

100-RICR-50-20-5

TITLE 100 – DEPARTMENT OF STATE

CHAPTER 50 – PUBLIC RECORDS ADMINISTRATION

SUBCHAPTER 20 – STATE AGENCY RECORDS RETENTION SCHEDULES

**PART 5 – DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL
DISABILITIES AND HOSPITALS RECORDS (BHD)**

5.1 Purpose, Authority, Severability, and Destruction

5.1.1 Purpose

To establish the official retention, maintenance, and disposal requirements for a public record based upon any administrative, legal, fiscal, and/or historical value related to that record created or received by an agency, department, division, board, commission, office, or quasi-public corporation under any branch of State or local government which performs functions relating to government, or acts on behalf of a governmental agency, pursuant to law or relating to the transaction of public business.

5.1.2 Authority

This Regulation is promulgated pursuant to the authority granted in R.I. Gen. Laws Title 38 (“Public Records”), including expressly but without limitation R.I. Gen. Laws §§ 38-3-1 et seq.

5.1.3 Severability

If any provision of these Regulations or the application thereof to any Person or circumstances is held invalid by a court of competent jurisdiction, the validity of the remainder of the regulations shall not be affected thereby.

5.1.4 Destruction Review Procedure

Government employees should also consult with their administration to determine if any records eligible for destruction may be involved in current, pending, or anticipated litigation, any government investigation or regulatory proceeding, or request under the Access to Public Records Act. (Part 10-2 of this Chapter (Legal Records) and R.I. Gen. Laws Chapter 38-2)

BHD **Schedule Note**

Even when eligible for destruction, files that may become or which are already involved in legal proceedings may not be destroyed until the legal matters are resolved. ESH may only destroy these records upon written confirmation by the state/hospital legal agency that the case has been resolved.

BHD1 **Common Records**

The records included in this section of the schedule may be created or received by any of the divisions within BHDDH. All sections of the agency should, therefore, utilize this section.

BHD1.1 **Quality Improvement Incident Investigation Files**

An incident is said to occur when a disabled adult with developmental disabilities receiving services from a state-run Developmental Disability Organization (DDO) or from a private sector DDO licensed by the department is harmed or is involved in an event that causes concern for the person's health, safety, and/or welfare. Most incidents and investigations occur when there is an allegation of abuse, neglect, mistreatment, or financial exploitation. As of the fall of 2016, Quality Improvement is also responsible for the review of incidents brought to its attention by the Division of Behavioral Healthcare. Quality Improvement is required to document such incidents and report them to BHDDH. By state law, all incidents must be reported to the Attorney General and the Human Rights chairperson. The records are organized by the name of the client. Each file's contents depend on the number and nature of incidents, the level of investigation, and the findings and results of investigations. The records include completed confidential provider incident report forms. They may also include, but are not limited to, initial findings, preliminary actions, accounts of the clients' services, provider name, client mental/physical status, risk assessment data, status report forms on which providers report actions taken to review an incident (for example a fall), recommendations to assure future safety, provider quality improvement plans (describing what was learned from an incident that can be applied to prevent the recurrence of similar incidents), status reports on psychiatric hospitalizations, reports of consumer-on-consumer abuse (which provide information relating to the admission of an individual to providers), staff notes, discharge documents, witness statements, medical records, personnel records (if personnel are implicated), case notes, progress notes, photographs, and employee time sheets. The file may also include copies of Individual Service Plans and Behavioral Support Plans filed with the Division of Developmental Disabilities. Occurrences that do not rise to the level of abuse, neglect, mistreatment, or financial exploitation, as defined by regulation, may be

reported to the case manager. The department also receives complaints, which are events that do not rise to the level of reportable incidents. (R.I. Gen. Laws § 40.1-27-3)

BHD1.1A Records of Incidents Investigated by Outside Agency

Retention: Retain seven (7) years or three (3) years after resolution of all litigation arising from investigation, whichever is later.

BHD1.1B Records of All Other Incidents

Retention: Retain seven (7) years or three (3) years after resolution of all litigation arising from investigation, whichever is later.

BHD1.2 Provider Incident Reporting System Data

In 2016, BHDDH made an electronic incident reporting tool available to all providers. This web-based system is for all BHDDH-licensed providers to report serious incidents. The data elements and documents may include but are not limited to information about the incident type (for example, civil rights violations, communicable disease, death, intoxication, environmental emergency, family concerns, hospital admission, medication issues, law enforcement, application of restraints) and primary data elements. These data elements may include, but are not limited to, client consumer information (name, gender, SSN, DOB), reporting agency information (agency identity, reporter's name and contact information), event information (program type, perpetrator relationship to individual, perpetrator name, diagnosis, location of incident, nature and description of event), results of provider reviews of the incident, follow-up notes, records of corrective actions taken, outcome notes, and investigator information (name, assigned date, investigation date, and case notes).

BHD1.2A Data Unrelated to Incidents Investigated by Outside Agencies

Retention: Retain ten (10) years or three (3) years after resolution of all litigation arising from investigation, whichever is later.

BHD1.2B Data Related to Incidents Investigated by Outside Agencies

Retention: Retain ten (10) years or three (3) years after resolution of all litigation arising from investigation, whichever is later.

BHD1.3 Licensing Files

To operate in Rhode Island Behavioral Health Organizations (BHOs)/Community Mental Health Centers (CMHCs) and Developmental Disability Organizations (DDOs) must apply for and obtain BHDDH certifications and licenses to practice. Organizations are issued an 'umbrella' agency license and additional site-specific licenses. The licensure period is for two years. Organizations can choose to apply for BHDDH licenses to provide any one, several, or all of the services listed in the BHDDH regulations regarding BHOs, CMHCs, and DDOs. This series documents the licensing of individual entities (which may include the licensing of several of sub-facilities). The records may include, but are not limited to, completed application forms as well as applications to add new services, or to add a new site or sites. The application form includes information about organizational identity, organizational structure, services offered, narrative descriptions of the basic program, the proposed financial plan and descriptions of staffing as well as information about the sites' physical facility. The records may also include State Fire Marshall Reports, audit reports, financial documents (including current budgets and tax returns), copies of policies and procedures, information on staff recruitment, information on staff selection, information on staff training, information on staff supervision, staff criminal background checks, lists of the names of the board of directors, information on staffing and scheduling patterns, complaints, investigations, listings of all sites, copies of non-BHDDH licenses, plans of correction, variances related to staff professional qualification requirements, bed capacity increase requests, site review-related notes (with documentation, findings, recommendations, and decision letters). In addition, BHO/CMHC/DDO licensing files also contain records related to the periodic auditing of facilities. Attachments may include, but are not limited to, written job descriptions for each position, descriptions of the organization's staff training program, daily program schedule (including hours of operation, emergency services, discharge criteria for completion of treatment, discharge criteria for dismissal from treatment, information on the process for follow-up of terminated clients, and necessary life-safety requirements. Finally, the files include records related to applications for the renewal of licenses, which are time-limited (two years as of 2016).

Retention: Retain twenty years (20) after closure of facility or twenty (20) years after expirations of the organization's umbrella license, whichever occurs earlier.

BHD1.4 Nursing Home Pre-Admission Screening and Resident Review (PASRR) Client

In 1987, the federal government established a Pre-Admission Screening and Resident Review process, known as PASRR. It is designed to help ensure that individuals with serious mental illness (SMI), an intellectual disability, or developmental disability are not inappropriately placed in nursing homes for long term care. PASRR requires that all applicants for admission to a Medicaid-certified nursing facility be evaluated for SMI and/or an intellectual or developmental disability be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings) and receive the services they need in those settings. The PASRR process requires that all applicants for admission to nursing facilities be given a preliminary assessment, called a "Level I screen," to determine whether they might have SMI or an intellectual or developmental disability. Those individuals who test positive at Level I are then given an in-depth evaluation, called "Level II" PASRR. The purpose of the Level II screening is to evaluate and determine whether nursing facility services and specialized services are needed. Both the Division of Behavioral Healthcare and the Division of Developmental Disabilities use the PASRR process to ensure appropriate placement of identified individuals in a Medicaid-certified nursing facility. The records document Behavioral Healthcare and Developmental Disability reviews of individual applications for admission or readmission to a nursing facility or DDO, often following discharge from a hospital, and BHDDH's periodic application review and placement decisions. The records may include, but are not limited to, application forms, medical records, notifications to patients of records review process, level 1 and level 2 screening forms, determinations about proper placement, physicians' notes, documentation of client guardianship, progress notes, occupational therapy notes, and notifications of significant change in client status. The records may also include documentation from nursing homes providing BHDDH with providers' annual reviews of individual residents' current condition and status as well as forms related to providers' discharge plan for individual clients, and related correspondence with hospitals, nursing homes, and DDOs.

BHD1.4A Approved Application Files

Retention: Retain seven (7) years after death.

BHD1.4B Denied Application Files

Retention: Retain ten (10) years.

BHD1.5 Provider Contracts

BHDDH contracts with various services for the provision of supplies and services for developmental disability and behavioral health services. The supplies include basic items such as food, cleaning supplies, and

personal hygiene items. The services include maintenance of facilities. This series consists of records that document the contractual arrangements between BHDDH and service providers. The records may include, but are not limited to, contracts and any associated documents. BHDDH does not always involve itself in these contracts. In some cases, the providers negotiate their own.

Retention: Retain ten (10) years after contract closure.

BHD2 Division of Behavioral Healthcare Services

The Division of Behavioral Healthcare Services (DBH) is responsible for planning, coordinating, and administering comprehensive statewide systems of clinical treatment services for substance use disorders, addiction and mental illness, and prevention initiatives, and promotion of mental health activities through contracts with community-based providers.

