Privacy & Security of Occupational, Behavioral & Deceased Patient Records

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Objectives

- **Occupational Health Records**
  - Roles & Challenges
  - Content
  - HIPAA or OSHA?
  - Authorizations & Disclosures
  - Retention
  - Scenarios

- **Behavioral Health Records**
  - Harm
  - Federal laws vs. North Carolina state laws
  - Health Information Exchange
  - Retention laws
  - Scenarios
  - Questions
Objectives Continued

- Deceased Patient Health Records
  - Standards
  - Challenges
  - Questions
“Information is powerful medicine”
OCCUPATIONAL HEALTH RECORDS
Occupational Health Records

• Definition
  – “…an occupation-related, chronological, cumulative record, regardless of the form or process by which it is maintained.”
  – Examples: paper document, microfiche, microfilm, automatic data processing media

• Alternate Terms
  – Occupational Health Record
  – Occupational Medical Record
  – Employee Health Record
  – Acronyms: OHR, OMR, EMR, EHR
Occupational Health Records

• Roles
  – Employer
  – Employee / Patient
  – Healthcare Provider
  – Health Plan

• Challenges
  – Application of regulations
  – Ownership of occupational records
  – Sharing of information
  – Management of records
  – HIEs
  – Patient portals
  – External reporting
## Occupational Health Records

### Documentation
- Identify the patient
- Record patient information during or post visit
- Legibly sign, date and time stamp
- Secure the information

### Content
- Drug testing forms and results
- Immunization records
- Medical certifications / recertifications
- Occupational and medical history
- Medical complaints resulting from workplace exposure or injury
- Provider opinions and recommendations
- Employee health department recommendations
- Results of exams and tests
- Progress notes from rehab
- Refusals to be examined/tested
- Wellness program participation
- Workers’ compensation and insurance records
- OSHO information
## Occupational Health Records

**OHRs Do **NOT** contain:**

- Non-work related patient health information
- Environmental hazard records
- Employee assistance program records
- Substance abuse records
- Workers’ compensation***
Occupational Health Records

- Health risk assessments
- Weight loss
- Nutrition classes
- Diabetes management classes
- Company gym with personal trainers
- External gym memberships at a discounted or paid rate
- Tobacco cessation
- Preventative services
Occupational Health Records

• HIPAA or OSHA?
  – Providers who are the employer and treat their own employees are not covered by HIPAA; they are covered by OSHA

• Ask the following questions prior to a patient being treated:
  – Is the healthcare provider providing services as an occupational health service provider to his/her employees?

    OR

  – Is the healthcare provider providing services to an external entity’s employees?
Occupational Health Records

- **Employees rights:**
  - Access
  - Examination
  - Photocopy
  - Management of use and disclosure

- **HIPAA regulation 45 CFR 164.512**
  - The patient must be a past or present member of the employer
  - Purpose of disclosure: (1) to conduct an evaluation
    (2) to evaluate whether the individual has a work-related illness or injury

- **Aggregated data**
  - De-identified
  - Contract
Occupational Health Records

• Questions to ask prior to disclosing information:
  – Is individually identifiable PHI present within the disclosure?
  – Has the patient signed a valid authorization?
  – Is the disclosure permitted or required?
  – Does the minimum necessary standard apply?
  – Are there any additional federal or state laws applicable to the disclosure?

• No Authorization Required
  – Government officials investigating employer compliance (i.e. ADA, FMLA, OSHA, EEOC)
  – Worker’s Compensation

• Authorization Required
  – Requests for external disclosure of patient occupational health information that do not fall into categories identified elsewhere
Occupational Health Records

• **Minimum Necessary**
  – “Protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.”

• **Safeguards**
  – Role-based access to information
  – Routine access audits
  – Administrative, physical, and technical safeguards
  – Random OHR reviews for accurate and complete documentation
  – Review of federal and state privacy and security regulations

• **Retention:** 30 years after termination of employment
OHR Scenario 1

- A healthcare provider renders occupational health services at a clinic site.

1. Who owns the records?
   The provider

2. Is the provider subject to HIPAA regulations?
   Yes

3. Can the provider distribute copies of the personal health information to the employer? Why or why not?
   No
OHR Scenario 2

- A healthcare provider renders occupational health services at the employer’s site.

1. Who owns the records?
   The employer

2. Is the provider subject to HIPAA regulations?
   OSHA
OHR Scenario 3

- A patient presents to a healthcare provider for an employer-required fitness exam. The patient completes a short medical history and review of systems form. On this form, the patient discloses that he has an unrelated chronic illness for which he is receiving treatment. The condition is currently under control and does not affect his ability to perform job-related functions. The provider has been requested by the employer to complete a short exam form indicating whether the employee is cleared for duty. The patient has signed an authorization allowing for this limited information to be disclosed to the employer.

