PURPOSE

To outline Agency's assessment of its functions and related information management needs.

POLICY

Agency leaders will be responsible for planning and designing information management processes to meet internal and external needs and for participating in an ongoing monitoring of the effectiveness of the process(es).

PROCEDURE

1. Agency leaders and other appropriate staff will assess Agency's information management needs based on its:
    - Mission,
    - Goals,
    - Care,
    - Personnel and their needs,
    - Service delivery environments,
    - Resources, and
    - Access to affordable technology.
2. Agency leaders and other appropriate staff will design, plan, select, and integrate an information management system that is interactive with both patient care and Agency operational information.
3. When designing, planning, and/or selecting an information management system, consideration will be given to:
    - Uniform data definition,

- Uniform method for collecting data, and
- Standardization with internal and external sources of minimum data sets, codes, classifications and terminology.

ACCESSING INFORMATION RESOURCES

PURPOSE

To ensure Agency staff has access to internal/external knowledge-based information and databases.

POLICY

Agency leaders will identify and attempt to provide databases and expert knowledge-based resources to all staff on a timely basis in order to meet Agency's information management needs. The needs may include but not be limited to management/operations, patient care, performance improvement and patients/caregivers. Data bases will be initiated and maintained to ensure the available knowledge-based resources are up-to-date

PROCEDURE

1. Information management needs will be assessed by appropriate Agency staff and prioritized for access.

2. Agency will attempt to provide the resources needed to access the appropriate external database/expert knowledge-based resource.

3. Relationships will be initiated and maintained with external organizations that facilitate information accessibility (e.g., university libraries, professional video/information lending organizations, National Hospice Organization, Hospice State Association, regional networks, etc).

4. A system for organizing, locating, using and sharing resources utilized by Agency staff will be maintained with current literature.

5. A listing of community resources, including phone numbers, will be initiated and maintained for all Agency staff use.

PURPOSE

To provide for the interfacing of accurate, complete, valid, reliable and consistent standardized information/data Agency-wide.

POLICY

Agency will provide patient care, organizational and management information/data that can be interfaced and utilized throughout all Agency departments and with all patient care providers.

PROCEDURE

I. Each department will identify informational needs and the appropriate staff responsible for generating needed information/data.

II. Agency will develop functions to:

   A. Coordinate collection of information,

   B. Make information available from one system,

   C. Organize data,

   D. Analyze data,

   E. Interpret/clarify the information,

   F. Provide and access long-term information.

III. Agency will identify and define all abbreviations and coding systems (i.e., CPT, ICD-10, etc.) to be used by all Agency staff.

IV. Appropriate Agency staff will receive training and education regarding Agency's abbreviations and coding systems.

V. Agency's abbreviations will be updated as needed.

VI. Agency will maintain current coding system material.

VII. Agency will implement the above processes and evaluate for effectiveness.

ACCEPTABLE ABBREVIATIONS	
A	Assessment
A & P	Anterior and Posterior
AAROM	Active Assist range of Motion
Abd	Abdomen
ABG	Arterial Blood Gases
ABH	Ativan/Benadryl/Haldol
ABS	Active Bowel Sounds
abx	Antibiotic
a.c.	Before meals
AD	Assistive Device
ad lib	As desired
Add	Address
Adeq	Adequate
ADL	Activities of Daily Living
Adm	Admitted, Admission
AHR	Apical heart rate
ALF	Assisted Living Facility
Alk Phos	Alkaline Phosphatase
a.m.	Morning
AMA	Against Medical Advice

ACCEPTABLE ABBREVIATIONS	
Amb	Ambulatory
Amt	Amount
Anes	Anesthesia
AODM	Adult Onset Diabetes Mellitus
AP	Anteroposterior
APGAR	Cry, reflexes, color, respirations of newborn
Approx	Approximately
APROM	Active/Passive range of motion
AROM	Active range of motion
ASAP	As soon as possible
Asp, ASA	Aspirin
ASHD	Arteriosclerotic Heart Disease
AUR	Acute Urinary Retention
Ax	Axillary
B & B	Bowel and Bladder
Bact	Bacteria
BAL	Balance
Baso	Basophil
BBB	Bundle Branch Block
BE	Barium Enema
bid	Twice a day
Bilat	Bilateral

ACCEPTABLE ABBREVIATIONS	
Bili	Bilirubin
BKA	Below knee amputation
BLE	Bilateral lower extremity
BM	Bowel movement
BMI	Body Mass Index
BMR	Basal Metabolic Rate
BP	Blood pressure
BPH	Benign prostatic hypertrophy
BR	Bed rest
BRP	Bathroom privileges
BS	Blood sugar
BSC	Bedside commode
BSD	Bedside drainage
BSO	Bilateral salpingo-oophorectomy
BUE	Bilateral upper extremity
BUN	Blood urea nitrogen
Bx	Biopsy
c	With
C	Centigrade or Celsius
CA, ca	Carcinoma
Cal	Calorie
CAD	Coronary Artery Disease

