemed necessary. It is important to maintain adequate confidentiality of records while still facilitating appropriate and timely care while the child or youth is in CFSA care and custody. Medical records should be comprehensive, concise, and contain accurate information and documentation of the child or youth's health history. It is important that the child or youth's medical records are reviewed and monitored on a routine basis to ensure accuracy of vital health care information.
IV. POLICY	It is the policy of CFSA to maintain the medical records of children and youth in its care according to prescribed Agency standards. The maintenance of medical records – both the physical records and the information recorded in FACES.NET - shall adhere to the following guidelines: 1. A diligent standard of maintenance that will allow for ease of access to critical health information. 2. A system of standardized processes that is flexible enough to account for the unique health situations for each child or youth. 3. A comprehensive health history and health plan for each child and youth that reflects thoughtful information management. 4. An accurate accounting of the child or youth's past medical history, current health status, and proposed future plan of treatment. 5. A high standard and respect for individual confidentiality and privacy that is consistent with HIPAA and other confidentiality laws.

V. CONTENTS	**A.** Access to Medical Records and Medical Information **B.** Medical Records Maintenance **C.** The Initial Medical Record **D.** Medical Section of the Official Case Record **E.** Monitoring of Medical Information in the Official Case Record **F.** Organization of Medical Records **G.** Confidentiality and Medical Information
VI. PROCEDURES	**Procedure A: Access to Medical Records and Medical Information** Access to the medical records and medical information of children and youth in CFSA's care and custody shall be governed in accordance with DC Official Code § 4-1303.06. Medical records shall be stored in the CFSA Central Filing Unit (CFU). *(*See CFSA's policy on *Client Records Management).* (For information on confidentiality and medical information, see *Procedure G: Confidentiality and Health Information*.) 1. The Office of Clinical Practice (OCP) administrators and managers, CFSA nurse practitioners, medical assistants and medical records technicians shall have round-the-clock access to the medical records of children and youth in CFSA care. 2. CFSA and private agency staff who are assigned case management responsibilities (i.e., the assigned social worker, supervisor, and family support worker) shall have access to the information contained in the child or youth's medical record to ensure proper case management and the delivery of services. 3. The staff of CFSA's Billing Services Units' Medicaid Claiming Unit (MCU) shall have access to the medical records of children and youth in CFSA care for the purpose of reviewing the medical records for Medicaid claiming and billing activities. • The OCP medical records technician transports all clinic records from the Healthy Horizons Assessment Center (HHAC) to the MCU, for billing purposes. Once the billing process is completed, the MCU staff returns the medical records to the OCP medical records technician, who then returns them to the CFU for storage. 4. Access to the information contained in the child or youth's medical record shall be available to the parents or legal guardians of minor children under the age of 18 (excluding reproductive health information), and medical and mental health providers for the purposes of securing evaluations and treatment. Certain medical information may also be available to the child or youth who is the subject of the health information, if it is clinically appropriate for the medical information to be shared (based on the age of the child or youth or the ability of the child to understand the information). *Note: The treating health care practitioner in consultation with the assigned social worker shall determine if it is clinically appropriate for the child or youth to have access to his or her medical information. The assigned social worker shall ensure that the assigned assistant attorney general (AAG) receives this information.*

	Procedure B: Medical Records Maintenance The maintenance of medical record information shall be the joint responsibility of the assigned social worker and the OCP. 1. Notes shall reflect current and past child or youth health and medical information and activities. 2. Current and past child or youth health and medical history, documents, and records shall be included in a child or youth's medical file. 3. Medical records shall contain all forms or documentation pertaining to medical consent (see *CFSA's policy on Medical Consents)*. 4. Medical records shall be maintained in an organized format to provide accessible, accurate, and concise health and medical information.
	Procedure C: The Initial Medical Record The initial medical record shall be developed by OCP. In addition, the assigned social worker shall team with OCP to ensure the following steps are taken for completion of the record: 1. Compile all past and current health care and medical activities, and information, including a copy of the initial screening documentation, and any treatment plans for on-going health care *(*see *CFSA's policy on the Initial Evaluation of Children's Health)*. 2. Obtain signed consent forms from the child or youth's parent or legal guardian for the release of past medical records and medical history, if applicable. 3. Request in writing health records from any known previous and current health care providers. 4. Verify health and medical activities of the child or youth through the District of Columbia's Department of Health Care Finance Medicaid, public health records, and private providers. 5. Ensure all medically-related activities, including the initial medical screening information, are documented both in the child or youth's physical case record and in the medical screens in FACES.NET. 6. Once the development of the medical record is completed, the OCP medical records technician transports the record from the HHAC to the MCU, for billing purposes (*see Procedure A.3 above*).
	Procedure D: Medical Section of the Official Case Record In addition to the medical information contained in the medical record maintained by OCP, all known health and medical history information on the child or youth shall be documented by the assigned social worker under the appropriate medical section of the child's official case record.

