Office Safety
Policy & Procedure Manual

2011

Section L

(Click on the sub-sections to jump to the specific section)

POLICY NUMBER	OS- L100
POLICY TITLE	**Confidentiality**
INITIAL EFFECTIVE DATE	01/00
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

1. Protection of the patient's right to privacy and their medical care records from loss, alteration, unauthorized use or damage.
2. To ensure the confidentiality of member information used for any purpose.
3. To protect the patient's right to access their medical records.
4. To define the guidelines for release of patient information.

Definitions

"Medical Information" means any individually identifiable information, in electronic or physical forms, in possession of or derived from a provider of health care, a health care service plan or a contractor regarding a patient's medical history, mental or physical condition, or treatment.

"Individually identifiable" means that the medical information includes or contains any element of personal identifying information, sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number of other information that, alone or in combination with other publicly available information, reveals the individual's identity.

Policy

It is the policy to maintain the patient's right to privacy and right to access their medical records in accordance with all applicable state and federal laws including but not limited to the Confidentiality of Medical Information Act and Insurance Information and Privacy Protection Act.

Procedure

A. Contract with Providers/Education
   1. The contracted practitioners/provider's contracts will explicitly state expectations about the confidentiality of member information and records.
   2. The medical group informs its members of its Confidentiality Policy and Procedure in the Office/Safety Manual.

B. Direct Access to Record

1. Court orders (subpoenas, search warrants, etc.) for patient medical records should be reviewed by legal counsel prior to turning over any records. Violation of the Confidentiality of Medical Information Act is punishable as a misdemeanor (Civil Code 56.35-36). A patient may not waive his/her rights under this Act.
2. A written release is obtained from the member when using data for reporting, training, research, publication, and/or marketing unless the identity of the member is blinded.
3. Professional personnel involved with the patient's care and related activities (i.e., physician, nurse, and other appropriate staff) are permitted access to the patient's medical record upon signing an employee confidentiality form.
4. Individuals not involved with the patient's care and related activities are not permitted access to the patient's medical record without a completed and signed Patient Medical Record Release Form.
5. Disclosure of patient medical records by a physician is permitted without patient authorization when otherwise specifically authorized by law. All such disclosures will be documented and accompanied by a statement that the information may not be further disclosed except in accordance with the Confidentiality of Medical Information Act.

C. Disclosure

1. Other Health Care Practitioners/Providers: Disclosures for diagnosis or treatment including disclosures by radio transmission between emergency medical personnel at the scene of an emergency or in an emergency transport vehicle and at a hospital, or to assist another practitioner/provider in obtaining payment for health care rendered by that practitioner/provider to the patient, but only to the extent necessary.
2. Third-Party Payers: Disclosure only to the extent necessary to allow responsibility for payment to be determined or to secure payment to insurers, employers, health plans, government entities, or others responsible for payment for health care services, or those who provide billing, claims management, medical data processing or administrative services for providers or payers. Disclosure to a government authority to the extent necessary to determine the eligibility of an incapacitated, indigent patient for payment under a governmental program for health care services.
3. Peer Review and Professional Liability: Disclosures to persons or organizations insuring or defending a practitioner's professional liability or organized committees or agents of professional societies, medical staffs, Knox-Keene plans, professional standards review organizations, or Pros engaged in the review of competency or qualifications of health care professionals or healthcare services for medical necessity, level of care, quality of care, or justification of charges.
4. Licensing: On-premises disclosures to private or public bodies responsible for licensing or accrediting practitioners/providers. The

removal of records is not permissible under this exception, nor should a physician permit original records to be removed from the practitioner's/provider's custody or control except in most extraordinary circumstances with the advice of counsel.