BHD2.1 Centers of Excellence Application Files

BHDDH's establishment of Centers of Excellence (COEs) came out of Governor Gina Raimondo's Overdose Prevention and Intervention Task force in 2015. The Centers are part of a state plan to cut opioid deaths. Any properly licensed, operating health care facility and approved Medicaid provider in good standing can apply to become certified as a Center of Excellence in the treatment of opioid use disorders. They are intended to provide assessments and medication-assisted treatment for opioid dependence, and to offer expedited access to care, and to serve as a resource of expertise for community-based providers. The Centers of Excellence support providers by providing a place for patients to be initiated on medication-assisted treatment and then to be stabilized if ever necessary. Centers of Excellence may also offer peer recovery coaches and behavioral health services. To become COEs, providers are required to meet COE standards and certification requirements for which they must apply to BHDDH. The records consist of completed application forms as well as supporting attachments, which may include but are not limited to, descriptions of organizational functions, financial audits, policies and procedures, knowledge of opioid epidemic, program approach/service delivery models, resumés of proposed executive staff, written service/practice guidelines and protocols, quality assurance plans, decision documentation and related correspondence.

Retention: Retain twenty (20) years.

BHD2.2 Substance Abuse Prevention Provider Application Records

BHDDH utilizes a prevention platform to track the performance of substance abuse treatment providers and participants involved in publicly funded prevention activities. It is part of a program in which states each select priority target populations for the provision of federally funded prevention services. This series consists of data related to BHDDH's focus on prevention of substance abuse services among the state's population. BHDDH collaborates with contractors, who may engage providers who deliver substance use prevention interventions within communities and student assistance services within the state's high schools and junior high/middle schools. BHDDH-funded student assistance prevention provider agencies place trained counselors in each school. The counselors perform assessments and conduct individual and group educational sessions for students not abusing, but who are determined to be at risk for alcohol, drug, school, family, peer, or other personal problems. Provider data submissions are required under state law R.I. Gen. Laws § 16-21.2-4. Providers regularly enter data into BHDDH's web-based prevention system, a database tracking software package. The purpose of collecting this data is to measure effectiveness of prevention efforts implemented by entities funded by BHDDH by tracking levels of Student Assistance Program participation over time. The use of the web-based prevention platform enables BHDDH to assess the providers' adherence to the federal Substance Abuse and Mental Health Services Administration's (SAMSHA) best practice strategies and resulting environmental changes. The prevention platform collects provider population-level data rather than individual client level data. For each reporting period, the data input into the prevention platform may include, but is not limited to, the following categories of information: target population's primary risk/protective factors; provider program objectives information, which includes data about the objectives as they relate to the identified risk/protective factors; program information, which includes data about the program's single and recurring services, evidence based policies, procedures, and practices, environmental factors, and funding sources and levels; aggregate data about the participant participation (number of individuals served, race, school, sexual orientation, gender, marital status, and location information), and information about provider membership in community coalitions and cooperative arrangements established in support of the provider program. Finally, the prevention platform is capable of generating a wide variety of reports for various provider monitoring and analysis purposes.

Note: BHDDH currently (as of 2018) collaborates with three contractors (R.I. Employee Assistance, Codac, and Child & Family Services of Newport County) to provide student assistance services within approximately twenty-six Rhode Island high school and junior high/middle schools.

BHD2.2A Successful Application Files

Retention: Retain seven (7) years, or until no longer providing services, or until application is superseded, whichever is longer.

BHD2.2B Denied Application Files

Retention: Retain three (3) years.

BHD2.2C Records of Contracts Retained by Agency

Retention: Retain ten (10) years.

BHD2.2D Records of Contracts Transmitted to Financial Authority

Retention: Retain seven (7) years.

BHD2.2E Records of Small Purchases (Established Legal/Regulatory Maximum)

Retention: Retain three (3) years.

BHD2.3 Substance Abuse Prevention Provider Data Reports

This series consists of records and data aggregated from sub-agencies of awarded contractors that provide substance abuse services and that document the application process. The record series includes data collected through web-based surveys. This survey collects data from BHOs about a variety of topics, including organizational capacity to build effective local prevention collaborations and coalitions; monitoring and evaluation processes; ability to offer evidence based policies, programs, and practices, strategic plans, including measurable goals and objectives, programs and activities; lists of participants and groups, logic models, work plans, number of students served, re-occurring services, and funding sources (sources, amounts received)and budget information.

Retention: Retain ten (10) years.

Note: BHDDH currently (2018) uses a contracted data collection and management software system called IMPACT, a product of Mosaix Software. The primary purpose of a logic model is to identify evaluation tools; enhance community involvement; determine appropriate staffing patterns; connect goals, strategies, and outcomes.

BHD2.4 Substance Abuse Prevention Provider Program Data

BHDDH's Performance Based Prevention System (PBPS) is used to track the performance of substance abuse treatment providers and participants involved in publicly funded prevention activities. It is part of a program in which states each select priority target populations for the provision of federally funded prevention services. This series consists of data related to BHDDH's focus on substance abuse among the state's student population. BHDDH collaborates with contractors, who may engage providers to provide student assistance services within the state's high schools and junior high/middle schools. BHDDH-funded student assistance prevention provider agencies place trained counselors in each school. The counselors perform assessments and conduct individual and group educational sessions for students not abusing but who are determined to be at risk for alcohol, drug, school, family, peer or other personal problems. Provider data submissions are required under state law R.I. Gen. Laws § 16-21.2-4. Providers regularly enter data into BHDDH's web-based PBPS system, a database tracking software package. The purpose of collecting this data is to measure the effectiveness of prevention efforts by tracking levels of Student Assistance Program participation over time. The use of the PBPS enables BHDDH to assess the providers' adherence to the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) best practice strategies and resulting environmental changes. The PBPS collects provider population-level data rather than individual client level data. For each reporting period, the data input into PBPS may include, but is not limited to, the following categories of information: target population's primary risk/protective factors; provider program objectives information, which includes data about the objectives as they relate to the identified risk/protective factors; program information, which includes data about the program's single and recurring services, evidence-based policies, procedures, and practices, environmental factors, and funding sources and levels; aggregate data about the participant population (number of individuals served, race, school, sexual orientation, gender, marital status, and location information), and information about provider membership in community coalitions and cooperative arrangements established in support of the provider program. Finally, the PBPS application is capable of producing a wide variety of reports for various provider monitoring and analysis purposes. (R.I. Gen. Laws § 16-21.2-4)

Note: BHDDH currently collaborates (2018) with three contractors (R.I. Employee Assistance, Codac, and Child & Family Services of Newport County) to provide student assistance services within approximately twenty-six Rhode Island high school and junior high/middle schools.

BHD2.4A Completed Survey/Questionnaire Forms

Retention: Retain one (1) year.

BHD2.4B Compiled Data

Includes compilations of survey data that were created from surveys/questionnaires.

Retention: Retain until reports are compiled and issued. Before disposal of compiled data, consult State Archives to review for historical value.

BHD2.4C Survey Data

Retention: Retain three (3) years.

BHD2.4D Reports

Retention: Retain seven (7) years.

BHD2.5 Treatment Alternatives – Street Crime (TASC) Records

Rhode Island promulgated legislation requiring the establishment of a program for diverting individuals stopped for driving under the influence, or who refuse breathalyzer tests, to be considered for substance abuse treatment programs rather than processing them through the justice system. BHDDH is no longer involved in this program. Individuals under a certain age (currently 18) convicted of Driving While Drunk violations and who met certain criteria of eligibility could undergo a clinical assessment at a facility approved by the Department of Health. When this clinical assessment identified problems of alcohol, drug abuse, or psychological problems associated with alcoholic or drug abuse, state required that they be referred to the T.A.S.C. (treatment alternatives to street crime) program for treatment placement, case management, and monitoring. These individuals were directed by the courts to undergo treatment and directed to BHDDH, which was responsible for assessing their suitability for treatment alternatives, evaluating them and assigning them to a treatment program. The records include court letters of referral to BHDDH, records that document the monitoring and assessment of progress, reports on success, discharge summary documents and letters of explanation in the case of individuals who fail to successfully complete a treatment program.

Retention: Retain seven (7) years from case closure.

BHD2.6 Transition from Prison to Community Files

This series concerns BHDDH's responsibility to provide assessments and recommendations for the Parole Board on the appropriate level of substance abuse treatment for eligible incarcerated clients should receive their release from prison. BHDDH must provide diagnoses that specify treatment requirements on the outside. The files may also be periodically updated to document individuals' violation of the terms of their parole. The records include assessments, release forms authorizing the release of client information, and emails between BHDDH and parole offices, police records, court records, and Department of Corrections information.

Retention: Retain seven (7) years.

BHD2.7 Access to Recovery (ATR) Records/Data

ATR was series of federal grant programs to help different cohorts with substance abuse disorders to develop more personalized recovery plans than are typically available through traditional programs, and to allow access to a wider range of treatment and recovery support services that best fit their needs and goals. The program provided funding for services through a voucher system for care coordination, coaching and recovery housing. The implementation of ATR in Rhode Island started in 2007 and ran to 2014. The program targeted individuals being released from RI's Adult Correctional Institution and from the RI Training School for Youth, as well as parents/guardians involved with the Department of Children, Youth, and Families. ATR has three primary goals: expanding consumer choice, tracking and improving outcomes, and increasing capacity. The priority populations included the criminal justice population, specifically people leaving prison, those on state or federal probation /or parole, or involved with the RI Attorney General's Diversion Program; parents and caretakers involved with or at risk of being involved with DCYF due to a substance use disorder; National Guard members returning from Iraq and Afghanistan, and their immediate adult family members. Individuals successfully completing or graduating from residential treatment program, and all women statewide. Access to Recovery grant includes a requirement for the collection and reporting of data. The data relates to reports of the client services provided and utilization data through the ATR program from initial screening, assessment, intake, and treatment to discharge and follow-up information. The data also includes encounter, cost, and voucher information.

BHD2.7A Grant Program Application and Report Records **[SUPERSEDED]**

See Also: For associated retention, see GRS1.18 (Grant Program Files).

BHD2.7B ATR Data

Retention: Retain seven (7) years.

