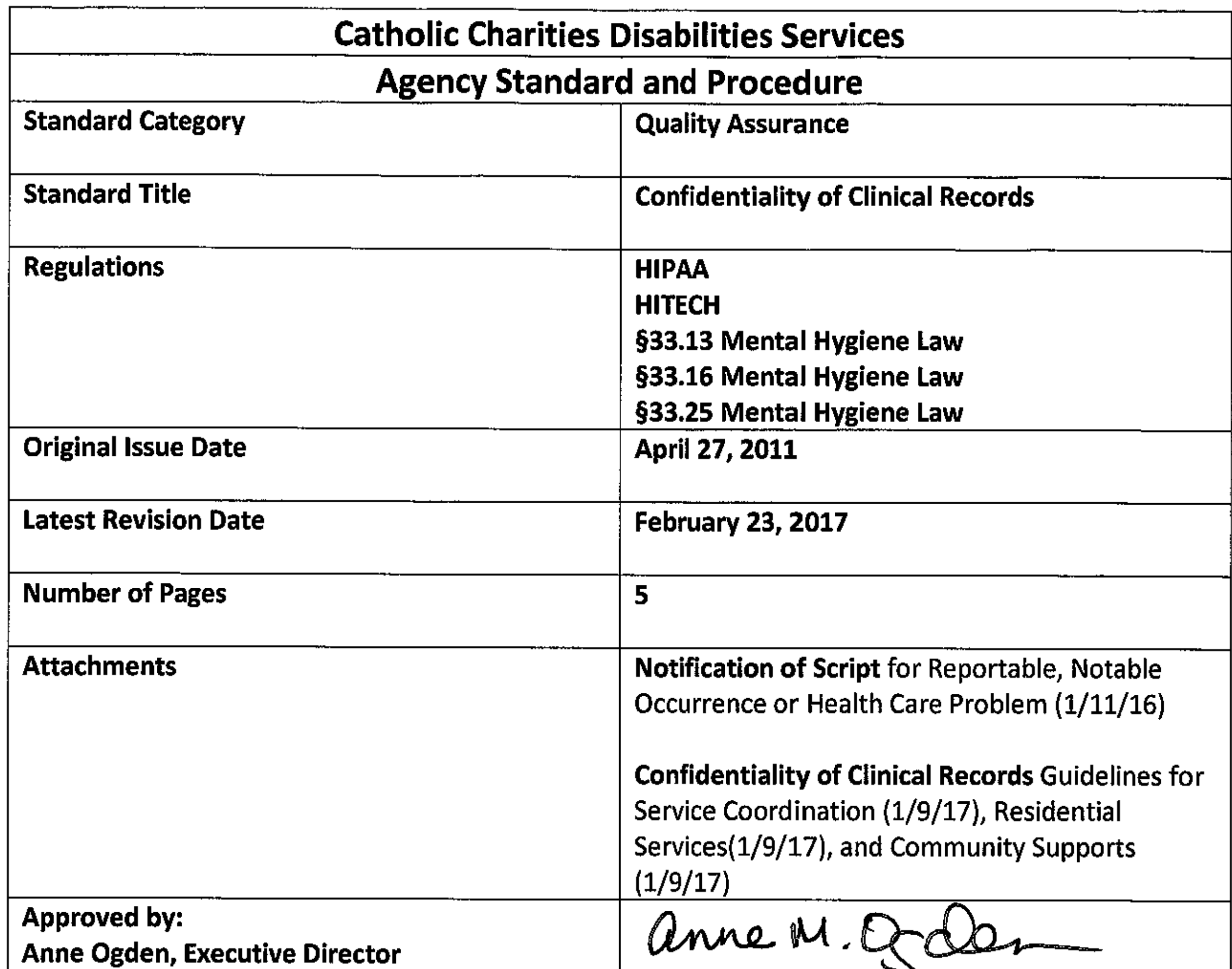

Catholic Charities Disabilities Services	
Agency Standard and Procedure	
Standard Category	**Quality Assurance**
Standard Title	**Confidentiality of Clinical Records**
Regulations	**HIPAA** **HITECH** **§33.13 Mental Hygiene Law** **§33.16 Mental Hygiene Law** **§33.25 Mental Hygiene Law**
Original Issue Date	**April 27, 2011**
Latest Revision Date	**February 23, 2017**
Number of Pages	**5**
Attachments	**Notification of Script** for Reportable, Notable Occurrence or Health Care Problem (1/11/16) **Confidentiality of Clinical Records** Guidelines for Service Coordination (1/9/17), Residential Services(1/9/17), and Community Supports (1/9/17)
Approved by: **Anne Ogden, Executive Director**	Anne M. Ogden

Standard: All clinical records maintained by Catholic Charities Disabilities Services (CCDS) will be kept strictly confidential. Any and all releases of clinical information will be made in full compliance with Federal and State Law.