5. Coroner: Disclosures to the county coroner as part of an investigation by the coroner's office.
6. Research: Disclosures to public agencies, clinical investigators, health care research organizations, accredited public or private non-profit educational or health care institutions for bona fide research purposes.
7. Employee Fitness: Disclosure to an employer of information created as a result of employment-related health care services performed at the specific prior written request and expense of the employer and which either is relevant to and will be used in a lawsuit, arbitration, grievance, or other claim or challenge to which the employer and employee are parties and in which the employee has placed the employee's medical history, condition, or treatment in issue, or describes functional imitations, not the medical cause, entitling the employee to obtain medical leave or limiting the employee's fitness to perform at work.
8. Insurance examination and other insurance requests: Disclosure to a sponsor, insurer, or administrator of a plan or policy from which a patient seeks coverage or benefits if the information was created as a result of the prior written request and expense of such person or entity to evaluate the application for coverage, and unless the practitioner/provider has been notified by the patient not to disclose the information. Disclosures to insurance institutions in situations not previously discussed are permitted only when the insurance company verifies that it has obtained the patient's prior authorization in accordance with Insurance Code 791 et seq.
9. Service Plans: Disclosure to prepayment health care service plans by practitioner/providers that contract with the plan. However, disclosure is limited to the purpose of administering the plan.
10. Probate Court Investigations: Disclosure to probate court investigators engaged in determining the need for an initial conservatorship or continuation of an existent conservatorship of information relevant to the patient's condition, care or treatment, if the patient is unable to give informed consent. Disclosure may also be made to a probate court investigator, probation officer of domestic relations investigator engaged in determining the need for an initial guardianship or continuation of an existing guardianship.
11. Donated Tissue: Disclosure to a tissue bank processing the tissue of a decedent for transplantation into another person's body but only with respect to the donating decedent, for the purpose of aiding the transplant.
12. Disaster Relief: Disclosure to State or federally recognized disaster relief organizations of basic information including the patient's name, city of residence, age, sex and general condition for the purpose of responding to disaster welfare inquiries.

D. The Patient Medical Record Release Form must include the following:

1. Handwritten or 8-point type
2. Plain language
3. Clearly separate from other language on the page and signed in a manner that serves no purpose other than execution of the authorization.
4. Date of Medical Record Release and specific date after which the practitioner/provider may no longer disclose the medical information.
5. Per the Insurance Information & Privacy Protection Act — the length of time the authorization shall remain valid, will be no longer than
    a) 30 months from the date the authorization is signed if the request involved life, health or disability insurance, and is for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for a change in policy benefits, or
    b) if the authorization is signed for the purpose of collecting information in connection with a claim for benefits either the term of coverage of the policy if the claim is for a health insurance benefit, or the duration of the claim if the claim is not for a health insurance benefit or the duration of all claims processing activity performed in connection with all claims for benefits made by any person entitled to benefits under a non—profit hospital service contract.
6. Names or functions of the persons or entities authorized to receive the medical information.
7. Types of persons, names or functions of the health care practitioner/provider that may disclose the medical information.
8. Nature of information authorized to be disclosed.
9. Specific purpose, use of and limitations on the use of the medical information by the authorized recipients.
10. Insurance institution or agent (if applicable) and identification by generic reference representative of the insurance institution to whom the individual is authorizing information to be disclosed
11. Advise of right to a copy of the Patient Medical Record Release Form
12. Completed and signed Patient Medical Record Release Form and the released patient information will be protected against their unauthorized use.

E. The Patient Medical Record Release Form may be signed and dated by any one of the following:

1. The patient (if a minor, only for medical services to which the minor can lawfully consent);
2. The legal representative of an incompetent or minor patient but not for services for which the minor can consent);
3. The spouse or the person financially responsible for the patient where the information is sought solely for the purpose of processing applications for dependant health care coverage;

4. The beneficiary or personal representative of a deceased patient.

F. A Specific Authorization Patient Medical Record Release Form is required to release some types of information (i.e., results of blood test for HIV, information/records concerning public social services, disclosure of information/records to the DHS concerning state health services, communicable diseases, and developmental disabilities, information/records pertaining to licensing, statistics, and adoptions, disclosure of information/records to public agencies pertaining to medical survey, workers-safety, or industrial accidents, investigation of on-the-job accidents or illness, patient discharge information for submission to the California Health Facilities Commission, medical information disclosed to, and for use by, the Insurance Commission, Division of Industrial Accidents, Worker's Compensation Appeals Board, DOI, or DOC, mental health information protected by the Lanterman-Petris Short Act and alcohol and drug abuse records) which are not covered by the Confidentiality of Medical Information Act.

