

Using the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) in Care Management Settings: Guidelines for Policies and Procedures

It is strongly recommended that Care Management program implementing PSYCKES follow the guidelines below in order to promote successful adoption of PSYCKES in Care Management settings. The program is advised to develop, document and implement policies and procedures for integrating PSYCKES into its routine workflow. Specific individuals should be designated to complete each of the following essential tasks, including:

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Step 1: Identify Potential PSYCKES Clients

Identify Medicaid enrollees, check if previously consented, obtain client’s Medicaid ID number and verify client’s identity.

Relevant Policies:

PSYCKES data should be obtained for all eligible individuals.

- All clients should be screened at intake for PSYCKES eligibility, and eligible clients should be consented at the earliest opportunity.
- All current clients should be assessed for PSYCKES eligibility, and eligible clients should be consented at the earliest opportunity.

Relevant Procedures:

Designate staff responsible for identifying PSYCKES-eligible clients and documenting Medicaid ID#

- This staff member will:
 - Identify potential PSYCKES clients
 - All Medicaid enrollees
 - Medicaid eligibility anytime the past 5 years
 - Determine whether the client is already consented (if yes, skip to Step 5)
 - Obtain and document the client’s Medicaid ID number
 - Obtain and document the client’s Social Security number
 - Verify client’s identity
 - 2 forms of ID, OR
 - Known to the program
 - Communicate this information to the person who will enter it into PSYCKES Consent Module (if not the same person)

Consider adding a flag/header on client’s chart and/or program face sheet to indicate whether the client

- Is PSYCKES eligible
- Has already signed a PSYCKES Consent Form

Step 2a: Obtain Written Client Consent

Obtain signature of PSYCKES-eligible client on PSYCKES Consent Form, and give a copy of the form to the client.

Relevant Policies:

- Consent to view PSYCKES data should be requested of all eligible individuals.
- Only the OMH PSYCKES Consent Form, printed from Consent Module, may be used.
- All clients capable of consenting must be asked for consent. Policy may designate specific clients for whom emergency access will be used.
- A copy of the PSYCKES Consent Form (which has instructions for the client regarding confidentiality of data and withdrawal of consent) must be given to the client.

Relevant Procedures:

- PSYCKES Consent Form is pre-printed and accessible to staff
- PSYCKES Consent Form is included in intake/admission package and signed routinely along with any other paperwork (e.g., receipt of Client Rights / HIPAA notice)
- Designate staff responsible for asking clients for consent and/or answering questions about PSYCKES, and specify when this will happen
- Consider having a script and/or training on how to introduce the PSYCKES Consent Form to clients / how to answer questions about it. (PSYCKES document available upon request.)
- Copy signed consent (front and back) and give copy to client
- If client initially refuses consent, when will another effort be made?
- If client consents, skip to Step 3

Step 2b: PSYCKES Access in a Clinical Emergency

In clinical emergencies client data may be accessed via PSYCKES without written consent from the client.

Relevant Policies:

- Specify who is authorized to make the determination of a clinical emergency
- Develop guidelines for what constitutes a clinical emergency (PSYCKES document available on website; program may have existing criteria)
- As stated on the PSYCKES Consent Form, if the client refuses to sign the form, but criteria for emergency access are met, provider may still access PSYCKES data

Relevant Procedures:

- Document in client's chart(specify where in record) why/how the client meets criteria for a clinical emergency (does not need to be sent to OMH, but **record must support** emergency access)
- Emergency access expires in 72 hours; at that time, another effort should be made to obtain consent. How/when will that take place?

Step 3: Use Consent Module to Enable Access to Client's Records

PSYCKES user with "Registrar access" uses Consent Module to look up client, verify client's identity, and document the rationale for access to clinical data.

Relevant Policies:

- Designate which staff or categories of staff will have Consent Module access; could be some or all PSYCKES users. (PSYCKES access guidelines available separately.)
- Consider developing guidelines for when/why clinicians may attest to client identity

Relevant Procedures:**Designate staff responsible for granting access to client's PSYCKES data**

- The designated staff will:
 - Enter PSYCKES Consent Module
 - Look up client based on Medicaid ID # or Social Security # (note: Medicaid enrollees with no prior behavioral health claims will not be found)
 - Specify the reason for access to the client's PSYCKES data
 - Client signed consent, OR
 - Clinical emergency
 - Verify client's identity and document:
 - 2 forms of ID, OR
 - Clinician attests to client's identity
 - May proceed directly to accessing/printing clinical summary

All PSYCKES users at the program (with or without Consent Module access) will now have access to the client's clinical information

Step 4: Retain PSYCKES Consent Form in Client's Chart

(If emergency access was used, skip to Step 5.)

