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Milwaukee County Behavioral Health Division Community Services Branch	Date Revised	Subject: Consumer Records and Confidentiality	

1. POLICY:

Per DHS 36.07 (5) (a) & (b) service records of all consumers will accurately reflect the needs, goals for recovery, progress and overall outcomes identified by the consumer and their recovery team. These service records will be held confidential. Service records for each consumer shall be maintained in a central location. Files shall be organized in a consistent format with legible, dated, and signed entries.

Milwaukee County is the centralized location for client records for CCS. Documents and information will be entered into the electronic medical records (EMR) system through Netsmart Avatar by CCS staff of Milwaukee County and contracted providers. Avatar includes but is not limited to: CCS assessment, Individual Recovery Plan (IRP), service entries, PPS client demographics, NOMS related information, and encounter data. CCS staff will have access to EMR data specific to their CCS role and pursuant to applicable confidentiality requirements.

2. PROCEDURE

- A. Per DHS 36.18 (1) each consumer service record shall be maintained pursuant to the confidentiality requirements under HIPAA, s. 51.30, Stats., ch. DHS 92 and, if applicable, 42 CFR Part 2. Electronic records and electronic signatures shall meet the HIPAA requirements in 45 CFR 164, Subpart C.
- B. Providers will be given access to Avatar through “Provider Connect” only after appropriate training on confidentiality laws and assurances to maintain and secure protected health information. HIPAA role based security will be issued by function within the agency and monitored by the county. “Provider Connect” is the link between the County EMR centralized record and the provider. Providers are required to complete and maintain components of the centralized record related to their provision of care and entered through “Provider Connect.” Documents that are not included in the EMR will be kept in the provider file and a copy provided to Milwaukee CC for the central file. The care coordinator will have access to all electronic and paper documents related to the consumers they serve.
- C. Per DHS 36.18 (2) the CCS program shall maintain in a central location a service record for each consumer. Each record shall include sufficient information to demonstrate that the CCS has an accurate understanding of the consumer, the consumer's needs, desired outcomes and progress toward goals. Entries shall be legible, dated and signed.

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D. Per DHS 36.18 (3) each consumer record shall be organized in a consistent format and include a legend to explain any symbol or abbreviation used. All of the following information shall be included in the consumer's record:

1. Results of the assessment completed under s. DHS 36.16, including the assessment summary
2. Initial and updated service plans, including attendance rosters from service planning sessions
3. Authorization of services statements
4. Any request by the consumer for a change in services or service provider and the response by the CCS to such a request
5. Service delivery information, including all of the following:
 - a. Service facilitation notes and progress notes
 - b. Records of referrals of the consumer to outside resources
 - c. Descriptions of significant events that are related to the consumer's service plan and contribute to an overall understanding of the consumer's ongoing level and quality of functioning
 - d. Evidence of the consumer's progress, including response to services, changes in condition and changes in services provided
 - e. Observation of changes in activity level or in physical, cognitive or emotional status and details of any related referrals
 - f. Case conference and consultation notes
 - g. Service provider notes in accordance with standard professional documentation practices
 - h. Reports of treatment or other activities from outside resources that may be influential in the CCS's service planning
6. A list of current prescription medication and regularly taken over the counter medications. Documentation of each prescribed medication shall include all of the following:
 - a. Name of the medication and dosage
 - b. Route of administration
 - c. Frequency
 - d. Duration, including the date the medication is to be stopped.
 - e. Intended purpose
 - f. Name of the prescriber – The signature of prescriber is also required if the CCS prescribes medication as a service.

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- g. Activities related to the monitoring of medication including monitoring for desired responses and possible adverse drug reactions, as well as an assessment of the consumer's ability to self-administer medication
 - h. Medications may be administered only by a physician, nurse, a practitioner, a person who has completed training in a drug administration course approved by the department, or by the consumer.
 - i. If a CCS staff member administers medications, each medication administered shall be documented on the consumer's individual medication administration record (MAR) including, the time the medication was administered and by whom and observation of adverse drug reactions, including a description of the adverse drug reaction, the time of the observation and the date and time the prescriber of the medication was notified. If a medication was missed or refused by the consumer, the record shall explicitly state the time that it was scheduled and the reason it was missed or refused.
7. Signed consent forms for disclosure of information and for medication administration and treatment.
 8. Legal documents addressing commitment, guardianship, and advance directives.
 9. Discharge summary and any related information.
 10. Any other information that is appropriate for the consumer service record.



Reviewed and Approved by: _____

Jennifer Wittwer, Associate Director
Adult Community Services Branch