1. Release of information must be documented in the patient medical records.
2. The documentation must include:
   a. date and circumstances under which disclosure was made,
   b. names and relationships to the patient, if any, of persons or agencies to whom disclosure was made,
   c. specific information disclosed.

G. Medical Record information will never be released via telephone by medical record personnel. Any discussion of a member's confidential medical information may be accessed via an analog cell phone; therefore, the member's name is to be protected from disclosure during such a conversation.

H. Patient medical records may be transmitted to a requesting physician or facility via facsimile machines making sure that the transmission is confidentially directed and received. Medical staff will verify the FAX telephone number with the recipient prior to sending the document, will attach a cover sheet explaining confidentiality of documents sent, and will verify receipt of document with recipient subsequent to sending the document. The FAX machine will be located in a secure area. Due to the breakdown of fax paper, faxed materials received must be photocopied prior to inclusion as part of the patient's record.

I. Computerized Medical Records
1. Appropriate steps will be taken to reduce the likelihood of record destruction and to back-up information adequately, such as anti-virus software, stringent protocols on data sharing and introduction of software programs, and off site, automatic tape back-up systems.

2. Physicians will implement a system for documenting corrections to computerized records, and make sure that no improper alterations are made, such as compact disc read-only memory (CD-ROM) systems that allow for automatic and tamper proof computer dating of subsequent entries.
3. An imaging mechanism will be implemented capable of copying signature documents.
4. Only authorized users are able to input data implementing security measures such as password protected and secure terminal location.
5. Computerized medical record storage should be only in systems that are protected against unwarranted third-party access.

J. Patients may request a copy of their medical record by completing and signing a Patient Medical Record Release Form and showing appropriate ID. Patient or patient designated representative access to their medical record must be permitted within 5 working days following receipt of the patient's written request.
1. If the patient requests copies, the practitioner/provider must ensure that the copies are transmitted within 15 days following receipt of the parent's written request.
2. If the record is voluminous or if the patient has been discharged from a licensed health facility within the preceding 10 days, the physician may, upon notification of the patient, have up to 30 days.
3. A minor (under 18 years of age) needs the consent of his/her parent or legal guardian unless the minors have a right to their own treatment consent. A minor with such rights will not be allowed to designate a representative if the practitioner/provider determines that access to a minor's medical record by that representative would have a detrimental effect on the practitioner/provider's professional relationship with the minor patient or would be detrimental to the minor's physical or mental well-being.
4. Proof of executor of estate is required if a relative of a deceased patient is requesting a medical record copy.

K. Patient access to medical records may be limited as follows:
1. Mental Health Record (including drug and ETOH abuse) when a practitioner/provider determines that there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of his or her own mental health record information, the practitioner/provider can refuse the patient access.
2. If the practitioner/provider denies access in this manner, the practitioner/provider must document the request and reason for refusal in the patient medical record and notify the patient of the denial and their right to designate another practitioner/provider for access to the patient's records.

L. Medical records

1. Original patient medical records will not be removed from the medical group except under court order or under special arrangements with the Director of Medical Records.
2. Patient medical records will be kept in a secure, confidential area.
3. Patient medical records will be retained indefinitely. Patient medical records may be converted to microfilm or computer disks for long term storage.

M. Practices regarding the collection, use and disclosure of medical information will be reviewed with this policy, and revised as necessary, annually.