BHD2.8 Adult Drug Court Case Files

This program seeks to integrate substance abuse treatment services within the criminal justice system and to divert eligible drug-court defendants from the traditional criminal-court process to a therapeutic program in order to modify behavior, improve individuals' overall quality of life, and reduce recidivism. The program is aimed at first-time offenders found to have been using illicit drugs. Those individuals that the court deems eligible for treatment must remain clean and sober for one year. Under guidance from BHDDH, individuals are evaluated diagnostically for abuse and dependence issues in order to determine the level of care required from providers to which individuals are referred. The records in this series document BHDDH's role in these cases. Included are drug screens, notes from clinicians treating clients, and from the Drug Court clinician coordinator as well as adult drug court biosocial assessments and documents of determination if the drug court is appropriate for the individual. The files also include documentation of the treatment process, including notes recording communications with clients and documents recording a client's missed appointments; directives to clients; invoices for drug screening services; and finally, reports to the courts about client compliance with the terms of the treatment and the success of the treatment.

Retention: Retain records for adolescents for seven (7) years post age twenty-one (21) and adults (seven) 7 years after file closure.

BHD2.9 Alcohol Server Training Curricula Certification Records

BHDDH is responsible for administering an alcohol server training program. It maintains a list of programs that are authorized to provide server training. BHDDH also maintains documents submitted by the training programs as a basis for certification in the event the program deviates from the materials it submits to qualify for certification. The records may include, but are not limited to, applications and review sheets as well as supporting materials, which may include the proposed curriculum; audio, video, and instructional materials; copies of all printed materials that will be disseminated to program participants; copies of the written examination materials to be administered in the program with answer key; and written description of testing and grading procedures and methods for safeguarding test integrity. Individual certification is valid for a period of three (3) years unless it is revoked.

Retention: Retain six (6) years.

BHD2.10 Synar Tobacco Compliance Program Files

In July 1992, Congress enacted the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (Pub. L. No. 102-321), which includes the Synar Amendment (Pub. L. No. 102-321 § 1926). This amendment aimed at decreasing youth access to tobacco. Compliance with the Synar Amendment and related federal rules and regulations is a condition of funding for states receiving the Substance Abuse Prevention and Treatment block grant. The state is required to conduct an annual statewide survey of a random sample of tobacco retailers to determine their compliance with state laws prohibiting the sale or distribution of tobacco products to underage individuals. BHDDH contracts with municipal police departments and the State Police to assist in conducting the annual survey and engage in on-going enforcement efforts. The records in this series include contracts with police departments and survey forms. The survey forms provide the data BHDDH uses to produce annual reports it is required to submit to the federal government. The files may also include data extracts from the survey forms, police incident reports, and consent forms from parents. (Pub. L. No. 102-321 § 1926)

BHD2.10A Annual Reports

Retention: Retain three (3) years.

BHD2.10B Survey Records

Retention: Retain ten (10) years.

BHD2.10C Contracts

Retention: Retain ten (10) years.

BHD2.11 FDA Tobacco Inspection Program Files

The Food and Drug Administration's (FDA) Tobacco Compliance Inspection Program is performed through a contract between the FDA and the State of RI (represented by BHDDH.) Its purpose is to enforce certain provisions of the federal 2009 Family Smoking Prevention and Tobacco Control Act (TCA) (Pub. L. No. 111-31). BHDDH contracts with municipal police departments to provide officers to conduct undercover buy attempts at licensed retail tobacco outlets by utilizing trained minors. BHDDH staff conduct random inspections to determine retailer compliance with the TCA advertising and labeling restrictions on regulated tobacco products. This data is used for enforcement of the provisions of the TCA Act. The records include data resulting from

tobacco vendor inspections, which are held in the Tobacco Information System (TIMS), files on commissioned FDA officers, files on minors who are recruited to participate in the program, and evidence, including actual tobacco products such as cigarettes. Files also include licenses, consent forms from parents for their children to participate in the program, documentation of proper training, certificates of trainers, correspondence, invoices for reimbursements of contracts with police to conduct undercover operations. The TIMS system includes data about school policy, student behavior, and cigarette outlet conduct and compliance, and other sources of tobacco supply to youth. The TIMS data is updated locally but managed by the federal government.

Retention: Retain five (5) years after vendor leaves program.

BHD2.12 DBH Health Homes and RI Systems of Care Encounter Data

The Medicaid Health Homes State Plan Option, authorized under the federal Affordable Care Act (Pub. L. No. 111-148 § 2703), allows states to create Medicaid health homes. The homes' main role is to coordinate the full range of medical, behavioral health, and long-term services and supports needed by individuals with chronic conditions. The target population for this program are individuals with Serious Mental Illness (SMI) and evidence of a need for support in order to remain in the community, individuals with mental health conditions, with a history of intensive psychiatric treatment, no or limited employment, and poor social functioning. The data relates to the services provided by CHMOs, various forms of encounter data (face- to-face care management, telephone contact with the client or collateral contacts, or face-to- face meetings with collateral providers), and billing data submitted by providers.

Retention: Retain twenty (20) years.

BHD2.13 Adult Correctional Institute (ACI) Data

This series consists of an ACI intake data file BHDDH downloads every day from the Department of Corrections. The data is cross-matched with current Division of Behavioral Healthcare client data in order to identify any current CMHC clients who may have been arrested or "intaked." Information about these clients is then forwarded to their CMHOs and methadone treatment providers to allow them to assist them.

Retention: Retain until no longer required for administrative purposes.

BHD2.14 Outcome Evaluation Records

The outcome evaluation program serves to enable BHDDH to focus on the measurement of Community Mental Health Care Center (CMHC) client outcomes. Under this program, service providers and their clients are required to provide BHDDH with annual data related to client satisfaction. The main method of collection of data is an Outcome Evaluation Instrument, which is a form that collects information about each client's rating of the various services provided by the CMHC. In this way, BHDDH is able to collect standardized mental health outcome data for analysis. Each CMHC uploads the data collected electronically. The records consist of satisfaction survey data. The data includes, but is not limited to, the client's report of current physical health and rating of degree of satisfaction in such areas as general satisfaction with the CMHC, the location of services, client relations with the BHO staff, staff supportiveness, timeliness of services, degree of client improvement as a direct result of services provided, and social relationships in the CMHC community. This data may be used during BHDDH audits of CMHCs.

Retention: Retain ten (10) years.

See Also: BHD2.16 (Community Mental Health Center (CMHC) Audit/Compliance Records).

BHD2.15 Behavioral Health Online Data (BHOLD)

All licensed behavioral healthcare organizations (BHOs) are required to submit all their behavioral healthcare clients' admission, discharge, and event data into BHDDH's Behavioral Health On-Line Database (BHOLD). The data must be submitted at least monthly. CMHCs are required to submit data about their individual clients on an annual basis. The BHOLD system is used to track individual client demographic and service information. The data encompasses client identification information, admission information (mental health program, substance abuse treatments, court referrals, recent arrests), "current client information" (residence arrangements, family size, employment status, income sources); current diagnoses and co-occurring conditions; current substance abuse, type of substance, method of administration, and frequency of use. The system also includes discharge information (reason for discharge, referrals at discharge, residential arrangements at discharge and employment status and type, and substance of abuse at discharge.) This data may be used during BHDDH audits of CMHCs (BHD2.16 (Community Mental Health Center (CMHC) Audit/Compliance Records)). This system is used to generate a wide variety of reports for different stakeholders, and to populate other BHDDH applications.

Retention: Permanent.

BHD2.16 Community Mental Health Center (CMHC) Audit/Compliance Records

BHDDH is responsible for periodically auditing BHOs/CMHCs. BHDDH uses data submitted by providers about their clients on an annual basis during audit visits to verify the accuracy of the submitted data. BHOLD data (BHD2.15 (Behavioral Health Online Data (BHOLD))) and the Outcome Evaluation Instrument (BHD2.14 (Outcome Evaluation Records)) provide input into the BHDDH audit process. Based on this and other data, Behavioral Healthcare then selects a randomized sample of client records for review during audit inspection visits to CMHCs. The inspections are comprised of comparisons between the submitted BHOLD data and the information about clients during onsite reviews of CMHC programs and clients during onsite visits. The audits also include check-offs for regulatory compliance; areas of improvement, program evaluations and related correspondence. The audits and inspections result in findings and recommendations provided to the CMHC in a final audit report. When audits find a CMHC has risen to a certain level of non-compliance, CMHCs are required to develop Corrective Action Plans to address each deficiency identified in an audit report. The records are organized by CMHC. This series may include but is not limited to, BHOLD data, OIS data, BHDDH audit notes, as well as spreadsheet data, findings and recommendations, final audit reports, CMHC corrective action plans, follow-up documentation, and related correspondence.

Retention: Retain ten (10) years.

BHD2.17 Human Resource Data Entry System (Provider Employee Data)

All providers of mental health services under contract with BHDDH are required to submit information about their complement of personnel on an annual basis. For each individual, the BHO provides personal identification information, education, experience, licensing and certification information, languages, employment history, the discipline for which the person was hired, work schedules, and major job function.

Retention: Retain three (3) years.

BHD2.18 Service Provider Lists

BHDDH maintains lists of service providers available for providing placement options.

Retention: Retain until updated or superseded.

BHD2.19 Certificates of Records Destruction [LEGACY – DUPLICATE]

Certification of Records Destructions forms signed by the authorized agency official and submitted to, and signed by, the State Archivist/Public Records Administrator. Certificates authorize the disposal of records listed in this and other applicable records retention schedules. (R.I. Gen. Laws L §§ 38-1-10, 38-3-6(j), and 42-8.1.10)

Retention: Permanent.

See Also: This record series is for information only, see GRS6.8B (Certificates of Records Destruction).

BHD2.20 Pre-Admission Screening and Resident Review

In 1987, the federal government established a Pre-Admission Screening and Resident Review process, known as PASRR. The process is designed to help ensure that individuals are not inappropriately placed in nursing facilities. PASRR requires that all applicants for admission to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI); be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and receive the services they need in those settings. The PASRR process requires that all applicants for admission to nursing facilities be given a preliminary assessment, called a "Level I screen," to determine whether they might have SMI. Those individuals who test positive at Level I are then evaluated in depth, called "Level II screen." Level II screening determines if the individual has any special needs due to his/her identified condition that can be addressed in a nursing facility, or whether those special needs are so significant that they cannot be met in a nursing facility and can be met only in a psychiatric hospital. The Division of Behavioral Healthcare (DBH) uses the PASRR process to assess applicants' eligibility for placement in a Medicaid-certified nursing facility. The records contain documentation of client medical records and PASRR determinations for admission or readmission to a nursing facility, often following but not limited to discharge from a hospital facility, and DBH's periodic application review and resulting placement decisions. The records may include, but are not limited to, application forms, medical records, notifications to clients of records review process, Level I and Level II screening forms, and determinations about proper placement. The files also include physicians' notes, documentation of client guardianship, progress notes, occupational therapy notes, and notifications of significant change in client status. The records also include documentation from nursing facilities that have provided DBH with forms related to providers' tracking for individual clients as well as related correspondence with hospitals and nursing facilities. (42 C.F.R. Part 483)

Retention: Retain ten (10) years, or five (5) years after discharge, whichever is later.

