CFP TECHNICAL ASSISTANCE BULLETIN

GUIDANCE ON CLIENT ACCESSIBILITY TO RECORDS

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INTRODUCTION:

Occasionally clients may ask for copies of or access to their case management records. The intent of this technical assistance bulletin is to clarify how Public Health Law (PHL) §18 and the Health Insurance Portability and Accountability Act (HIPAA) regulations may apply to your organization and the Community Follow-Up Program (CFP) staff, and to assist you in developing your own agency and program specific policy as it relates to client requests for access to case management records.

POLICY OVERVIEW:

Because CFP case managers are usually neither Licensed Clinical Social Workers (LCSW), mental health professionals, nor nurse/medical practioners, there are few clear rules regarding releasing the information in client charts. Conversely, the onset of HIPAA encouraged the notion that clients should have full access barring any issues that having the information might cause harm to them or their family members, or would interfere in a court, criminal or police matter. Case management best practice suggests that clients should be given access to their records unless otherwise indicated.

CFP Service Plans are case summaries of work including identified needs and goals, what was accomplished, what needs remain, new needs and how they will be addressed. A client should always be given a copy of the service plan. The Service Plan is a contract between the client and the case management program, and the client's signature indicates a willingness to try to work to accomplish identified goals.

Assessments, Reassessments and progress notes must be reviewed before being released. According to PHL §18, non-social worker notes do not have to be released. However, according to HIPAA regulations, a client does have the right to full access to the medical record. While the case management record is not a "medical record" as defined in HIPAA regulations, a client should have access. Progress notes should be factual, brief and informative so as to have a clear record of what the client need was, what the intervention was and any follow-up that occurred. They should be directly related to the goals and activities outlined in the service plan. They should never be judgmental or show bias on the part of the staff.

In case management, information prohibited from further disclosure is usually obtained from other agencies and may be included in the client record. That information must be redacted and not released by this program. Clients should be advised to contact those agencies directly.

The original record must never be given to the client. Records must be maintained for at least six years past case closure or three years past the minor's age of majority (age 21), whichever period is longer.

We encourage you to review the record with the client in person. If the client requests a copy of the record, your program may impose a "reasonable cost-based" fee, not in excess of seventy-five cents per page for copying expenses.

PUBLIC HEALTH LAW (PHL) §18

All health care facilities are subject to PHL §18, which requires that patients be given access to their records. While non-health care facilities are not subject to the PHL §18, some employees, such as licensed nurses or LCSWs are "practioners" as defined in PHL §18, and are subject to the PHL §18 regardless of the type of facility in which they work.

1. **Are there certain records that a case management provider is required to provide to a client upon request?**

An agency which is not a health care facility is not subject to Public Health Law (PHL) §18 requests for copies of records. Some employees, however, such as licensed nurses or clinical social workers (LCSW) are "practitioners" as defined in PHL §18, which mandates that patients be given access to their records. The record must qualify as "information concerning or relating to the examination, health assessment…or treatment of an identifiable subject maintained or possessed by a…health care practitioner who has provided or is providing services for assessment of a health condition…or has treated or is treating such subject…."

For programs that employ licensed nurses or LCSWs as case managers who write progress notes reflecting client contacts or advocacy related activities, these notes would not qualify as patient information and would not have to be disclosed if the notes were not written within the parameters of a licensed practitioner's scope of practice.

A nurse working as a case manager would not likely write notes that would be considered nursing progress notes, but each record should be reviewed to determine whether they contain nursing notes which are within the scope of PHL §18. The same cannot be said about the notes made by a LCSW who is keeping track of a client's progress. Education Law §7701 defines the practice of social work as including "community organization or administration of a social work program…in accordance with social work principles…for the purpose of helping individuals [and] families…to prevent or to resolve problems caused by social or emotional stress." Arguably, the progress notes made by a LCSW could be considered professional notes made within the scope of practice and therefore subject to PHL §18. While some of those notes might also be exempt from disclosure if they were "personal notes and observations," not all progress notes can be considered personal. A determination of whether a LCSW were working within the scope of his or her professional practice when writing progress notes could be made with certainty only by the Department of Education.

The records in issue also clearly contain "confidential HIV related information" as defined by §2780 (7) of the PHL §18. While a person in possession of confidential HIV related information may disclose that information to the subject of the information, a review of PHL §2782 (Confidentiality & Disclosure) reveals that such disclosure is not mandatory. However, since PHL §18 would require disclosure (with certain minor exceptions), the laws should be read in harmony and disclosure to the client at his/her request must generally be granted.

2. **Are there certain client records that a provider is obliged not to release to anyone, including the client?**

The client record often contains a composite of records from other agencies, practitioners and facilities. Given such a composite, it is assumed that there will be certain records which, pursuant to the Mental Hygiene Law, Probation Law or Social Services Law, are not to be released to anyone, including the subject, absent a court order. For example, the program may have records regarding possible child abuse in the subject's family, which is confidential pursuant to §422 of the Social Services Law.

You may wish to contact those State agencies from which you believe there will most frequently be records in clients' files (e.g., Department of Family Assistance, Department of Probation, Division of Parole, Office of Alcoholism & Substance Abuse Services and the Office of Mental Health), and ask each agency for guidance regarding prohibitions on disclosure of that agency's records.

