Originating Unit	[ ] Administration [ ] Alice! [X] CPS [ ] Disability Services [ ] Patient Services [ ] Medical Services [ ] Sexual Violence Response		
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SUBJECT: CPS PATIENT ELECTRONIC HEALTH RECORDS

SCOPE
Applies to all Counseling & Psychological Services staff with electronic health records responsibilities.

POLICY
An electronic health record (EHR) will be created for each patient treated at Counseling and Psychological Services (CPS) and will include adequate identifying information (at minimum: name, address, phone number, email, and emergency contact information). It is the responsibility of both clinicians and Health Services Assistants (HSAs) to ensure that patients provide this information, and sign the Acknowledgement of Privacy Practices and Consent for Treatment forms. These forms will generally be signed electronically through the Patient Portal, but when that is not practical, a paper version ***(CPS-EHR-Form 1***) of the treatment consent may be signed and scanned.

Under no circumstances may a patient be seen anonymously at CPS. This does not limit the ability to assure patients that CPS maintains strict standards of privacy and confidentiality.

All paper records are stored offsite. Staff may request retrieval of paper medical records for students who return to CPS for treatment and who were seen prior to the implementation of the electronic health records. When paper records are retrieved, they are to be stored in a separate area not accessible to the public and may only be retrieved by Columbia Health staff. Once reviewed by staff, paper records will be scanned into the documents section of the electronic health record and then shredded, with the exception of records which have been subpoenaed or are otherwise the subject of a legal action or official investigation. Such records will be scanned and the original paper records will also be retained at GRM, the contracted storage facility.

While CPS providers work as a team, providers will access a student's electronic health record **only** when there is a legitimate need to do so in order, for example, to: provide treatment to a student; supervise or provide consultation to a clinician engaged in treatment; participate in a quality assurance activity, such as a peer chart review, or the review of a potentially adverse incident; resolve a student complaint; or comply with a subpoena or other legal requirement. In addition, The Executive Director, Director of Clinical Services, and other senior administrators designated by the Executive Director will, as needed, review charts as part of their general oversight responsibilities, including, but not limited to, performance appraisals of clinical staff under their direct supervision.

PROTOCOL:
General Principles

1. Electronic Health Record entries must be kept up to date:
   a) Initial Treatment Planning assessments are to be completed at the time of the treatment planning interview.
   b) First Visit and Drop-in notes will be completed at the time of the unscheduled contact

c) Initial Intakes (counseling, psychiatric, and couple), and all other clinical notes, including follow-up visit notes, and substantive telephone contacts will ordinarily be completed **within two business days.** In high-risk situations notes will be completed on the day of the contact.
d) Disposition will be updated at the conclusion of every visit
e) Mental status will be periodically updated, even if only to indicate that there have been no changes
f) Response to medications, for students under psychiatric cared, will be frequently updated
g) Treatment plan, including progress toward goals, must similarly be periodically updated, typically at least once every fourth visit

2. Inconsistencies in diagnoses recorded by two or more different providers will be discussed promptly, and the record will reflect the resolution of these differences.

3. Consultations with a dean, resident advisor (RA), faculty member, or other administrator about a student or campus situation of concern is classified, for reporting purposes, as a consultation, and will be placed in the schedule as a "Consultation—Deans," "Consultation—RA," etc. as appropriate. The reason for the consultation should be noted in the "Reason" field (e.g., "thinks student might be depressed" or "help with disruptive student") of Open Schedule. If the student under discussion is in treatment with CPS, depending on circumstances, it may be appropriate to place a "Consultation Note" in the electronic health record.

4. When the **subject** of a consultation is a worrisome employee, the consultation will be scheduled as "Consultation—Employee." In contrast to the other consultation categories, in which the consultation type is defined for the person consulted, any consultation **about** an employee, be it with a faculty member, dean, another employee, etc. is coded as "Consultation—Employee" in Open Schedule.