To ensure that CCDS is in compliance with the law, with only two exceptions, <u>all</u> requests for clinical information should be forwarded to the Director of Quality Assurance before information is released. The QA department will ensure that the agency response is appropriate, timely, and in full compliance with law and regulation.

The exemptions to this rule are for routine billing and when clinical information is shared between service providers with the consent of the individual. For example, with consent it is appropriate to share clinical information with medical providers or with other service providers such as day programs, external services coordinators, etc.

All other requests for clinical information, including from the Mental Hygiene Legal Service, the Justice Center, Disability Rights New York, a court, an attorney, the police, the media, etc, must immediately be forwarded to Quality Assurance. While in most circumstances it is appropriate to share information

verbally with individuals, parents or guardians, if copies of records are requested, this request should go to Quality Assurance.

I. Relevant Law

a. Health Care Portability and Accountability Act of 1996 (HIPAA) covers the privacy and security of individual health information used, transmitted, or retained by CCDS with rules that place limits on accessibility and dissemination of protected health information.

b. Health Information Technology for Economic and Clinical Heath Act (HITECH) amends the HIPAA act to include breach reporting and notification requirements.

c. §33.13 of Mental Hygiene Law establishes the confidentiality of clinical records.

d. §33.16 of Mental Hygiene Law defines who may gain access to confidential records and under what circumstances these records may be accessed.

e. §33.25 of Mental Hygiene Law establishes procedures for qualified persons to obtain records pertaining to allegations and investigations of abuse and mistreatment.

II. Definitions

Clinical Record means any information concerning or relating to the examination or treatment of an individual receiving or has received services from CCDS maintained by this agency. All information contained in the record is considered protected health information.

Health Information means any oral or recorded information that is created or received by CCDS that relates to the past, present, or future physical or mental health condition of the individual.

Protected Health Information means health information, which relates to the individual's health, provision of care, or payment for care and identifies or could reasonably be used to identify the individual.

Qualified Person means any properly identified individual receiving services, as well as the guardian, parent, spouse, or adult child of an individual.

Service Provider means the executive director or the director of the program who has or had primary responsibility for the care of the individual.

III. **Internal Access**

Access to clinical records will be limited to those staff to whom such confidential information is necessary to carry out their duties.

IV. **External Access**

All clinical records maintained by CCDS will be kept confidential and can only be released under certain circumstances including:

- pursuant to an order from a court of competent jurisdiction;
- to the Office for Persons with Developmental Disabilities (OPWDD);
- to the Mental Hygiene Legal Service;
- to the Justice Center for the Protection of People with Special Needs;
- to an endangered person and law enforcement agency when a treating psychiatrist or psychologist has determined that an individual served by CCDS presents a serious and imminent danger;
- with authorized consent to persons and entities who have a demonstrable need for such information;
- governmental agencies, insurance companies, and other third parties requiring information necessary for payment of services;
- persons and agencies needing information to locate missing persons; and,
- governmental agencies in connection with criminal investigations.

V. **Access by Qualified Persons**

Upon the written request of a qualified person, clinical records and certain investigatory records will be made available for inspection, according to rights and restrictions imposed by Mental Hygiene Law and Regulations:

- Upon the written request of a qualified person, within ten working days the agency will provide an opportunity for the qualified person to inspect any clinical record in possession of the agency pertaining to the person served;

- Copies of the requested records may be provided to the qualified person. The agency may charge a reasonable fee for the cost of copying the record;

- Upon receipt of a written request for a record, the treatment team and the pertinent treating practitioner(s) will be informed of the request;

- The service provider may request the opportunity to review the clinical information with the qualified person requesting the information;

- The qualified person will not be able to inspect the clinical record if the service provider determines that the review of all or part of the clinical record can reasonably be expected to cause substantial and identifiable harm to the individual or others.

VI. Denial of Access by Qualified Persons

In the event of a denial of access to records, the qualified person will be informed in writing of the denial and of their right to obtain a review free of charge by the clinical records access committee designated by the Commissioner of OPWDD.