BHD3 **Division of Development Disabilities**

The Division of Developmental Disabilities (DDD) funds a state-wide network of privately-operated and publicly operated community supports for adults with developmental disabilities. The division is responsible for planning, administering, and providing supports for adults with developmental disabilities by ensuring equitable access to and allocation of resources, to promote independence and participation in community life, and provide safeguards from abuse, neglect, exploitation, and mistreatment.

BHD3.1 **Case Management Files**

BHDDH is responsible for making eligibility determinations for individuals applying for Adult Developmental Disabilities services. Applicants determined to be eligible for services remain eligible for life and need not re-apply. Case management files are created for those deemed eligible. The Division of Developmental Disabilities (DDD) has social caseworkers on staff who are responsible for participating in an individual's plan of care, reviewing individual service plans, monitoring, reassessing, and facilitating access to services and supports, and responding to participants' changing needs as well as determining an individual's level of care. The records in this series document the case management activities of social case workers serving individuals. There are social caseworkers in the Division and a social caseworker in Rhode Island Community Living and Supports (RICLAS). The records in this series are individual client case files. The records may also include, but are not limited to, referrals for service, individual service plans, situational assessments, vocational assessments, communications with providers and clients related to the provision of services, referrals to the Office of Rehabilitation Services (ORS) or other services not funded by DDD, data sheets, demographic information, periodic progress reports, and other related correspondence. The file may also include documents related to the individual's eligibility under the Title 19 waiver program.

Retention: Retain eighty (80) years or ten (10) years after death, whichever is sooner.

BHD3.2 **Eligibility Denials/Withdrawals**

BHDDH is responsible for making eligibility determinations for individuals applying for Adult Developmental Disabilities services. The records in this series document the eligibility application, and the determination of approval or denial of eligibility for each applicant. An eligibility committee

reviews the applications. Applicants determined to be eligible for services remain eligible for life and need not re-apply. Case management files are created for those deemed eligible and their application files are moved to those files. When applications are denied based on the information the committee has, they are referred to case workers for face-to-face meetings. If the application is once again denied, a denial letter is sent to the applicant along with instructions on how to appeal if the applicant wishes to do so. Applications for individuals who do not complete the process are considered withdrawn. The records of those whose applications are denied or withdrawn are maintained separately from those that are determined eligible. If the circumstances of a denied applicant change and the person applies again and is determined eligible, a case management file is created and all records (including those of the previous application) are moved to that file. The Application for Services documentation may include but is not limited to, completed application forms, assessments of functional abilities and limitations, proof of guardianship, copies of birth certificates and social security cards, school records, hospital records, medical records, competency evaluations, vocational evaluations, and psychological and neurological evaluations.

BHD3.2A Denied Application Files

Retention: Retain eighty (80) years or ten (10) years after death, whichever is sooner.

BHD3.2B Withdrawn Applications

Retention: Retain three (3) years.

BHD3.3 Support Intensity Scale (SIS) Files

Supports Intensity Scale (SIS) is a standardized assessment tool designed by the American Association on Intellectual and Developmental Disabilities (AAIDD.) BHDDH uses the SIS instrument to determine the pattern and intensity of supports an adult diagnosed with developmental disabilities requires to be successful in community settings. The SIS assessment results in a score, which is then processed through an algorithm that indicates the assignment of a service "tier." The service tier in turn determines the package of services for which BHDDH will allocate resources. Participants in BHDDH's DD system must have an assessment prior to the start of funded services and are re-assessed once every five years. If an individual has a Major Life Change prior to the next scheduled SIS assessment, BHDDH may conduct a new SIS to more accurately measure the supports that the individual needs due to the Major Life Change. The records in this series may include, but are not limited to, the following completed forms and

documentation: Administration of the SIS, signed forms of attendance at interviews, post SIS Interview follow-up documentation, documentation concerning the need for supplementary support beyond the results of the SIS, Checklist of Participant's SIS Assessment Documents, Quality Assurance of SIS Interviewers, forms requesting review of the SIS based on various factors, including the interview protocol and major life changes, SIS Committee Review Letter for Request Based on Major Life Change, and Tier Review, and Justification for Funding Extraordinary Supports. In addition to various completed forms, the files may also include submitted documentation to support requests for changes to the level of support, such as Individual Service Plans, current support summaries, current staffing patterns, behavioral and medical plans (including diagnoses, progress notes, consultations, and nursing notes). Finally, the files contain copies of tier letters sent to the individuals.

Retention: Retain ten (10) years.

BHD3.4 Eligibility, Supports Intensity Scale (SIS) and Funding (S-106/S-109) Appeals

An individual has the right to appeal a denial of eligibility, the administration of the SIS, the SIS Tier result, and funding for additional supports via an S-106/S-107 or S-109/S-110 (or any other forms utilized to request additional funding about the individual's tier). To file an appeal, the participant or representative files a written request to the Office of Legal Counsel at BHDDH. A participant's records are kept in the individual's case management file. The appellate records consist of any documentation relating to the appeal. The records in this series may include medical reports, psychological reports, doctors' notes, vocational reports/assessments, Individual Service Plans, Individual Educational Plans, Behavioral Support Plans, Medical Plans, PASRR evaluations, and any other documentation that an individual would present as evidence in an appeal hearing. The hearing decision or other record of resolution by consent in lieu of hearing decision will also remain in the record.

Retention: Retain for ten (10) years from the date of filing the appeal.

BHD3.5 Provider Financial Statements

The financial office of BHDDH receives financial statements from DD providers, as required by R.I. Gen. Laws § 38-3-6(a) through (m) and departmental regulations. Once certified, the providers must subsequently submit a single year's statement on an annual basis. The statements are used for reference, to determine if providers meet standards, and to illustrate how the funds provided are being spent. The

records in this series may include, but are not limited to, financial statements, copies of liability insurance information, supplemental schedules, engagement letters, audit findings, and audit recommendations (including corrective action plans). (Departmental Regulation 1.17.1(B)(3) and R.I. Gen. Laws § 38-3-6(a) through (m))

Retention: Retain ten (10) years.

BHD3.6 Resident Support Monthly Attendance Records (Group Homes)

Group homes and Shared Living Arrangements under the jurisdiction of the Developmental Disabilities Division document the daily attendance of residential clients. They include notes about participant hospitalization, nursing home stays for short-term rehabilitation, overnight visits to family or friends, vacations, or any other overnight stays out of the group home. Notes concerning a participant leaving a group home are also included, such as moves out of a group home, moves to a new group home, permanent admission to a nursing home, death, or any other case closure reason. The records in this series may include, but are not limited to, documents received from each home for each client concerning presence or absence. The data in the documents lists days present, days absent, and reasons for absences.

Retention: Retain seven (7) years.

BHD3.7 Individual Service Plans (Fiscal Office)

DDD receives copies of Individual Service Plans (ISP) for each participant. ISPs indicates the goals participants have for the upcoming year and what services and supports they need to achieve these goals. An attached Purchase Order details how their funding packages will be allocated based on their plan. The records consist of the ISP, purchase order, and any attachments including, but not limited to, behavior plans and nursing care plans. A review signoff sheet may also be included.

Note: Original copies of many of these documents may be found in SIS files (BHD3.3 (Support Intensity Scale (SIS) Files)) and in case management files (BHD3.1 (Case Management Files)).

BHD3.7A Plans Relevant to Investigations by Outside Agencies

Retention: Retain ten (10) years or three (3) years after all litigation is resolved, whichever is later.

BHD3.7B All Other Plans

Retention: Retain seven (7) years.

BHD4 Rhode Island Community Living and Supports (RICLAS) Records

RICLAS operates under the aegis of the DDD. RICLAS is a publicly operated Developmental Disability Organization (DDO) that supports adults in a variety of group homes and apartment settings throughout the state. RICLAS arranges for the provision of nursing services, psychological services, social services, nutrition services, physical and occupational therapy, respite care, residential services for individuals in crisis, medical services, transportation services, and self-advocacy groups. The RICLAS residences and programs are subject to the same recordkeeping requirements as BHDDH regulations requires for private DDOs.

BHD4.1 RICLAS Administrative Files – Client Case Files

RICLAS maintains file on each client it serves, a residence or administrative file. The administrative file, may include, but are not limited to, authorization documentation (for example, safety device authorization and authorization to use restrictive procedures, and medical and surgical care consent), prescription drug plans letters, incident reports, team evaluations and reviews, home supervisor quarterly reports, communications with psychologists, and the doctor's office calls. RICLAS also keeps Team Books to guide day-to-day activities and services for each resident or client. These Team Books include information about birthdays, training methods specific to individual clients, menus, menu substitution sheets, staffing schedules, and monthly highlights. The records may also include clients' emergency information, vital statistics, support plans, support plan documentation, hygiene charts, sleep charts, food intake charts, fluid intake and output charts, and social service notes.

Retention: Retain eighty (80) years or ten (10) years after death, whichever is sooner.