5. **Employees** are not ordinarily treated at CPS, but as a courtesy may be assisted with a referral to an off-campus resource or redirected to the Employee Assistance Program (EAP). However, in certain extraordinary circumstances, with the approval of the Executive Director or in their absence, the Director for Clinical Services, CPS may provide brief crisis intervention to employees, (e.g., when employees have experienced traumatic events in the course of their work day). In these rare instances, when a CPS provider enters into a doctor-patient relationship with an employee, an electronic health record MUST be created. For ease of reporting, when the employee registers at CPS, HSAs will manually enter "EMPLOYEE" in the EHR system. An electronic health record must be opened even for single face-to-face encounters. In an acute situation, it may be necessary to see an employee more than once or twice in the interest of safety, but in general, visits are limited to a very time-limited interventions.

6. Brief encounters <u>intended</u> to assist an employee, that are strictly administrative (e.g., providing referral information) do not require an electronic health record entry; more complex interactions may require documenting the management of risk factors, though in general, if no doctor-patient relationship exists with the employee, an electronic health record is not appropriate. For scheduling/reporting purposes, use "Consultation— Employee" for this type of encounter and enter "Referral" in the "Reason" field.

7. Chart entries will be written in a concise, objective, and professional manner; and with awareness that patients have the right to review their records, and that other CPS clinicians may rely upon a record to inform their handling of emergent situations.

8. **No electronic health record can be altered retroactively in any fashion.** Should new information come to light, requiring revisions of earlier findings, this data will be recorded in a new, dated entry or as an addendum to the original note.

9. Clinicians will take care to distinguish between objective information, the patient's subjective impressions of events, and the clinician's own assessment. For example, the notation "mother is bipolar" is ambiguous as to the basis of the assertion. Is this a medical finding? If so, the notation might better read "mother has reportedly been diagnosed as bipolar by her psychiatrist." If this a clinician's own impression, the record more accurately will state: "Based on the patient's description of mother's behavior, there are indications of possible bipolar illness." If this the patient's characterization, a suitable chart entry might be: "Patient's impression is that her mother is bipolar, but she has not been formally diagnosed as such."

Electronic Health Record Security

1. Records are electronically stored and are password protected.

2. During office hours, when computer terminals are on, offices will not be left unlocked and unattended.

3. All staff members will lock the EHR when stepping away from the computer, even if briefly.

4. The contents of all records will be regarded by professional and HSAs alike as privileged and confidential.

5. When new professional staff or HSAs are hired, they will be trained thoroughly in issues of privacy and confidentiality. All staff will periodically completed HIPAA training provided centrally by the university.

6. **It is a HIPAA violation to read a record without a legitimate clinical or administrative reason.**

7. For release of records, see ***CPS-EH REC 1: Confidentiality and the Release of Information***; for matters pertaining to the HIPAA Security Rules please see HIPAA guidelines outlined on the notice to students.

Quality Improvement

1. Records will be audited periodically to insure the timely completion, appropriate content, and adherence to electronic health records policies and procedures.

2. Substantive clinical audits also will be conducted periodically.

Specific Contents of Records

1. *Consent for Treatment and Acknowledgment of Receipt of Privacy Practices*
   Must be included in very chart. It is the mutual responsibility of HSAs and clinicians to ensure that either an electronic consent is on file or that the paper version of the Treatment Consent form (provided in ***CPS-EHR-FORM-1)*** has been signed. Missing information will be addressed, if possible, by clinicians during intake sessions. HSAs will scan the paper version of the treatment consent form into the document section of the electronic health record

2. *First Meeting Interview*
   Is completed when a student's first contact with CPS is through a Drop-In appointment. Should the student continue at CPS, an Initial Intake will be completed at a subsequent meeting.