Should the provider disclose the chronic condition to the employer?
No
BEHAVIORAL HEALTH RECORDS
Behavioral Health Records

• **Examples of Harm**
  – Social stigma
  – Employment discrimination
  – Insurance discrimination
  – Possible criminal prosecution
  – Job termination
  – Forfeiture of legal protections

• **Consumers want providers that are involved in their care to have access to the behavioral records**
  – Patients may fear unauthorized disclosures and deny or neglect treatment
  – Repercussions for damage done provides no relief
Behavioral Health Records

- Federal laws governing disclosure of mental illness & substance use disorders
  - HIPAA
  - 42 C.F.R. Part 2
  - Family Education Rights and Privacy Act
  - Medicaid Law

- State laws governing disclosure of mental illness & substance use disorders
  - North Carolina Mental Health Act
Behavioral Health Records

- HIPAA
  - Health plans, health care clearinghouses, and healthcare providers protected
  - Disclose information for treatment, payment and healthcare operations
  - Minimum necessary
    - Does not apply to a request for information intended for treatment purposes
  - More stringent state and federal laws apply
Behavioral Health Records

• HIPAA & Psychotherapy Notes
  – Greater protection
  – Definition
    – “Notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separate from the rest of the individual’s medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.”
    – Must separate psychotherapy records from all other behavioral health records
Behavioral Health Records

• 42 C.F.R. Part 2
  – The Federal Confidentiality of Alcohol and Drug Abuse Patient Records law
  – Greatest impact on sharing PHI related to behavioral health
  – Disclosure of PHI for federally assisted alcohol and drug programs is prohibited
  – Disclosure
    – Communication of patient identifying information
    – Verification of a person’s communication of patient identifying information
    – The communication of any information from the record of a patient who has been identified
  – Disclosure without Authorization
    – Medical emergencies
    – Research activities
    – Audits
### Behavioral Health Records

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<td>– Protects student education records</td>
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<td>– Enables:</td>
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<td>  – Access to student records</td>
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<td>  – Prevents third party access</td>
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<td>  – Prohibits the record release without consent</td>
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<td>  – Enables amendments</td>
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<th><strong>• Medicaid Privacy Statute</strong></th>
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<td>– Not interpreted</td>
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Behavioral Health Records

- Four types of state laws governing the privacy of mental health records, dependent upon setting:
  - Records in mental hospitals
  - Records in mental health programs
  - Records for patients involuntarily committed to mental institutions
  - Records for patients receiving mental health treatment in any setting
Behavioral Health Records

• **North Carolina Mental Health Act**
  – Permits the disclosures of confidential mental health information with the consent of the client or his legally responsible person

  – Mental health information permitted for disclosures without client’s consent:
    – To the extent necessary for a facility to fulfill its treatment responsibilities to the client
    – To a healthcare provider who is providing emergency care to the client
    – To referring physicians and psychologists upon specific request
    – The fact of a client’s admission or discharge to the client’s next of kin whenever the responsible professional believes the disclosure is in the best interest of the client
    – To enable the internal client advocate to fulfill her monitoring and advocacy functions
    – In response to a court order compelling disclosure of the confidential mental health information
Behavioral Health Records

Continued…

- If a court orders a mental examination of a criminal defendant, the results of the examination must be sent to the clerk of court, to the district attorney or prosecuting officer, and to the client's attorney.

- If determined by the facility director to be in the client's best interests, the facility may disclose the confidential mental health information necessary to file a petition for involuntary commitment or for an adjudication of incompetency and the appointment of a guardian for the client.

- In competency or commitment hearing, the results of mental examinations must be sent to the client's attorney, the attorney representing the State, and to the court.

- To an attorney who represents the facility or a facility employee, if such information is relevant to litigation, to the operations of the facility, or to the provision of services by the facility.

- To the Department of Correction when an inmate is determined to be in need of treatment for mental illness.
Behavioral Health Records

- Continued…
  - If the responsible professional believes there is an imminent danger to the health or safety of the client or another person
  - If the responsible professional believes the commission of a felony or violent misdemeanor is likely
  - To the Department of Health and Human Services for the purpose of indexing clients
  - To contract support services, if the contract service agrees in writing to maintain confidentiality
  - To State and federal agencies to determine the client’s eligibility for financial benefits
  - For research, clinical and administrative audits and quality assurance purposes
Behavioral Health Records

• **Psychotherapist / Client Privilege**
  – Does not prevent psychologists and therapists from reporting child or disabled adult abuse or neglect
  – Provider must obtain a HIPAA compliant authorization to release notes
    – Exceptions:
      – Use of the notes by the originator for treatment purposes
      – Use or disclosure of the notes by the covered entity for its own training programs
      – Use or disclosure of the notes by the covered entity to defend itself in a legal action or other proceeding brought by the individual to whom the notes refer, and
      – As otherwise expressly required by law
Behavioral Health Records