The following in prohibited:

1. Negligent disposal or destruction of medical information
2. Intentional sharing, sale or use of medical information for any purpose not necessary to provide health services to the patient, except as otherwise authorized.
3. Practitioner requirement of members, as a condition to receiving health care services, to sign an authorization, release, consent to waiver permitting the disclosure of any medical information subject to confidentiality protections.
4. A physician or health care professional is prohibited from releasing medical information on a member's psychotherapy outpatient treatment to a requesting agent without a written request to the practitioner (specifying what the information will be used for and how long it will be kept) and a notice to the member (unless the member has signed a waiver of this notice requirement.

Responsibility/Department Linkages

1. Physician(s), nursing and office staff
2. All employees shall sign a confidentiality statement which shall be kept in the employee's file
3. QA Assessment Department

POLICY NUMBER	OS- L101
POLICY TITLE	**Confidentiality -- Fax**
INITIAL EFFECTIVE DATE	04/02
REVISION EFFECTIVE DATE (S)	08/02
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

Insure confidentiality of documents that are faxed.

Definitions

"Medical Information" means any individually identifiable information, in electronic or physical forms, in possession of or derived from a provider of health care, a health care service plan or a contractor regarding a patient's medical history, mental or physical condition, or treatment.

"Individually identifiable" means that the medical information includes or contains any element of personal identifying information, sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number of other information that, alone or in combination with other publicly available information, reveals the individual's identity.

Policy

Faxed documents shall be processed in a manner that protects the confidentiality of individually identifiable medical information.

Procedure

When transmitting a fax that contains individually identifiable medical information:

1. Verify the fax number.
2. Call and notify the addressee to expect the transmission.
3. Use a special fax sheet that includes a privacy statement.
4. Each sheet is marked as "Confidential".
5. Send the fax.
6. After the fax is sent, review the confirmation to ensure that all pages were received.
7. Periodically, update all fax numbers.
8. Store fax transmittal summaries and confirmation sheets for an audit trail.

Responsibility/Department Linkages
UM/CM Department, Provider relations, Claims

POLICY NUMBER	OS- L102
POLICY TITLE	**Sensitive Document Disposal**
INITIAL EFFECTIVE DATE	08/02
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

Dispose of confidential documents in an appropriate manner.

Policy

To dispose of patient identifiable materials to reduce the risk of inadvertent disclosure.

Procedure

1. Sensitive documents include any documents that contain patient identifiable material, i.e. bills with diagnosis, lab work, extra copies of reports, etc.
2. DO NOT dispose of confidential material in the trash.
3. Use a shredder or tear the documents into very small pieces.

Responsibility/Department Linkages

Any Department with patient identifiable materials.

POLICY NUMBER	OS- L103
POLICY TITLE	**Security Precautions**
INITIAL EFFECTIVE DATE	10/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

Protect office staff and allow patient to receive quality care with minimal threat against their personal well being and property

Policy

Provide a safe environment for staff and patients

Procedure

1) Identify office risk factors
2) Access control
    1. Key control for office
    2. Syringes, needles, medications in locked area
    3. Computer Security Plan
        a. Limit use to appropriate
        b. Use of passwords
        c. Protect against virus
        d. Physical protection of hardware
    4. Medical Records kept in a secure area
    5. Confidentiality of patient information
    6. Protect personal belonging in secure area

Responsibility/Department Linkages

Physician(s), nursing and staff. / Quality Assessment Department

POLICY NUMBER	OS-L104
POLICY TITLE	**Violence Precautions**
INITIAL EFFECTIVE DATE	10/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

Assessment of workplace violence

Definitions

Workplace violence is defined as "any physical assault, threatening behavior or verbal abuse" occurring in the work setting.

Policy

Provide a safe environment for staff and patients

Procedure

1) Each office should identify and discuss violent situations (disruptive patients, staff arguments) before they happen.

2) Develop a plan of action
   Who will be called the doctor, office manager and police?
   Who makes the call?

3) Have emergency numbers for staff to call - posted in visible area and easy to see.

Responsibility/Department Linkages

Physician(s), nursing and staff / Quality Assessment Department