BHD4.2 RICLAS Administrative Files – Daily Operations Records

RICLAS monitors the daily operations of all facilities under its jurisdiction. The process of this generates a variety of records including, but not limited to, the following: Shift Reports – these are compiled from a variety of sources, including information from the homes within their region. These records may document medical issues, incident reports, employee information (sickness, absences) non-routine activities and events, property maintenance activities, and reports of visits from outside vendors to locations during a particular shift. Daily Logs – the

team at each RICLAS location must maintain a written daily log of events and occurrences. The daily log provides a roster of all persons currently served by the team, as well as brief documentation of any service contacts with each client which occurred over the twenty-four period. The log may also contain concise descriptions of each person's daily status as well as such events as a record of meal service, client travel, outside visitors, home deliveries, new admissions, transfers to other RICLAS homes, hospitalizations, nursing homes, 911 calls as well as nursing communication notes. The log may also report the amount of cash in the building on a particular day. Medical Order Records – RICLAS maintains records documenting each periodic medical reorder, pharmacy sheets, control substances inventory records, pharmacy delivery slips, and beacon orders. Group Training Sign-Off Records - each RICLAS residence maintains a log of training and instruction memos and documents that staff, with a signature, are required to signify as having read. The documents are often ad hoc training and instruction documents prepared in response to specific client needs as they may arise. The memos may relate to such matters as client mobility, buckle guards, newly identified client needs, environmental issues, or work schedules. Regional Coordinator Files - RICLAS coordinators are responsible for the management of RICLAS locations within their geographical region of responsibility. Their responsibilities include the visiting and monitoring of each location within their region and keeping documentation on home or client issues, reported incidents, employee information, non-routine activities, events, and maintenance issues. The records of this are included in this series.

Retention: Retain ten (10) years.

BHD4.3 RICLAS Administrative Files – Quality Improvement Plans

RICLAS is required to produce annual written quality assurance/improvement plans. These plans describe priorities and identify problems found during the quality improvement review. They also enumerate who is involved in the resolution of these problems and describe methodologies for improvement. In addition, they assess the success of actions taken, keep documentation of the quality improvement review, and report outcome measures and goals. Written reports on the findings of the quality assurance/improvement plan evaluation are prepared in the process. The records in this series consist of these plans and any supporting documentation.

Retention: Retain three (3) years.

BHD4.4 RICLAS Administrative Files – Client Satisfaction Surveys

RICLAS gathers feedback from clients and client families through questionnaires. The surveys elicit feedback regarding support services, activities, medical needs, and effectiveness of communication. Categories are tabulated and an overall satisfaction rating is calculated. This measure is defined as the average satisfaction rating of family members of people receiving RICLAS supports and calculated as the sum of satisfaction ratings across all survey respondents. The records in this series may include, but are not limited to, questionnaires and tabulations of data.

Retention: Retain three (3) years after completion of plan.

BHD4.5 RICLAS Social Service Case Management Files

The Division of Developmental Disabilities includes two groups of social case workers who handle client cases. A first group of social case workers oversees the delivery of services to clients who have been placed in private DDO agencies (See BHD3.4 Client Case Management Files.) This series concerns a second group of social case workers who work with RICLAS participants. RICLAS social caseworkers track clients' residences. They also maintain overall health information, family contacts, changes in funding, funding sources and amounts. Case workers may also assess clients' home situations. The records in this series may include, but are not limited to, the following: Any Medical or Psychiatric Records - these can include but are not limited to notes, communications with mental health counsellors, documentation related to discharges from any psychiatric hospital, behavioral data, medical data, client cycle of behavior information, functional assessments, and testing data. Records of Physical Exams – these may include, but are not limited to, x-rays, physicians' orders and referrals, extended protocols, treatment plans developed by registered nurses or physicians, nutritional assessments, lab documentation, diagnostic tests, and immunization records. They may also include nursing evaluations and physicians' progress notes as well as documentation of communication with guardians, documentation of communication services (audiology and speech evaluation, and progress notes), consent forms, and dental service records. Occupational Therapy Records – these may include evaluations, guidelines and support plans as well as progress notes. Physical Therapy Documentation – this can include records of treatment, reports and supplemental data sheets, progress notes, physician referrals or approval for treatment, and documentation of exercise and support programs provided. The files may also include, but are not limited to, vocational and educational records and assessments of clients, clients' progress notes and case notes, copies of medical cards, documentation of benefits information (such as Long-Term Care, Supplemental Nutritional Assistance Program (SNAP), and Supplemental Security Income award letters and statements of

amounts/re-certifications), tier letters (BHD3.3 (Support Intensity Scale (SIS) Files)), documentation of death of contacts, information on new contacts, contact changes of address, changes in income, and social history (record of past events as they relate to a person and their medical background), personal needs information, admission/discharge forms (for example, from hospitals or other expert health care facilities), individual service plans, copies of birth certificates, and funeral contracts.

Retention: Retain eighty (80) years or ten (10) years after death, whichever is sooner.

BHD4.6 Essential Client Records

RICLAS has designated certain types of records in its client files as “essential.” These records may include, but are not limited to, copies of birth certificates, copies of death certificates, admission and intake notes and documentation, discharge notes, last social services/nursing and direct support notes, copies of social security cards, pictures, vital status, case history information, and burial information.

Retention: Retain eighty (80) years or ten (10) years after death, whichever is sooner.

BHD5 BHDDH Hospitals

BHD5.1 Patient Application Records

BHDDH admits applicants to its hospitals who meet “level of care” requirements established by the patient’s insurance company (or other payer). This series documents the hospital admission process. Individuals who apply to the agency’s hospitals must meet these requirements to be eligible for admission. Admission files may include, but are not limited to, completed application forms, copies of records documenting applicants’ medical history, physical examinations, medications, therapy notes, nurses’ notes, and progress notes from the referring facility (all of which are transferred to the medical ward upon approval of admission.) The records may also include hospital physicians’ applicant interview notes. For those deemed eligible, the files may also include, but are not limited to, consent for admission forms, face sheets, unique lifetime patient ID assignment, patient demographic information (including address, religion, sex, marital status, and language preference). The files also contain patient benefits and resources information, including medical insurance information (coverage cards) as well as copies of advance directives, next-of-kin and discharge information. The admissions office keeps copies of certain records while forwarding the originals to ward floors for placement in the

patient medical file (BHD5.2 (Patient Medical Files)). Applicants who are denied admission are informed by telephone.

BHD5.1A Successful Applications

Retention: Retain five (5) years after admission or three (3) years after discharge, whichever is later.

BHD5.1B Denied Applications

Retention: Retain three (3) years.

BHD5.2 Patient Medical Files

Responsible Department: Medical Records. BHDDH documents the history of individual patients admitted to the agency's hospitals. The records in this series reflect that. In addition to records transferred from the hospital admission office (BHD5.1 (Patient Application Records)), the admission portions of patient files may include, but are not limited to, authorization documentation (patient agreements to treatment, release of information forms, HIPAA-related forms, photographs, guardian information, medical information provided by the institution from which the individual is being transferred, and patient summary face sheets). Any patient who returns more than five years after a previous discharge will be regarded as a new admission. The patient care portion of each patient file documents the history of the various treatments and care services hospitals provides to individual patients. The records may include, but are not limited to, histories, physical exams taken upon admission, physicians' orders for treatment, records of therapy administered (occupational, physical, and speech), nursing assessments, psychological assessments, treatment plans, records of treatments administered, physicians' progress notes, nurses' progress notes; nurses' shift notes, medical consultation records (BHD5.3 (Patient Clinical Consultation Files)), medication administration records, X-Rays, EKG charts, daily vital signs records, lab section reports, rehabilitation services records, and utilization review documentation. The files also include legal records, which may include, but are not limited to, patient authorizations for various kinds of treatment, copies of authorizations from other medical facilities, continuity of care forms, documentation for patients temporarily transferred to outside facilities for special treatment, and documentation of consent to or refusal of anatomical gift upon death. Finally, the files contain discharge information, whether to the community, to another facility, or as a result of death.

Retention: Retain five (5) years after discharge.

See Also: For patient financial information that is kept by the hospital's finance management office, see BHD5.26 (Billing and Claims Records – Patient Billing Files), BHD5.27 (Billing and Claims Records – Patient Claims Records), and BHD5.28 (Billing and Claims Records – Hospital (Medicaid) Cost Reports), and BHD5.29 (Risk Management Files).

BHD5.3 Patient Clinical Consultation Files

Responsible Department: Medical Records. BHDDH hospitals maintain records of visiting consultant physicians who examine patients in their facilities. These physicians may include neurologists, optometrists, urologists, cardiologists, podiatrists, ophthalmologists, dermatologists, wound care physicians, orthopedists, and other types of specialists. Upon examining patients, consulting healthcare specialists create records of diagnoses and the clinic keeps copies of these reports.

Retention: Retain three (3) years after discharge.

Note: The primary consultation records reside in each patient's medical file.

BHD5.4 Master Patient Index (MPI)

Each hospital operated by BHDDH has an Office of Medical Records. Each of these offices keeps a Master Patient Index, which is a standard requirement for keeping data on individual hospital patients (mandated by the Joint Commission of HealthCare Organizations). The MPI's include cards on each patient. The cards cover the period from the establishment of the Institute for Mental Health and the General Hospital (1960s) up to the present as of 2019. The MPI enables the Medical Records Unit to find the patient's medical record number to retrieve the individual's file. The patient database (BHD5.5 (Electronic Patient Database)) can do this search as well and at a much faster rate (for patients admitted after 1994.) However, the MPI information, which is more complete, still serves as the hospital's MPI. The personal information on each card may include, but is not limited to, patient name, patient address, date of birth, gender, assigned lifetime universal patient identifier, religious affiliation, and spouse's name. The medical information may include, but is not limited to, admission date, diagnosis, guarantor name, physician's name, service type, surgical history, and date of discharge.

Retention: Permanent.

Note: The Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission), mentioned

throughout this document, is an independent, not-for-profit national organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States (as of 2016). The Joint Commission has been approved by the federal government's Centre for Medicaid and Medicare Services as having standards and a survey process that meets or exceeds Medicare's requirements. To be considered to have met or exceeded Medicare and Medicaid requirements, healthcare organizations are required to achieve accreditation through a Joint Commission "deemed status" survey.

See Also: BHD5.21 (Quality Assurance – Joint Commission Accreditation Records).