- **Substance Abuse Records**
  - Federal and State law restrict disclosure of information about clients receiving drug or alcohol treatment
  - Cannot assume use and disclosure of such records is for TPO
  - Disclosure without client/responsible person consent:
    - To medical personnel to the extent necessary to meet a bona fide medical emergency
    - To FDA personnel who assert a reason to believe that the health of a client may be threatened by an error in the sale, manufacture, or labeling or a product
    - To qualified individuals conducting scientific research, management or financial audits, or program evaluation, provided the identity of individual clients is not disclosed in any reports resulting from these studies
    - If authorized by court order, granted after application showing “good cause” for the disclosure
  - Redisclosure of confidential substance abuse information is prohibited without consent
Behavioral Health Records

• Continued…
  – Minor Clients
    – Minor must consent to disclosures of confidential information
Behavioral Health Records

- “Separate may not be equal”

- “Recent initiatives like interoperable implementation of electronic health records (EHRs) and the development of Health Information Exchanges has made it possible for behavioral and physical health providers to exchange information...Privacy, security, policy, compliance, and other barriers have made the wide exchange of this type of sensitive information difficult...”

- No meaningful use incentives
  - 2 bills to advocate for equality for meaningful use incentives: S.539 & H.R. 6043
### Behavioral Health Records

#### Health Information Exchanges
- Programmed to follow HIPAA
- 42 C.F.R. Part 2 is more stringent and requires
  - Reason for sharing information
  - Who specifically can have access to the patient information
    - Pre HIE world: identify name, title, organization

#### Tagging metadata
- Confidential or not confidential?
- When does the sharing of the data expire?
- What providers may access information?
- No standards established
Behavioral Health Records

- Direct Messaging
  - Supported by the ONC
  - Allows sharing of information to coordinate care with medical partners and improves quality of care provided to the patients
  - [http://directproject.org/](http://directproject.org/)

*The Direct Project Abstract Model*
BHR Scenario

- A woman arrives to the emergency room unconscious from a car accident. The woman must immediately have surgery due to multiple fractures. Her daughter presents to the provider to inform him that she has been prescribed a long-acting opiate antagonist to treat her alcohol dependence. If true, the woman may not respond to the normal course of analgesics and could be undertreated for pain caused by the fractures. The physician needs to know the name of the medication, the time of the last administration, and the lady's medical compliance of the drug. The provider calls the substance abuse treatment program...

1. Will the provider be able to receive the information needed from the substance abuse treatment program?
   - Yes
2. Why?
## BHR Question 1

- This regulation creates major barriers for the sharing of alcohol and substance abuse information in a health information exchange because it restricts sharing information for treatment, payment, and healthcare operations

(A) HIPAA

(B) 42 C.F.R. Part 2

(C) Medicaid Law

(D) Family Education Rights and Privacy Act
BHR Question 2

What does the tagging of metadata refers to?

(A) Identifies expiration dates and the specific provider information it can be shared with

(B) Identifies if a HIE meets HIPAA compliance

(C) Informs the provider of information received via HIE

(D) Sharing of information through Direct Messaging
BHR Question 3

• There is a higher incidence of readmission for patients whose behavioral health records were not shared in an inpatient setting.

TRUE
OR
FALSE
DECEASED PATIENT HEALTH RECORDS
Deceased Patient Health Records

• **Standard 164.502 (f)**
  - A covered entity **must** comply with the requirements of the HIPAA Omnibus Rule in regards to the protected health information of a deceased individual for a period of 50 years **following death** of the individual.

• **The most stringent law always trumps**
  - “the concerns regarding protected health information about decedents that is sensitive, such as HIV/AIDS, substance abuse, or mental health information, or that involved psychotherapy notes, the 50-year period of protection for decedents health information under the Privacy Rule does not override or interfere with state or other laws that provide greater protection for such information, or the professional responsibility of mental health or other providers.”
Deceased Patient Health Records

- **Standard 164.510 (b)**
  - A covered entity may disclose PHI to persons involved in the deceased patient’s care or payment unless a previously expressed preference of the individual is known.

- **Not a record retention policy**

- **Challenges**
  - Determining the date of death of an individual
  - One cannot assume based on the age of the patient’s health record
  - Accounting of disclosures must remain as long as the records are maintained
DPR Question 1

• If the patient didn’t die at your facility, what type of documentation should be required to validate the patient’s death?

**ANSWER:** death certificate, obituary
DPR Question 2

• May a covered entity disclose a deceased patient’s PHI to a close personal friend who was involved with the individual’s health care or payment related to the individual’s health care?

ANSWER: Yes
DPR Question 3

- A decedent’s sister is asking about medical history of her brother. Can a covered entity release the PHI?

ANSWER: No
QUESTIONS?
References


References Continued