VII. Access to Records Pertaining to Reportable Incidents and Notable Occurrences

The agency will make at least a verbal notification to all qualified persons within 24 hours of discovery of a reportable incident or serious notable occurrence. The agency will use an approved script to ensure that law and regulation are properly followed.

A report on actions taken (OPWDD 148) will be provided to qualified persons within 10 working days.

Upon written request by a qualified person, once an investigation is closed the agency will provide copies of all records and documents pertaining to reportable incidents, redacted by the agency in compliance with pertinent law and regulation.

VIII. Notification of Rights

All individuals served by the agency as well as their families and/or advocates will be notified how their protected health information/clinical record may be used and disclosed. This notification will be made upon admission and at annual reviews thereafter.

IX. Staff Prohibition

Staff are not allowed to divulge, copy, release, sell, loan, review, alter or destroy any protected health information unless required or permitted by law.

X. Storage of Clinical Records

Every effort will be made to keep both electronic and paper records of protected health information confidential. Due to the array of services offered by CCDS, and the variety of settings in which they are offered, each department will be responsible for the development of practices designed to keep records confidential.

Please also see "CCDS Record Retention and Destruction" Standard.

XI. Complaints

Complaints about possible breaches of confidentiality can be made by individuals served and/or qualified persons. These complaints may be accepted by any staff member.

All complaints are to be forwarded to the CCDS Director of Quality Assurance and/or the CC Director of Corporate Compliance, for investigation. These investigations will be done with the knowledge of the privacy officer for Catholic Charities of the Diocese of Albany (CCDA), who will approve any findings.

The results of any investigation will be transmitted to the complainant in writing.

XII. Discovery of Possible Breach of Confidentiality

Any employee who believes that there has been a violation of this standard should immediately report it to their supervisor, the CCDS Director of Quality Assurance, or the privacy officer for CCDA.

Any breach or failure to report a breach will be considered a serious matter and may result in disciplinary action up to and including termination. Employees may be subject to criminal prosecution.

Any reported breach will be investigated promptly, thoroughly and impartially. The investigation will be conducted and approved by the CCDA privacy officer.

Individuals who may be the subject of a breach as well as their qualified person will be notified in writing within sixty days via first class mail at the last known address of the individual and qualified person.

If the nature of the breach puts the individual in imminent danger of misuse of unsecured protective health information, we may contact the individual via telephone as well.

The Federal Department of Health and Human Services must be notified of any confirmed breach of protected health information.

Catholic Charities Disabilities Services
Parent/Guardian/Advocate Notification Script

A **Notification Script** (attached) is to be used whenever a parent/guardian/advocate is required to be notified of a **Reportable Incident or Notable Occurrence,** or of a **Health Care Problem**. If the individual is a capable adult who objects to such notification, the individual shall receive the notification.

Reportable Incidents and Notable Occurrences – Complete Items 1 - 6 and return to the Director of Quality Assurance immediately by hard copy, email or fax. If immediate transmission is not possible then you should leave the Director of QA a voice mail and send the documents the next date you report to work.

Reportable Incidents are: **Allegations of Abuse/Neglect** and **Significant Incidents,** which are Conduct between individuals which would be abuse if committed by a custodian, Seclusion, Unauthorized time out, Medication error with adverse effect, Inappropriate use of restraints, Mistreatment, Missing person, Choking with known risk, Self-abusive behavior with injury, Choking with no known risk, Unauthorized absence, Injury with hospital admission, Theft/financial exploitation (more than $100/credit/benefit card), and Other significant incidents.

Notable Occurrences are: **Serious Notable Occurrences,** which are Death, and Sensitive situations; and **Minor Notable Occurrences,** which are Injury requiring more than first aid, and Theft or financial exploitation [more than $15].

Health Care Problems – Complete Items 1 – 3 and return to the Director of Quality Assurance immediately by hard copy, email or fax. If immediate transmission is not possible then you should leave the Director of QA a voice mail and send the documents the next date you report to work.

Health Care Problems are when an individual receives services in an emergency room or urgent care center or is admitted to a hospital or is unable to participate in scheduled activities for a week or more due to a health care problem, even if that individual has not sustained a reportable or serious injury. For example, notification is required where an individual is taken to the ER but is found to be without injury, or an individual is hospitalized for an illness or where an individual is unable to attend their day program for a week or more due to some health concern.