ACCEPTABLE ABBREVIATIONS	
Cath	Catheter
CBC	Complete Blood Count
cc	Cubic centimeter
CC	Chief Complaint
CCU	Coronary Care Unit
CDI	Clean, dry, intact
CG	Caregiver
CGA	Contact Guard Assist
CHF	Congestive Heart Failure
CHO	Carbohydrate
cm	Centimeters
CM	Case Manager
CNA	Certified Nurse Assistant
CNS	Central Nervous System
c/o	Complains of
CO2	Carbon Dioxide
cont	Continue
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardiopulmonary resuscitation
CRNA	Certified Registered Nurse Anesthetist
C-Section	Caesarean Section
CSR	Central Service

ACCEPTABLE ABBREVIATIONS	
CVA	Cerebrovascular Accident
CVP	Central Venous Pressure
Cysto	Cystoscopy
D & C	Dilation and Curettage
da	Day
DBP	Diastolic Blood Pressure
d/c	Discontinue
D/C	Discharge
Dec	Decrease
Del	Delivery, Delivered
Delta symbol (Δ)	Change
DEP	Dependent
Dept	Department
DF	Dorsiflexion
Dk	Dark
DKTC	Double Knee to Chest
DM	Diabetes Mellitus
DNR	Do Not Resuscitate
DOA	Dead On Arrival
DOD	Date of Death
DON	Director of Nurses
DPOA	Durable Power of Attorney

ACCEPTABLE ABBREVIATIONS	
Dr.	Doctor
Drsg.	Dressing
DSD	Dry sterile dressing
DTI	Deep tissue injury
d/t	Due to
Dtr.	Daughter
Dx	Diagnosis
Dx & Rx	Diagnosis and Treatment
EBL	Estimated Blood Loss
ECG, EKG	Electrocardiogram
EDC	Estimated date of confinement
EEG	Electroencephalogram
EENT	Ear, eye, nose and throat
EGD	Esophagogastroduodenoscopy
EMS	Emergency Medical Services
EOB	Edge of Bed
Eos	Eosinophil
Ep	Epithelial
ER	Emergency Room
ES	Endstage
Estim	Electrical Stimulation
etc.	And so forth

ACCEPTABLE ABBREVIATIONS	
Eval	Evaluation
Exc	Excision
Exs	Exercises
Ext	Extremities
EXT	Extension
Extr	Extraction
F	Female
F°	Fahrenheit degrees
FAST	Functional Assessment Staging Tool
FB	Foreign body
FBS	Fasting Blood Sugar
FC	Foley Catheter
Fe	Iron
FF	Force fluids
FH	Family history
FHM	Fetal heart monitor
FHR	Fetal heart rate
FHT	Fetal heart tone
FLEX	Flexion
FSBS	Finger Stick Blood Sugar
ft	Foot
F/U, f/u	Follow-up

ACCEPTABLE ABBREVIATIONS	
FUO	Fever of undetermined origin
FWB	Full Weight Bearing
FWW	Front Wheel Walker
Fx	Fracture
gal	Gallon
GB	Gallbladder
Gen	General
GI	Gastrointestinal
gm	Gram
gr	Grain
Grav	Gravida
gtts	Drops
GTT	Glucose Tolerance Test
GU	Genitourinary
GUI	Genitourinary infection
GYN	Gynecology
H & H	Hemoglobin and hematocrit
H & P	History and physical
H2O	Water
H2O2	Hydrogen peroxide
HA	Headache
Hct	Hematocrit

ACCEPTABLE ABBREVIATIONS	
HCVD	Hypertensive Cardiovascular Disease
HBP	High blood pressure
HCO3	Bicarbonate
HEENT	Head, ear, eye, nose, throat
HEP	Home Exercise Program
Hgb	Hemoglobin
HHA	Home Health Aide
HIPAA	Health Information Portability Accountability Act
HOB	Head of bed
hr	Hour
HR	Heart rate
HS	Bedtime
Ht	Height
HTN	Hypertension
HW	Hemi Walker
Hx	History
I	Independent
IADL	Instrumental Activities of Daily Living
ICF	Intermediate Care Facility
ICP	Intracranial pressure
ICU	Intensive Care Unit
ID	Intradermal