BHD5.5 Electronic Patient Database

Responsible Department: Medical Records. Since 1984, BHDDH-affiliated hospitals have been maintaining an electronic patient data base. The database keeps information on patients dating back to that time. The database includes data entered from hospital face sheets (BHD5.1 (Patient Application Records)) as well as additional data. The database information is not as detailed as the information in the Master Patient Index. Face sheets (BHD5.4 (Patient Medical Files)) must be completed upon each patient's admission to the hospital, and then updated as needed. The sheets list demographic data (including, but not limited to, name, address, gender, parents' names, nearest relative's name, nearest relative's address, and race). The sheets may also include, but are not limited to, insurance provider information, medical information (such as attending physician, admitting diagnosis as well as more detailed diagnosis information) and extensive insurance information used to run various census and other reports.

Retention: Permanent.

BHD5.6 Physician Credentialing Files

Responsible Department: Medical Staff Administration. The Medical Administration Office of BHDDH has responsibility for credentialing and re-credentialing physicians who apply for and who then occupy staff positions at agency hospitals. The office verifies that all information physicians provide in their application is true and accurate. The office also ensures that licenses and DEA (Drug Enforcement Administration) approvals for prescribing are current, and that no actions are outstanding against applicants. This series documents the credentialing and re-credentialing of hospital medical staff. As of 2019, re-credentialing was being done every two (2) years. The records in this series may include,

but are not limited to, medical staff applications, medical school verification, residency training verification, health information, medical licenses, copies of DEA cards, NPI (National Practitioner Identification) number verifications, delineations of clinical privileges (indicates their specialty), National Practitioner databank query (indicates any actions against physician), Federation of State Medical Boards verification (verifies school, no actions, etc.), three (3) peer references (needed when hired), and subsequent references for re-credentialing. These references may include, but are not limited to, continuing medical education credits, skill and performance evaluations, BCI (background checks), Medicare physician acknowledgement statements, statements of confidentiality, medical staff code of conduct statements, releases allowing the hospital to contact school and residency programs, copies of board certifications, and photo IDs. Once physicians retire or resign, the credentialing files are removed from active storage and placed in inactive storage. Physicians who wish to rejoin the hospital staff after separation must complete the entire credentialing process again.

Retention: Retain five (5) years after separation.

BHD5.7 Medical Professional Staff Assignment Sheets

Responsible Department: Nursing Office. Hospitals affiliated with BHDDH maintain records of the daily assignments of individual medical professionals including, but not limited to, nurses, occupational therapists, speech language pathologists, physical therapists, therapeutic recreation specialists, and respiratory therapists (not including physicians). The records may include, but are not limited to, the names of all levels of nursing staff for each shift, assigned workstations, assigned tasks, schedules for breaks and meals, scheduled meetings, in-service, and any special assignments.

Retention: Retain three (3) years.

BHD5.8 Medical Professional Staff Schedules

Responsible Department: Nursing Office. Hospitals affiliated with BHDDH maintain work schedules for medical professional staff employed by them – including, but not limited to, nurses, occupational therapists, speech language pathologists, physical therapists, therapeutic recreation specialists, and respiratory therapists (not including physicians). This series includes those schedules and any documentation associated with them.

Retention: Retain five (5) years.

Note: Nursing clinical records, including progress notes and nursing plans for patients, are kept in the patient medical files.

BHD5.9 Laboratory Records – Patient Case Files

Responsible Department: Laboratory. The laboratories of hospitals affiliated with BHDDH perform a variety of tests on patients and maintain the results of those tests. The tests include blood tests, urine tests, or any other kind of test that physicians may request. The results are recorded on various forms which are then maintained to monitor the health of patients. Doctors may refer to these records again and patients' families may also have occasion to examine them. The records may include, but are not limited to, forms filled out to document the results of the tests conducted by the lab, test printouts, and communications with the doctors (including physician's requisitions for tests and lab reports). They also include culture specimens, such as serum, plasma, blood, and gram stains used to extract needed data. The documentation also includes transfusion records.

BHD5.9A Histology/Cytology Test and Transfusion Records

Retention: Retain ten (10) years or three (3) years after discharge, whichever is later.

BHD5.9B Culture Specimens

Retention: Retain until no longer needed for data extraction.

BHD5.9C All Other Records

Retention: Retain five (5) years or three (3) years after discharge, whichever is later.

BHD5.10 Laboratory Records – Equipment Testing and Maintenance

Laboratories in hospitals affiliated with BHDDH regularly conduct tests on their equipment to make sure it is functioning properly. This is done by running quality control and calibration tests for preventive purposes as well as to test proof of accuracy. Proficiency results are provided to the College of American Pathologists who inform the laboratories if results are satisfactory or not. This documentation is required by Rhode Island state law and regulation (216-RICR-60-05-4.10) and the Joint Commission. The records in this series may include, but are not limited to, quality control records, calibration reports, general maintenance records, preventative maintenance records, proficiency testing results, and correspondence with the College of American Pathologists.

Retention: Retain five (5) years.

BHD5.11 Electrocardiogram (EKG) Records

Responsible Department: Medical Records. Electrocardiogram (EKG) units within hospitals affiliated with BHDDH maintain copies of patients' EKG test results and physicians' orders based on these results. The original EKGS, which may later be annotated by physicians, go into patient medical files.

Retention: Retain three (3) years or until updated, whichever is later.

BHD5.12 Radiation Dosimetry Records

Responsible Department: Radiology. Hospitals affiliated with BHDDH keep track of levels of radiation exposure for each employee. Reports are filed four (4) to six (6) times per year. If any individual has received too much exposure, an investigation is conducted. The records in this series may include, but are not limited to, reports of exposure levels (not separate for each employee, just lists), associated correspondence, and records of investigations of overexposure.

BHD5.12A Investigations of Overexposure

Retention: Retain seventy-five (75) years or ten (10) years after the death of the employee, whichever is sooner.

BHD5.12B All Other Records

Retention: Retain for thirty (30) years after separation.

BHD5.13 X-Rays – Critical Results Reports

Responsible Department: Medical Records. Hospitals affiliated with BHDDH, just like other hospitals, utilize X-rays reveal critical medical situations that demand immediate attention. These are reported to the doctor in charge of the case at the time, normally within twenty (20) minutes of results. These results are listed monthly. The records in this series consist of lists of reports of these critical cases. The information in these reports may include, but is not limited to, date, type of study (body part examined), patient ID number, name of ordering doctor, time read, description of critical finding, time of the call to the doctor, and time of response.

Retention: Retain three (3) years.

BHD5.14 X-Rays and Associated Reports

Responsible Department: Medical Records. Hospitals affiliated with BHDDH require that patients sent for x-rays have a paper requisition generated from an order in the patient's chart. X-rays are then performed and interpreted. The Radiology office then generates a report which is entered into an electronic reporting system. Two (2) copies of each report are generated, signed, and dated. One (1) copy is kept and the second one is attached to the initial requisition and sent back to the patient unit that requested the x-ray. Copies of reports of X-rays taken at hospitals away from the main office are sent to the main office and put into patient charts. The records in this series may include, but are not limited to, original requisitions, X-rays, printed X-ray reports (at hospitals where patients are), and, on rare occasions, personal correspondence about reports.

Retention: Retain three (3) years after discharge.

BHD5.15 Pharmacy – Patient Files

Responsible Departments: Pharmacy and Medical Records. Pharmacies in hospitals affiliated with BHDDH create assessments of each patient based on medication orders and discussions with physicians. The assessments are then placed in the patient's file, and the pharmacy also retains copies for its own use. The assessments are conducted every six (6) to eight (8) months. The records in this series may include, but are not limited to, assessments, lists of physicians' patient medication orders, and diagnoses (which are essentially snapshots of the status of patients at specific times.) The records also include recommendations by pharmacists for medication therapy (drug interactions).

Retention: Retain three (3) years after discharge in patient files.

BHD5.16 Pharmacy Database – Physicians' Orders for Medication

Responsible Department: Pharmacy. Physicians in hospitals affiliated with BHDDH send orders for patient medications to the hospitals' pharmacies. Pharmacists enter the orders in each patient's file within the database. The information in the orders may include, but is not limited to, when the use of the medications begins and ends and the dosage and strength of the medication. The information is entered and attached to the patient's identification information.

Retention: Retain three (3) years after discharge.

BHD5.17 Pharmacy – Controlled Substance/Narcotics Inventory and Dispensing Records

Responsible Department: Pharmacy. Pharmacies in hospitals affiliated with BHDDH maintain ongoing records of controlled substances/narcotics in their inventories and track any distribution. Pharmacies update and monitor the inventories on a regular basis, and periodically. This information is shared with the Drug Enforcement Administration when hospitals are audited. The records in this series may include, but are not limited to, inventory forms and dispensing and administration forms. For the latter, the nurses record anything administered to patients, after which the subtraction from the balance of the medication in the pharmacy's stock is recorded.

Retention: Retain five (5) years or until audit period concludes, whichever is later.

BHD5.18 Quality Assurance – Employee Performance Appraisals

Responsible Department: Quality Assurance. Quality Assurance (QA) is the specification of standards for quality of service and outcomes. It is an organization-wide process within BHDDH for assuring that patient care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards (Source: Centers for Medicare and Medicaid Services). The hospitals' QA office is responsible for its QA program. As part of this, each hospital employee undergoes an annual performance appraisal. These records document that process. The records may include, but are not limited to, the actual performance appraisals and any remediation plans that may be created in the process. This meets the Joint Commission's requirement for assessment of ongoing competency and education. This documentation is kept in order to meet additional accreditation requirements (this documentation is not included in employees' Human Resources Personnel file).

Retention: Retain five (5) years.

BHD5.19 Quality Assurance – Employee Orientation Records (Education Records)

Responsible Department: Education. New hospital employees undergo orientation in basic hospital policies and procedures. These records document that process for each individual employee. Documentation for nursing staff includes records related to initial competency training and any certificates of completion of education outside. The records in this series may include, but are not limited to, signed "completion of orientation" records, post-tests on relevant competencies, information on the organization of the hospital, the hospital's mission, job safety requirements, copies of the established code of conduct, statements of

patient rights, competency assessments, information on cultural diversity training, procedures for prevention of falls, unusual incident reporting/risk management, hospital policies (concerning such matters as smoking, cell phones, and dress code), identification badges and keys, security information, physical defense training material, verbal defense training material, procedures for application of restraints, client abuse policy, and HIPAA/confidentiality. These records are not kept in employee personnel/human resource files.