	1. The social worker shall insert all collected medical history information in chronological order in the official case record, including but not limited to the following information: a. Child or youth's medical history from known healthcare providers b. Medical forms, prescriptions, and medical information available from the public health system, including a copy of the child or youth's Medicaid card or Medicaid card application. 2. The medical section shall also include all forms or documentation pertaining to the release of confidential medical information. 3. The child or youth's social worker shall collaborate with OCP to gather the following critical information and file it in the official case record: a. Birth history b. Developmental history c. Previous and current health care providers d. Previous and current insurance carrier e. Previous and current diagnoses f. Previous and current major treatment, including previous and current prescription history g. History of hospitalization h. Known drug or other allergies. 4. The child or youth's social worker shall document all medical information in FACES.NET.
	Procedure E: Monitoring of Medical Information in the Official Case Record 1. During each supervision with the assigned social worker, the supervisor shall complete the following tasks: a. Review the medical status of the child or youth. b. Ensure that the child or youth's medical information is properly documented in the FACES.NET medical screens. c. Review the child or youth's case files for compliance with Agency standards as outlined throughout this policy. 2. The supervisor shall also complete the following tasks throughout the life of a child or youth's case: a. Request that the assigned social worker gather additional health information whenever deemed necessary. b. Seek consultation from CHSA as needed.

Procedure F: Organization of Medical Records

All medical records shall contain the following categories of information:

1. A summary of all current and historical information on the child or youth's health:
   a. Client name
   b. FACES.NET identification number
   c. Assigned social worker
   d. Date of Birth (DOB)
   e. Height and weight (and date of most recent measurement)
   f. Gender
   g. Primary care health care provider (PCP) name and contact information
   h. Insurance carrier and number
   i. Medicaid card (or copy)
   j. Emergency contact and next of kin
   k. Major diagnoses and/or treatment (historical or ongoing), if any
   l. History of hospitalization(s), if any
   m. Notifications/precautions for children or youth with special needs, if any
   n. Consents for release of information, including a list of individuals to release private health information
   o. Known drug or other allergies
   p. Other

2. A medication history, provided by the child or youth's health care provider:
   a. Current medications (including psychotropic medications), dosage, and frequency
   b. Past medications (including psychotropic medications), dosage, and frequency
   c. Drug allergies
   d. Insurance carrier
   e. Pharmacy
   f. Prescribing physician
   g. Special instructions
   h. Other significant information

3. Other information and documents collected from health care providers:
   a. Medical assessments
   b. Immunizations
   c. Dental assessments
   d. Mental and behavioral health screenings, and applicable assessments
   e. Developmental screenings and applicable assessments
   f. Vision and hearing screenings, and applicable assessments
   g. Substance abuse assessments, if applicable
   h. Past medical records
   i. Laboratory reports

4. Pre-placement screenings and medical records, with the exception of the results of the HIV screening (*See HIV and AIDS Policy.)*

5. All applicable consent forms (from the parents and/or the child or youth)

6. Other Agency medical and dental forms and notices

Procedure G: Confidentiality and Medical Information

CFSA ensures that the medical records of children and youth in its care are kept confidential and protected from public or unauthorized disclosure. Information contained in the medical records may only be released in accordance with federal and District privacy and confidentiality laws and regulations *(see the CFSA policy on Confidentiality) and HIPAA*).

1. The medical section of the case file should reflect all privacy or sharing transactions including the following information:
   a. HIPAA forms, signed by parents or legal guardians
   b. Consent for the release of information
   c. Requests for private health Information
   d. The release, or receipt, of private health information
   e. Consent to receive treatment
   f. Any other documentation related to private health information

2. All forms and documents containing medical information are subject to the HIPAA Privacy Act. If this information is scanned for the purpose of saving to a network or to be emailed or faxed, it becomes Electronic Protected Health Information (e-PHI) and falls within the guidelines of CFSA's HIPAA Security policy. (For additional guidance, CFSA staff should review the HIPAA policies located on CFSA's Intranet Website. Private agencies should contact the CFSA contract monitor to access a copy of the relevant policy.) Any questions regarding CFSA's HIPAA policy or privacy practices should be directed to the Agency HIPAA Privacy Officer or the Security Officer.

	3. All HIV or AIDS-related documents shall be kept strictly confidential within the CFSA medical record and in the case record. (For further criteria regarding the confidentiality of medical information related to a child or youth's HIV and/or AIDS status, s*ee CFSA's policy on HIV and AIDS*.) a. HIV-related medical information (e.g., HIV risk assessment materials, test results, treatment reports) shall be maintained in a sealed manila envelope in the medical record and in the medical section of the case record. b. The envelope must be clearly labeled "Confidential" and instructions should appear on the outside of the envelope as to who may have access to the information (e.g., CFSA's medical director, nurse care manager, parents, legal guardians, and those responsible for the child or youth's daily care). • A child or youth who is of an appropriate age and mental status may give informed and written consent for information to be shared with others (e.g., a medical or dental care provider).