Catholic Charities Disabilities Services
Notification Script for Reportable and Notable Incidents and Health Care Problems

1. **Hello, this is (name/title) from Catholic Charities Disabilities Services. I'm calling to let you know about an incident involving (individual's name).**

   Name of Individual:____
   Name of CCDS staff making call:____________________________________
   Date and time of call:____
   Name of person called:____

2. **Briefly describe the Incident or Health Care Problem which occurred.** [For allegations of abuse/neglect, make it clear that you are describing an **allegation** that has been made or reported but not confirmed. Explain that just because an allegation has been made, it does not mean that it is true; that is why we will be conducting an investigation. Do not mention names of staff or other consumers involved in the incident.] Briefly describe below.

   ____
   ____
   ____

3. **Describe the initial steps that were taken to assure the individual's safety-medical attention, staff suspensions, etc. Do NOT provide the name/s of staff who may have been involved.**

   ____
   ____
   ____

4. **CCDS Quality Assurance staff will be investigating any Reportable or Notable Incidents and will provide you with a written report (OPWDD 148) of the initial actions taken, including the protections implemented.** [For allegations of abuse or neglect **only**, offer to let the individual contacted know the outcome of the investigation.]

   Offer extended? Yes_______ No________

   Offer Accepted? Yes_______ No________

5. **Ask if there is any additional information which would assist the investigator in communicating more effectively with the individual and record response.**

   ____
   ____
   ____

6. **Offer an opportunity to meet with the CCDS executive director or designee and record whether or not a meeting is requested.**

   Offer extended? Yes_______ No________

   Offer Accepted? Yes_______ No________

Do NOT offer to provide a copy of the Incident Report, but check here ____ if it is requested.

Catholic Charities Disabilities Services
Confidentiality of Clinical Records
Guidelines for Service Coordination Department

This document is prepared as an adjunct to the CCDS Agency Standard and Procedure for the Confidentiality of Clinical Records. The information contained herein is specific to the protection of Clinical records in the Service Coordination Department; all Service Coordination staff should review the full Agency Standard for knowledge of all expectations pertaining to the Confidentiality of Clinical Records. The major goal of these guidelines is to assure that individual specific information is properly protected while allowing the flow of information needed to provide Service Coordination Services.

Agency Standard: All Clinical records maintained by Catholic Charities Disabilities Services will be kept strictly confidential. Any and all releases of clinical information will be made in full compliance with Federal and State Law.

In addition to the Agency Standard and Procedure for Confidentiality of Clinical Records the following guidelines must be followed.

Service Coordination Department Guidelines

- All clinical records will be kept in an individual file in the work space of those staff that is qualified to have the confidential information that is necessary to carry out their duties. The individual file will be labeled with the individuals' First name and Last initial on the outside of the file.

- Service Coordination staff should be mindful to only take the specific individual and clinical records that they need for a particular off site meeting, visit etc.

- Computer users will log off or place their computer in "lock" mode when leaving the workstation for breaks, meetings, and at the end of each business day.

- All clinical documents will be in the individuals file or folder and not left exposed with identifying information in any part of the work place to include being left on copier machines etc.

- All identifying information about a person must be released only at the consent of the individual and/or guardian. All clinical information must be encrypted when sent to people outside of Catholic Charities Disabilities Services staff.

- Disposal of all written/printed documents with individual specific information will be done using the agency-provided locked information disposal bins at all times.

- Records can only be released under certain circumstances as stated in the Agency Standard and Procedure for Confidentiality of Clinical Records.

- Access to an individual's clinical record can be requested by a qualified person in writing to the organization as stated in the Agency Standard and Procedure for Confidentiality of Clinical Records.

- In the event of a denial of access to records, the qualified person will be informed of the denial and of their right to obtain a review free of charge by the clinical records access committee designated by the Commissioner of OPWDD.

- Please reference Agency Standard and Procedure for Confidentiality of Clinical Records on Access to incident reports and records to pertaining to investigations of abuse.

- The qualified staff will present and review annually the notification of rights on how the individuals' health protected information and clinical record may be used and disclosed.

- Staff must properly discard any and all health protected information and are not allowed to divulge, copy, release, sell, loan, review, alter or destroy any health protected information unless required or permitted by law.

- Reference Agency Standard and Procedure for Confidentiality of Clinical Records for Complaints and Discovery of Possible Breach of Confidentiality.

- Reference The Service Coordination Work from Home Contract for the practice of confidentiality of clinical records when working outside of Catholic Charities Disabilities Services Office.