3. *Treatment Planning Session assessment*
   Must be completed for all students who have a treatment planning interview. Details may be found in ***CPS-CLIN-8 Treatment Planning Sessions.***

4. *Initial Counseling or Psychiatric Intakes* will include entries for each category on the template appropriate to the discipline of the provider conducting the intake.
   a) For **counseling intakes** these categories are:
      - Referral source (when known)
      - Presenting Problems
      - History of Presenting Problem/Treatment History
      - Academic/occupational functioning
      - Social Functioning
      - Sexuality, Sexual Health, and Gender Identity
      - Medical/Developmental History
      - Substance Use screening
      - Family Mental Health History
      - Trauma/Relationship Violence History
      - **Risk Assessment for Suicide and for Violence**, including protective factors and interventions intended to reduce risk. In higher-risk situations, providers will take care to note their reasoning when certain actions generally consistent with standard practice are not taken. For instance, should a provider not enlist the support of the parents of an at-risk student because they are estranged from their family, and contacting the family is likely to alienate the student from treatment, increasing, rather than reducing risk, it will be so noted in the chart.
      - **Mental Status Exam**: Remarks in the Mental Status section will speak to formal aspects of a mental status exam (e.g., appearance, judgment, mood, speech, thought, etc.), if only to note no abnormalities in these areas. A positive response to any question will also include a narrative statement describing the issue noted.
      - Diagnostic Impressions
      - Collaborative Treatment Plans/Goals
      - Disposition
   b) **Psychiatric Intakes** include all of the above categories as well as:
      - Medications
      - Allergies
      - Vitals
      - Orders
   c) **Symptom reviews**, which map to the DSM-V, are available to be used as appropriate. Providers need not complete each symptom review. Only those relevant to presenting complaints and a student's clinical presentation need be completed.
   d) It may not be possible to complete every item in an intake template after a single initial interview, however, at minimum all items documenting presenting complaints, risk assessment, mental status, diagnostic impressions, treatment planning, substance use screening, and disposition must be completed. Information that cannot be gathered during an initial interview that is necessary to complete the assessment will be included in subsequent notes.
   e) While an entry must be made in the "Initial Diagnostic Impression" section of the Counseling or Psychiatric Intake, when adequate diagnostic data are missing, several options are available, listed here in descending order of specificity:
      i) Indicate a provisional diagnosis.
      ii) Indicate a series of possible diagnoses (e.g., "Rule out: OCD; Rule out: Anxiety Disorder")
      iii) Indicate the very broad, provisional diagnosis of F99 "Unspecified Mental Disorder"

5. *Releases, Correspondence, Evaluations, Lab Results* and student emails containing substantive clinical information will be scanned into the document section in the electronic health record by HSA staff.

6. *Counseling/Psychiatric visit notes* will be made for each contact. These visit notes will emphasize changes in mental status, risk factors or diagnostic impression; important new objective developments; progress or lack thereof in meeting treatment goals; and changes in treatment plan, including referral, consultation, etc.

Lengthy descriptions of psychodynamics are to be avoided.

7. *Behavioral Health note* is completed to document visits conducted at Medical Services by embedded CPS staff.

8. Substantive phone contacts with students will be recorded on either the "*Phone Encounter*" or "*Psychiatric Phone Encounter"* note depending on the discipline of the clinician.

9. The *Consultation Note* will be used to record consultations regarding a patient's treatment with other professionals; and contacts, initiated with the patient's consent, to mobilize family or academic support.

10. *General Non-Appointment Notes* are used to record any relevant clinical information obtained from, or to document coordination of care with, involved persons outside of Columbia Health, among other general uses.

11. *Social work notes* will be used to record consultations with students for the purpose of case management, including, but not limited to, assistance with referrals.

12. *Missed Appointment Notes* may be generated when a patient misses an appointment without prior cancellation. The clinician with whom the student "no showed" will ordinarily generate the note under the conditions described in ***CPS-APPT-2 Missed Appointment Policy and Procedure***. An HSA will generate a "Missed Appointment Note" only when students cancel and refuse to accept another appointment at CPS. The provider with whom the student "no showed" is then responsible to respond to that "Missed Appointment Note" to document follow-up with the student.

13. *BHM-20,* when administered, automatically populates in the chart. This objective measure of symptoms is required in many CPS settings, including Urgent Mental Health Drop-in hours, and is recommended in all situations in which it will not prove disruptive to engaging and treating students

14. *Termination or Final Contact:* When a student terminates in a planned manner, the last follow-up visit note will reflect the conditions of the termination; progress made; plans for further treatment outside CPS; and any other relevant clinical information. If the termination is unplanned, resulting from a student unilaterally discontinuing treatment, the "Missed Appointment Note" will document the student's termination and the clinician's decision to allow the treatment to lapse with no further follow-up. If the termination occurs in a phone contact, a "Phone Encounter" note will describe the termination.