Retention: Retain three (3) years after employee separation.

BHD5.20 Quality Assurance – Annual or Ongoing Competency and In-service Training

Responsible Department: Education. Employees at hospitals affiliated with BHDDH receive ongoing education and competency training per hospital policy. These records document the training that occurs. These records may include, but are not limited to, sign-in sheets (for employee signature/proof of attendance) and post-tests (when applicable). Post-tests are given after training to determine how well employees understand the material.

Retention: Retain three (3) years after employee separation.

See Also: For other training records, see GRS1.4 (Employee Training Records).

BHD5.21 Quality Assurance – Joint Commission Accreditation Records

Responsible Department: Quality Assurance. Health care organizations that achieve accreditation by meeting Joint Commission standards for “deemed status” are, thereby, determined to meet or exceed Medicare and Medicaid requirements. The standards relate to hospital performance as it may affect patient safety, quality of care, and anything that may have an impact on health outcomes, including standards related to the creation and retention of documentation. Eligibility for Medicare and Medicaid funding Facilities hinges on accreditation and certification from the Joint Commission. Quality Assurance oversees preparation for Joint Commission accreditation for any hospitals affiliated with BHDDH. To do this, Quality Assurance is responsible for collecting from the various departments and programs copies of certain kinds of documentation created during their normal course of business that pertain to the Joint Commission accreditation process. Quality Assurance holds this documentation in preparation for review by Joint Commission members during periodic survey visits to the hospital (every three years as of 2019). The Quality Assurance office’s copies of documentation cover a broad range of hospital functions. The records

are meant to document certain kinds of activities the Joint Commission has identified as current priority areas. This documentation may include, but is not limited to, hospital licenses, organizational structure and functions, the identification of the sites of certain medical procedures, documentation of performance improvement projects (BHD5.23 (Quality Assurance – Performance Improvement Records)), Environment of Care records (emergency operations, drill records, management plans and annual evaluations), blood transfusion policies, governing body minutes, medical staff bylaws, infection control plans and surveillance data. Other items that may be included are various policies such as medication management policy, restraint and seclusion policies, abuse and neglect policies, grievance policies, and fall risk assessment policies. Finally, the records may include Corrective Action Plans. At the conclusion of each hospital survey, the Joint Commission issues a report identifying areas of strength and requirements for improvement, whereupon the hospital in question must respond with a Corrective Action Plan to receive or renew accreditation. Joint Commission-related accreditation documentation gathered and kept in individual hospital departments and offices also includes both regular and “living” documents. As may be required, hospital offices and departments periodically review and update/replace records in their bundled Joint Commission-related documentation in anticipation of the Joint Commission’s triennial visits.

BHD5.21A Quality Assurance Accreditation Records

Retention: Retain five (5) years.

BHD5.21B Individual Hospital Office Regular Accreditation Documentation

Retention: Retain three (3) years or one (1) year after Joint Commission accreditation, whichever is longer.

BHD5.21C Individual Hospital Office Living Accreditation Documentation

Retention: Retain until updated or superseded (minimum three (3) years).

BHD5.22 Quality Assurance – Hospital Survey Records

Responsible Department: Quality Assurance. Hospitals affiliated with BHDDH survey staff and patients as part of the process of maintaining quality assurance. The records in this series include these surveys. The staff surveys may include, but are not limited to, questions about the work environment, working hours, and staff working relationships. They may also include employee evaluations of management staff, workload,

the unit's handling of errors, processes for corrective action and improvement related to patient safety, whether or not working too many hours, effectiveness of staff communication; numbers of events reported, openness of supervisor/manager communications, frequency of events reported, and overall patient safety grades. Data is tabulated by outside vendors. The records also include training materials (from modules for training). The Joint Commission requires that hospitals survey patients for their perspective on hospital services. The hospitals' Social Service Unit conducts patient satisfaction surveys. The patient surveys are done and tabulated internally. These are federally standardized surveys from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), part of the Department of Health and Human Services' Agency for Healthcare Research and Quality. The surveys may include, but are not limited to, questions about patient demographics, patient-hospital staff interactions, nurse and doctor communication, staff attentiveness and responsiveness, the hospital and room environment, pain management, and medication management.

Retention: Retain three (3) years.

BHD5.23 Quality Assurance – Performance Improvement Records

Responsible Department: Quality Assurance. The Quality Assurance overseen by the Joint Commission currently included five "elements" as of 2019: Design and Scope, Governance and Leadership, Feedback, Data Systems, Monitoring, Systemic Analysis and Systemic Action, and Performance Improvement Plans. The hospitals' Quality Assurance office oversees general hospital operational and clinical performance, including the development of Performance Improvement Plans. The performance improvement process consists of the quarterly performance of self-audits by each department of the hospitals. QA oversees the preparation of the audit reports and performance improvement plans in collaboration with each department's leadership and members of the hospitals' Performance Improvement steering committee. The quarterly reports of self-audits identify issues and deficiencies, select top priorities, set goals, propose measures for reaching them, and generate reports on progress in meeting those goals. The assumption of this program is that performance improvement on a continuing basis is the most effective means of achieving compliance with Joint Commission standards and preparing for their Commission's triennial visits. The plans deal with the full range of services offered by the hospital. The process addresses all systems of care and management practices, including clinical care, quality of life, and resident choice. On a rotating basis, plans from different hospital departments are presented to the Performance Improvement Steering Committee for quarterly review. The plans are bundled and presentations made before the hospitals' Performance Improvement Steering Committee. Once reviewed and finalized, the

committee forwards quarterly summary data and trend reports to the director of BHDDH, the hospital's Medical Director and the hospital's CEO. As a Medicaid/Medicare facility, the hospital also annually forwards a copy of the plan to the federal Centers for Medicaid/Medicare Services.

Retention: Retain three (3) years.

See Also: For ESH Performance Improvement Committee Records, see GRS1.7 (Meeting Minutes).

BHD5.24 Hospital Employee Health Records (Immunizations and Incident Reports)

Responsible Department: Employee Health Office. Hospitals affiliated with BHDDH require all employees (including health care workers) to receive flu shots and other vaccines on an annual basis. Other vaccines are also mandatory but less frequently. Providing evidence of the vaccine in those cases is adequate. Also, when an employee has been out sick for five days or more (three for nurses), a note from a doctor is necessary before returning to work. Periodic physicals are also required for employees. The employee health office keeps track of this information. The records in this series may include, but are not limited to, immunization records, incident reports, records of physicals (done in the past), documentation identifying next of kin, allergy screenings for latex (no longer created), and acknowledgements of having received physicals.

Retention: Retain thirty (30) years.

BHD5.25 Infection Control Reports

Responsible Department: Infection Control Department. Hospitals affiliated with BHDDH extract information from patient files in order to compile infection reports. The Infection Control program reviews the files to determine whether they currently meet the criteria for any specific infection. The results of these reviews are then compiled into monthly infection reports. The reports are sent to hospital leadership to keep track of trends to identify increases and decreases of certain types of infections among patients over time. The information is also used in cases of widespread infections to trace their causes. These reports, produced monthly, may include, but are not limited to, patient names, what it is each patient suffers from, and antibiotics utilized for treatment (in individual accounts of cases of infection). The reports also include statistics on types of infections.

Retention: Retain three (3) years.

BHD5.26 Billing and Claims Records – Patient Billing Files

Responsible Department: Patient Finance. The financial management offices of hospitals affiliated with BHDDH are responsible for the management of information related to patient billing, and for submitting claims to various payers, including Medicaid and Medicare, for payment for the delivery of hospital services. The units are also responsible for keeping track of hospital costs. The hospitals are responsible for identifying each patient's financial resources for the purposes of billing the appropriate party for payment for the delivery of various services. This series includes records documenting the process of identification of billing parties for delivery of medical services to individual patients. The records include Billing Instruction Forms (Patient Benefit and Resources forms,) which summarize each patient's financial sources eligible for billing – for example Medicare, Medicaid, family, individual's resources) established billing rates, Medicaid Assistance Payments and Managed Care Organizations (MCO) payments. The files may also include, but are not limited to, factsheets, case notes, birth certificates, admission histories, records of payments, records concerning changes in liability status, or social insurance payments. The hospitals use the reports to calculate hospital daily rates for various services, and the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) uses them to assess the appropriateness of charges for various services when compared to other, similar hospitals.

Retention: Retain ten (10) years.

BHD5.27 Billing and Claims Records – Patient Claims Records

Responsible Department: Patient Finance. The financial management offices of hospitals affiliated with BHDDH are responsible for the management of information related to patient billing, and for submitting claims to various payers, including Medicaid and Medicare, for payment for the delivery of hospital services. The units are also responsible for keeping track of hospital costs. As medical providers, BHDDH's hospitals use a HIPAA-compliant electronic provider claiming software (Hewlett Packard Enterprise's Medicaid software, Provider Electronic Solutions, as of 2019) to submit claims to Medicaid for services they provide. The system enables the hospitals to gather data about claims to verify beneficiary eligibility, request prior authorizations, and submit claims to Medicaid electronically. The data includes information that hospitals, as providers, enter onto an Inpatient Claim Form which consists of a set of reference files with patient, payer, provider, and submitter information – all of which can automatically populate individual claims submissions. The claims may include diagnosis information, date and type of service, billing information, medical procedure information, and physician identifier information as well as the identification of other

sources of medical insurance payments. BHDDH's hospitals also use an electronic healthcare claims submission and management system to file claims related to Medicare Part B. This system is contracted by the Center for Medicaid and Medicare Services (CMS). The financial unit uploads data into a claims processing system. The system creates a patient database and allows a hospital to electronically submit Medicare Part B claims for payment. The system includes payer information, provider (hospital) information, patient information, submitter information, and facility information. The system also can generate various electronic billing and claims transaction acknowledgement reports, and it feeds the hospital's accounts receivable system.

Retention: Retain ten (10) years.