Confidentiality of Clinical Records – Residential Department

This document is prepared as an adjunct to the CCDS Agency Standard and Procedure for the Confidentiality of Residential Clinical Records. The information contained herein is specific to the protection of Clinical records in the Residential Department; all Residential staff should review the full Agency Standard for knowledge of all expectations pertaining to the Confidentiality of Clinical Records. The major goal of these guidelines is to assure that individual specific information is properly protected while allowing the flow of information needed to provide Residential Services.

- Catholic Charities Disabilities Services utilizes an electronic health record for many of our clinical records for the individuals receiving services.
- The current electronic health record is a web based program that is password protected and limits a staff member's access solely to the individuals that are currently on that staff member's caseload.
- Staff members do not have access to electronic health records for individuals they do not work with.
- All residential computers will be password protected and utilize a screen saver that will lock the computer when left idle for a specified time frame.
- All clinical records that are maintained on paper format will be kept in an office area and will not be left in the common areas of a residence. Access will only be granted to staff members that are employed by Catholic Charities Disabilities Services and that are working with that particular individual. When a staff member is done using a particular record, it should be immediately returned to its original location.
- Agency clinical records may only be brought off site for work related meetings. If agency records are being brought off site, they must remain in the possession of the staff member that removed the files from their original location. If copies of relevant information are to be given to qualified individuals (other service providers), the staff member that brought the clinical record will be responsible to make the given copies of the approved documents.

- Agency clinical records are not permitted to be left unattended in a staff member's vehicle at any time.

- Any information that is posted in the residences should be done so in a normalizing and discreet manner. No posting should include information that identifies whom the information pertains to or include information that is of a sensitive or personal nature.

- Personal information should be kept in a binder or file and not be available to be seen by a person who is simply visiting a particular residence.

Community Supports Department Confidentiality of Clinical Records Guidelines

This document is prepared as an adjunct to the CCDS Agency Standard and Procedure for the Confidentiality of Clinical Records. The information contained herein is specific to the protection of Clinical records in the Community Supports Department; all Community Supports staff should review the full Agency Standard for knowledge of all expectations pertaining to the Confidentiality of Clinical Records. The major goal of these guidelines is to assure that individual specific information is properly protected while allowing the flow of information needed to provide Community Support Services.

Workstation Security: Workstations/computers are placed in such a way that they can be secured from public access and view. In addition, the following workstation security guidelines are also in place:

- Full names and/or other identifying information is not to be placed on the outside of binders or folders.
- Credenzas are to be used to house the individuals' records; credenza doors are to be closed when not in use and at the end of each business day.
- Written documentation or records containing individual specific information will not be left face up on cubicle desktops. Rather, documents will be secured into folders and/or face down at the end of each business day.
- Computer users will log off or place their computer in "lock" mode when leaving the workstation for breaks, meetings, and at the end of each business day.
- Disposal of all written/printed documents with individual specific information will be done using the agency-provided locked information disposal bins at all times.

Information Sharing and Release: All clinical records are to be kept confidential and limited to those who require the information to perform their work duties. In addition, the following information sharing guidelines are also in place:

- Specific releases will be obtained for all of the following prior to the dissemination of information to an outside party: Information, medical and photo.
- Emails containing individual specific information will be encrypted prior to sending.
- Therap Secure Communications (SComms) will be used by all staff working with an individual when relaying information specific to that person.
- Print protect will be used at all times when printing individuals' information to the printers; Supervisors will enter their code to retrieve this information and will remove it from the printer area immediately following printing.
- Staff are prohibited from using social media to share photos or other individual specific information.

Staff working in the field/outside the office setting: Community Supports Services are delivered by staff supporting individuals' in their own homes and communities. Staff providing these services are required to carry individual specific information when they are working, as well as to electronically provide documentation from their personal computer, cell phone, or a public computer (i.e. library). As such, the protection of this information is often more critical due to the nature and location of the service provision and must adhere to the following guidelines at all times:

- All CSPs are responsible for maintaining their home/home office in compliance with confidentiality and protection of individual information.
- Individual specific information is privileged information to be used only for the purpose of CCDS business.
- Individual specific information carried in the field must be safeguarded at all times in the trunk of a locked vehicle.
- CSPs are prohibited from the sharing or release of individual specific information and clinical records with any party outside of CCDS.
- Any and all information related to an individual receiving services from CCDS must be turned back into CCDS upon dissolution of the working relationship.
- The use of personal email to relay individual specific information is prohibited; Therap Scomm is the only acceptable method to relay written correspondence to CCDS regarding the individual supported.

CS Supervisors should be mindful to only take the specific individual and clinical records that they need for a particular off site meeting, visit etc.