Records of Patients in Group and Couples Treatment

1. Each member of a confidential psychotherapy group will have an individual electronic health record, which includes a treatment consent and acknowledgment of receipt of Privacy Practices , and, at a minimum, Group Therapy follow-up notes.

2. For groups for which members are individually pre-screened, a separate Initial CPS Counseling Intake will also be completed for each group participant. Group Therapy progress notes will be recorded in the electronic health record using the "*Group Therapy Visit Note"* template. This template allows a single progress note describing group discussions or skill-building exercises to populate the appropriate field of each group member's electronic health record.

3. Clinicians will record each group member's disposition along with additional clinical information specific only to that group member by adding free text entries or by dropping sections (such as "Mental Status Update") into that student's chart alone.

4. For each group session, attendance is kept by initiating a Group Progress or Missed Appointment Note.

5. Group participants will be referenced by their initials only. Should an individual's record be released, the confidentiality of the other group members will thus be safeguarded.

6. When a student in a group presents specific management issues or other serious concerns (e.g., suicidal ideation), or is seen for individual appointments outside the group setting, an individual "Counseling Visit Note" will be recorded and sections added to their existing "Group Visit Note" to reflect the issues raised.

7. The same general principles will be followed when couples are seen. An electronic health record will be established for each member of the couple, with a Treatment Consent form completed for each partner.

8. If a student has not been seen at CPS prior to being seen for couple counseling, the standard CPS Counseling Intake will be used to record history, mental status and the like; the CPS "Couple Intake Section" will be imported into the standard Intake form and used to record information about the couple, such as the history of this relationship and presenting problems as a couple. If a member of the couple has been seen at CPS before and has an Intake on file, only the Couple's Intake form need be completed.

9. When writing notes that pertain to both members of a couple, information about the couple can be copied and pasted into the other member of the couple's record or printed out and scanned into the other record. When a single note is completed about a couple session each partner should be referred to by initials only.

   Individualized progress notes will be added to the record of either member of the couple should they present suicidal risk or other severe symptomatology using the appropriate section template (CPS supplement to Group or Couple Note, Diagnosis and/or Patient History).

10. The Couple Intake form and Intake section includes two check-off boxes to document a discussion of confidentiality issues with the couple. A note must also be written in the "Narrative" section below describing their interaction with the clinician and any clinical issues raised.

11. Contacts with group members or one member of a couple which occur outside of group or couple sessions, respectively, will be noted only in the record of that patient.

Reopening Records

1. A new CPS Counseling Intake is not required when records are reopened. Ordinarily, current impressions, additional history, current treatment planning, etc. will be entered in the Counseling or Psychiatric Visit Notes. However, under some circumstances, such as when the original assessment was unclear, or a great deal of new information comes to light, clinicians may, at their discretion, find it convenient to enter information on a new CPS Counseling Intake.

2. Clinicians are required to complete a current "Mental Status," to note any changes in diagnosis or symptom picture ,and to record current treatment goals each time a record is reopened.

RELATED POLICIES:

CPS-CLIN-8	Treatment Planning Sessions
CPS-EH REC 1	Confidentiality & Release of Information
CPS-EH REC 4	Treating Couples & Groups: Special Considerations of Confidentiality
CPS-EHR-FORM-1	CPS Treatment Consent form
CPS-APPT-2	Missed Appointment Policy and Procedure

APPROVALS

[x] Senior Vice President	11/11/21 Date	[x] Executive Director, Medical Services	11/11/21 Date
[x] Executive Director, Counseling and Psychological Services	11/11/21 Date	[x] Executive Director, Disability Services	11/11/21 Date
[x] Executive Director, Alice! Health Promotion	~~11/11/21~~ Date	[x] Executive Director, Sexual Violence Response	11/11/21 Date
[x] Chief of Administration	11/11/21 Date		

(12/9/14)