As noted earlier, access to medical records is governed by PHL §18. That section provides that a patient generally may have access to his/her medical records except for:

a) Information regarding the individual's treatment in a substance abuse program, or by a facility licensed or operated by the Office of Mental Health;
b) Personal notes and observations of a health care provider, provided that the notes have not been disclosed by the practitioner to any other person;
c) Information maintained by the practitioner regarding the prior treatment or examination of the patient by another provider (such information may be requested from the prior practitioner by the patient); and
d) Data disclosed to a practitioner by a third party on the express condition that such information would not be disclosed to the patient or other persons, provided that the information has never been disclosed previously.

Information in the client's record which falls into any of these four categories should be reviewed carefully in determining what, if any, material in these categories should be given to the client. Any request for records held by the program but originating from another provider should be made by the client directly to his/her health care provider.

3. If a client dissociates from a case management provider and requests that all records be destroyed, should the provider oblige?

No. A program should not destroy a former client's records for at least six years after the termination of service. Such records provide documentation of services provided to the client that may be important to other providers and/or government agencies that have had contact or may have contact with the client in the future. In addition, if the client were ever to sue the program for any act or omission, the program's records would be crucial evidence.

4. For how long must a program maintain a client record after the case is terminated?

As noted above, client records should be maintained for a minimum of six years, but if the records pertain to a minor, the records should be kept for a minimum of six years or three years past the minor's age of majority (age 21), whichever period is longer. (The standard Appendix A of State contracts requires maintenance of records for six years for contract auditing purposes.)

HIPAA & RIGHT OF ACCESS TO HEALTH RECORDS

45 CFR Subpart E—Privacy of Individually Identifiable Health Information

§ 164.524 Access of individuals to protected health information

Right and Exceptions: HIPAA requires providers to give patients access to their own health records upon request. HIPAA also provides very specific procedures, which must be followed when processing a patient's request to see his or her health records. 45 C.F.R. § 164.524.

There are a few exceptions to the general right of access. Providers do NOT have to give patients access to:

1. Records that contain "psychotherapy notes."

   Psychotherapy notes are notes recorded in any medium "by a health care provider who is a mental health professional

documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record."

Excludes medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, and progress to date.

2. Information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding.

Procedural Requirements: When processing a patient's request to access his or her own records, a provider covered by HIPAA must comply with the following requirements:

1. Providers must act on a request for access no later than *30 days* after receipt of the request.

   - Providers have *60 days* if the requested information is not maintained or accessible at the provider's site.

   - If the provider is not able to act on the request within the required time period, it can have a one-time, 30-day extension if it provides a written statement explaining the delay and the date it will complete the request.

2. If the provider *grants* the request in whole or in part, it must inform the patient and provide the requested access.

   - The provider must provide the access, including inspection or obtaining copies or both.
   - The provider may provide a summary of the requested information in lieu of providing access, or may provide an explanation of the information, if the patient agrees in advance.
   - The provider must provide requested access in a timely manner and either arrange with the individual a convenient time and place to inspect or copy the information, or mail the information at the individual's request.
   - If the individual requests copies of the information or agrees to a summary or explanation of the information, the provider may impose a "reasonable cost-based" fee.

Denial of Access: HIPAA provides "unreviewable" and "reviewable" grounds for denying a patient access to his/her own records.

<u>Unreviewable</u> denial of access: A provider can deny the patient access *without* giving an opportunity for review in the following circumstances:

- The records contain psychotherapy notes or information compiled in anticipation of or for use in a civil, criminal, or administrative action.

- A correctional institution, or a health care provider acting under the direction of a correctional institution, may deny in whole or in part an inmate's request for protected information if obtaining the information would jeopardize the *health, safety, security, or rehabilitation* of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting the inmate.
- If the information is created or obtained in the course of *research* that includes treatment, then access may be *temporarily suspended* for the period the research is in progress, provided that the patient *agreed*

to the denial of access when consenting to participate in the research, and the provider or researcher informs the patient that the right to access will be reinstated upon completion of the research.

- The information is contained in records that are subject to the federal Privacy Act, 5 U.S.C. § 552a, and the denial of access meets the requirements of that Act.

- The information was obtained from someone other than a health care provider under a *promise of confidentiality* and the access would likely reveal the source of the information.

Reviewable denial of access: A provider can deny the patient access, as long as the patient is given a right to have the denial *reviewed* in the following circumstances:

- A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the *life or physical safety* of the patient or another person.

- The information refers to another person (who is *not* a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause *substantial harm* to such other person.

- Request for access is made by the patient's *personal representative* (includes a minor's parent or guardian), and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause *substantial harm* to the patient or another person.

If the provider denies a patient access on any of the above three *reviewable* grounds, the provider must:

1. To the extent possible, exclude only that information to which the provider has grounds to deny access, and provide access to any other requested information;

2. Provide a *written denial within 30 days* of the request, which explains the basis for the denial, a statement of the patient's review rights (see below), and a description of how the patient can complain to the provider or to HHS (must include the name or title and telephone number for the contact person for complaints).

3. If the provider does not maintain the requested information, but knows where the information is maintained, it must inform the patient where to direct his request for access.

If a patient is denied access on a *reviewable* ground, the patient has the right to have the denial reviewed:

1. The provider must designate a licensed health care professional who did not participate in the original decision to be the *reviewing official*.

2. A request for review must be "promptly referred" to the reviewing official.

3. The reviewing official must make a determination "within a reasonable period of time."

4. The provider must "promptly" provide the patient with a *written notice* of the determination.