Relevant Policies:

- Only the OMH PSYCKES Consent Form, printed from Consent Module, may be used.
- The PSYCKES Consent Form (original or scanned) must be retained in the client's medical record.
- A copy of the PSYCKES Consent Form, which has instructions for the client regarding confidentiality of data and withdrawal of consent, must be given to the client.

Relevant Procedures:

- Designate staff responsible for filing PSYCKES Consent Form in client's medical record
- Specify how/when Consent Form will be filed:
 - Will paper Consent Form will be retained, or will it be scanned into electronic medical record (EMR)?
 - In which section of the record will the PSYCKES Consent Form be filed?
 - When will the Consent Form be filed/scanned into chart?
 - Consider bar-coding PSYCKES Consent Form for inclusion in EMR
 - Consider placing bar-coded Consent Form as cover sheet on Clinical Summary and scanning into EMR as a single document

Step 5a: Place Summary in Client's Chart

Relevant Policies:

- PSYCKES Clinical Summary should be obtained and reviewed for all eligible clients
- Designate which staff or categories of staff will have PSYCKES access. (PSYCKES access guidelines available separately.)
- Designate what aspects of the Clinical Summary will be exported/printed (see below)
- Prohibit saving the printable Clinical Summary PDF document anywhere other than a secure server. The program's existing policies may be sufficient but should be reviewed in relation to PSYCKES.

Relevant Procedures:

Designate staff responsible for printing clinical summary

- The designated staff will:
 - Access client's Clinical Summary by searching on Medicaid ID # in
 - Recipient Search, OR
 - Consent Module
 - Make selections for printing Clinical Summary
 - Specify time period (up to 5 years is available)
 - Specify which sections of clinical summary
(can de-select some sections)
 - Consider printing detail on specified items (e.g., active medications)
 - Export Clinical summary to PDF, and print
 - If applicable, append PDF to EMR
 - Close PDF document without saving (or save only to secure server)

Step 5b: Print Clinical Summary

Relevant Policies:

- PSYCKES Clinical Summary should be obtained and retained in chart for all eligible clients
- Prohibition on redisclosure of confidential information, particularly since PSYCKES Clinical Summaries may include health information with special protections (HIV, Substance Abuse, Family Planning, Genetic). The program's existing policies may be sufficient but should be reviewed in relation to PSYCKES.

Relevant Procedures:

- Designate staff responsible for filing PSYCKES Clinical Summary in client's chart
- Specify how/when Clinical Summary will be filed:
 - Will hard copy of Clinical Summary be retained? Will PDF document be appended to client's EMR? Will printed summary be scanned into EMR?
 - In which section of the record will the PSYCKES Consent Form be filed?
 - When will the Clinical Summary be filed/scanned/appended to EMR/chart?
 - Consider placing bar-coded Consent Form as cover sheet on Clinical Summary and scanning into EMR as a single document

Step 5c: Review Clinical Summary

Relevant Policies:

- PSYCKES Clinical Summary should be obtained and reviewed for all eligible clients
- Designate which staff or categories of staff will have PSYCKES access. (PSYCKES access guidelines available separately)
- PSYCKES data should be incorporated into evaluation and assessment as appropriate

Relevant Procedures:

- Designate categories of staff responsible for reviewing PSYCKES Clinical Summary (e.g., Field Supervisor, Care Manager, Quality Assurance staff, others?)
- Specify when Clinical Summary will be reviewed
 - At intake prior to completing the comprehensive assessment or initial treatment plan?
 - Every 6 months prior to updating the follow up assessment or the treatment plan?
- Clinical staff reviewing a printed summary should have access to PSYCKES in order to facilitate “drilling down” on the data for further information.

Please see also:

PSYCKES Access for Care Management Programs: Guidelines for Policies and Procedures