BHD5.28 Billing and Claims Records – Hospital (Medicaid) Cost Reports

Responsible Department: Patient Finance. The financial management offices of hospitals affiliated with BHDDH are responsible for the management of information related to patient billing, and for submitting claims to various payers, including Medicaid and Medicare, for payment for the delivery of hospital services. The units are also responsible for keeping track of hospital costs. To receive compensation for delivery of federally reimbursable Medicare/Medicaid services, BHDDH's hospitals must annually submit comprehensive hospital cost reports to the CMS. In addition to hospital identification data and hospital health care program services data, the reports include settlement summaries and then provide detailed direct and indirect accounts of hospital costs. These costs include payroll, utilities, drugs, supplies, physician salaries, wage and labor costs, cost of uncompensated services, capital assets and costs, cost allocations, cost of various administrative and medical services, pharmacy services, laboratory costs, and laundry services. They also cover management, facilities, and administrative services as well as the time studies completed by licensed independent practitioners. These data files contain the highest level of cost report status for cost reports. The report also includes accounting information related to costs and expenses as well as revenue and expenditures. The data is broken down into multiple statements, each presenting statistical breakdowns of costs and allocations of costs with respect to a wide range of financial matters ranging from facilities and equipment, staff education, wages, and labor costs and benefits, capital asset balances to individual internal medical services, outside services, and calculations and apportionments of computations of patient service costs, and calculations of several reimbursement settlements. The record series also includes associated support documents, data, and working papers generated during the preparation of the annual reports.

BHD5.28A Hospital Cost Reports

Retention: Retain seven (7) years after final settlement.

BHD5.28B Supporting Documentation

Retention: Retain seven (7) years after final settlement.

BHD5.29 Risk Management Files

Responsible Department: Quality Assurance. The Risk Management program of hospitals affiliated with BHDDH is responsible for responding to unusual incidents affecting patients. These may include, but are not limited to, patient-patient abuse, staff-patient abuse, sexual abuse, accidental falls, medical error, self-inflicted injuries, suicide, thefts, and patients gone missing. Cases rising to a certain level of gravity may be referred to external parties such as the Attorney General, the State Police, or the Department of Health (Professional Licensing) for action and resolution. The incident files may include, but are not limited to, Confidential Reports of Incidents (which indicate the nature and causes of incidents), descriptions of incidents (with actions taken), supervisor evaluations, recommendations, witness statements, Risk Management incident reviews, analysis, and physician assessments. In instances of possible medication errors, the files may also include documentation related to medications, dosages, required interventions, and medication administration reports. The files may also contain interview notes, statements, meeting notes, records related to addressing or fixing the problem, and notifications of guardians and family. These files are organized by case. Finally, as required by state law, the hospitals must report “reportable incidents” (as defined by state law, R.I. Gen. Laws § 23-17-40 and Department of Health, Rules and Regulations for Licensing of Hospitals, 216-RICR-40-10-4.3). The records also include Excel Spreadsheets containing incident data used for the purposes of tracking and analysis, identification of patterns, and the development of risk management plans.

Note: Department of Health retains hospital incident reports for ten (10) years.

See Also: HL7.4 (Hospital Incidents and Events Reporting).

BHD5.29A Incident Case Files – Internal

Retention: Retain ten (10) years.

BHD5.29B Incident Case Files – External Referral

Retention: Retain ten (10) years, or until case is resolved, whichever is later.

BHD5.29C Electronic Case Data and Spreadsheets

Retention: Retain until no longer useful for administrative purposes (minimum ten (10) years).

BHD5.29D DOH Audit Reports

Retention: Retain ten (10) years.

BHD5.30 Environment of Care – Hazardous Materials Records (Chemical Inventory Worksheets)

Responsible Department: Environment of Care. Hospitals affiliated with BHDDH maintain an Environment of Care program. This program focuses on the prevention of risks in the hospital environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The program educates staff about the elements of a safe environment, and how to identify, report, and act on environmental risks. The program monitors hazardous materials and the records in this series consists of hazardous materials inventory sheets and any associated records. The records include forms that locations and programs across the hospitals' facilities use to report on chemicals housed or used in various areas of the hospitals. Each sheet is a form containing information about the location of materials in a specific area. The data entered on each sheet may include, but is not limited to, the material name, the name of the manufacturer/importer, the CAS number (a unique numerical identifier assigned to individual substances by the Chemical Abstract Service, which is administered by American Chemical Society) the average quantity on hand, labeling information, and whether or not a Material Safety Data Sheet (BHD5.31 (Environment of Care – Material Safety Data Sheets)) is available for the substance.

Retention: Retain until the hospitals permanently discontinue the use of substance/material referenced plus ten (10) years.

BHD5.31 Environment of Care – Material Safety Data Sheets

Responsible Department: Environment of Care. Hospitals affiliated with BHDDH maintain an Environment of Care program. This program focuses on the prevention of risks in the hospital environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The program educates staff about the elements of a safe environment, and how to identify,

report, and act on environmental risks. A safety data sheet (SDS) is an important component of product stewardship, occupational safety and health, and spill-handling procedures. SDS formats can vary from source to source. For hospitals affiliated with BHDDH, safety data sheets are derived from the Chemical Inventory Worksheets (BHD5.30 (Environment of Care – Hazardous Materials Records (Chemical Inventory Worksheets))). They are used for cataloging information on chemicals, chemical compounds, and chemical mixtures located on hospital facilities. SDS information may include, but is not limited to, instructions for the safe use and potential hazards associated with a material or product. The SDS are meant to be posted and available for reference in the work area where the chemicals are being stored or in use. The SDS is primarily related to the hazards of working with the material described in an occupational setting.

Retention: Retain until the hospitals permanently discontinue the use of substance/material referenced plus ten (10) years.

BHD5.32 Environment of Care – Regulated Medical Waste Control Records

Responsible Department: Environment of Care. Hospitals affiliated with BHDDH maintain an Environment of Care program. This program focuses on the prevention of risks in the hospital environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The program educates staff about the elements of a safe environment, and how to identify, report, and act on environmental risks. The hospitals arrange for the collection, transportation, and disposal of regulated medical waste. The records in this series include documentation related to this process. The records may include, but are not limited to, documentation related to the identification and certification of vendors, medical waste generator ID registration (assigned by the Department of Environmental Management), vehicle registration, insurance information, manifest sheets, vendor purchase orders, request forms for approval to process regulated medical or chemotherapeutic waste streams (designated Form 34 as of 2019), medical waste control sheets, and yearly collection figures.

Retention: Retain three (3) years.

BHD5.33 Environment of Care – Patient Dietary Records

Responsible Department: Environment of Care. Hospitals affiliated with BHDDH maintain an Environment of Care program. This program focuses on the prevention of risks in the hospital environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The program educates

staff about the elements of a safe environment, and how to identify, report, and act on environmental risks. Diet is a part of what the program concerns itself with. Physicians complete dietary instructions for each patient under their care. These orders are transmitted to the dietary unit. The dietary unit uses these forms to ensure that patients are receiving diets appropriate for their medical condition. The records in this series consist of these forms and any associated documentation.

Retention: Retain three (3) years after discharge.

BHD5.34 Environment of Care – Pest Control Records

Responsible Department: Environment of Care. Hospitals affiliated with BHDDH maintain an Environment of Care program. This program focuses on the prevention of risks in the hospital environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The program educates staff about the elements of a safe environment, and how to identify, report, and act on environmental risks. Among the concerns of this program is pest control. This record series concerns the daily control and removal of pests from hospital facilities. The records may include, but are not limited to, daily control sheets, safety data sheets reporting products used for extermination or removal, purchase order specifications, and work orders received from the hospital involved.

Retention: Retain seven (7) years.

BHD5.35 Hospital Licensing Records

Responsible Department: Medical Staff Administration. Healthcare facilities meeting certain criteria under state law (R.I. Gen. Laws § 23-17-4) cannot operate without possession of a license issued by the state's Department of Health and certification from the CMS. Unless sooner suspended or revoked, hospital licenses expire on the last day of each year following their issuance and may be renewed from year to year after inspection, report, approval, and collection of fees by the Department of Health. Hospitals affiliated with BHDDH are subject to the same licensing requirements as any other hospitals in the state. The records in this series document the process. The records may include, but are not limited to, license applications and supporting documentation. The supporting documentation may include, but is not limited to, ownership information and survey information. The survey information may include, but is not limited to, statements of deficiencies, plans for corrections, correspondence between hospitals and the Department of Health, information on clinical criteria to maintain licensing, records of provider-reported incidents, and operation approvals. These approvals include, but not limited to, city/municipal

approvals, occupancy authorizations, state fire marshal reports, variance requests, and variance approvals.

Retention: Retain ten (10) years.

BHD5.36 Organ/Tissue Donation Records

Responsible Department: Medical Records. Under R.I. Gen Law Chapter 23-18.6.1, it is the responsibility of each hospital to develop procedures for addressing the issue of organ and tissue donation. These procedures apply to deaths that occur in the hospital and also in situations when the intention of the deceased is unknown. Hospitals affiliated with BHDDH are subject to this regulation. When, in the opinion of the attending physician or other competent medical personnel, a death is imminent (or has occurred) a representative designated by the hospital administration must notify a federally designated organ/tissue procurement organization of pending death. Discussions of possible organ/tissue donation must take place among designated hospital staff. These discussions must be documented, and the documentation must be placed in the individual's medical record (BHD5.2 (Patient Medical Files)). In the absence of a record of gift, the hospital staff may discuss the options with individuals designated (spouses, other relatives or guardians) by the aforementioned regulation. Documentation of such these discussions must also be placed in the individual's medical record. The records in this series may include, but are not limited to, documentation of the hospital's protocol for organ and tissue donation and notifications sent to organ and tissue procurement organizations.

BHD5.36A Hospital Organ/Tissue Donation Procedures and Protocols

Retention: Permanent.

See Also: GRS1.3 (Policies and Procedures).

BHD5.36B Hospital Notification of Organ/Tissue Procurement Agency Records

Retention: Permanent.

BHD5.36C Patient/Representative Consent Records

Retention: Retain five (5) years after death.

See Also: BHD5.2 (Patient Medical Files).