ACCEPTABLE ABBREVIATIONS	
IDT	Interdisciplinary Team
I & D	Incision and drainage
IH	Inguinal hernia
IM	Intramuscular
Imp	Impression
Inc	Increase
INH	Isoniazide
Insuff	Insufficiency
Int	Internal
I & O	Intake and Output
IPPB	Intermittent Positive Pressure Breathing
irr	Irregular
Isol	Isolation
IV	Intravenous
IVF	Intravenous fluids
IVP	Intravenous Pyelogram
IVPB	Intravenous fluids piggyback
IVH	Intravenous hyperalimentation
IUD	Intrauterine device
Juv.	Juvenile
K	Potassium
KCL	Potassium Chloride

ACCEPTABLE ABBREVIATIONS	
Kg.	Kilogram
KUB	Kidney, Ureter, Bladder (X-ray)
KVO	Keep vein open
L	Liter
lab	Laboratory
lac	laceration
lap	Laparotomy
LAQ	Long Arc Quads
lat	Lateral
lb	Pound
LCSW	Licensed Certified Social Worker
LCTA	Lungs clear to auscultation
LDH	Lactic Dehydrogenase
LE	Lupus Erythematosus
Liq	Liquid
Lg	Large
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LP	Lumbar puncture
lpm	Liters per minute

ACCEPTABLE ABBREVIATIONS	
LPN	Licensed Practical Nurse
LOA	Left Occiput Anterior
LOB	Loss of Balance
LoN	Low sodium
LS	Long Standing
lt.	Left
LTCF	Long term care facility
LTL	Laparoscopic Tubal Ligation
LTR	Lower Trunk Rotations
LUE	Left Upper Extremity
LUL	Left upper lobe
LUQ	Left upper quadrant
LVH	Left ventricular hypertrophy
LVN	Licensed Vocational Nurse
Lymph	Lymphocyte
Lytes	Electrolytes
(m)	Murmur
M	Male
MAR	Medication administration record
MAX	Maximum assist
M.D.	Medical Doctor
meas.	Measure

ACCEPTABLE ABBREVIATIONS	
mec.	Meconium
Med	Medication
Mets	Metastatic disease/process
mg	Milligram
MI	Myocardial Infarction
MI	(Therapy) Modified Independent
Min	Minute
MIN	Minimum Assist
ml	Milliliter
mm	Millimeter
MN	Midnight
mo	Month
MOD	Moderate assist
MOM	Milk of magnesia
Mono	Monocyte
MPOA	Medical Power of Attorney
MR	Medical record
MSS	Medical Social Services
MSW	Medical Social Worker
N/A	Not applicable
Na	Sodium
NaCl	Sodium Chloride (salt)

ACCEPTABLE ABBREVIATIONS	
NC	Nasal cannula
neb	Nebulizer
Neg	Negative
NF	Nursing facility
N/G	Nasogastric tube
NH	Nursing home
NKA	No known allergies
NKDA	No known drug allergies
No.	Number
Noc	Night
NPI	National Provider Identifier
NPO	Nothing by mouth
NR	Non-reactive
NS	Normal saline
Nsg	Nursing
NSR	Normal sinus rhythm
NT	Not tested
N/V	Nausea and vomiting
N/V/D	Nausea, vomiting and diarrhea
NWB	Non-Weight Bearing
O	Objective
O2	Oxygen

ACCEPTABLE ABBREVIATIONS	
O & P	Ova and parasites
OA	Occiput Anterior
OB	Obstetrics
obt.	Obtained
O/C	On Call
occ	Occasional
O.D.	Right eye
oint	Ointment
OOHDNR	Out of hospital do not resuscitate
Op	Operation
OOB	Out of bed
O.P.	Out patient
OR	Operating Room
O.S.	Left eye
O.T.	Occupational Therapy/Therapist
OTA	Occupational Therapy Assistant
O.U.	Both eyes
oz.	Ounce
p	After
P	Pulse
pc	After meals
Pap	Papanicolaou Stain Test

ACCEPTABLE ABBREVIATIONS	
PAT	Pre-admission testing
PCG	Primary Caregiver
PCN	Penicillin
PE	Physical examination
Ped.	Pediatrics
PERLA	Pupils equal, reactive to light and accommodation
per	By
PF	Plantar Flexion
PH	Past history
pH	Acidity
PHI	Personal Health Information
PI	Performance Improvement
PID	Pelvic Inflammatory Disease
p.m.	Evening
PLOF	Prior Level of Function
PMH	Past medical history
PMC	Post Mortem Care
PMS	Pre-menstrual Syndrome
p.o.	By mouth
P.O., T.O.	Phone/telephone order
POA	Power of Attorney
POC	Plan of care

ACCEPTABLE ABBREVIATIONS	
POMR	Problem-oriented medical record
Pos	Positive
Poss	Possible
PP	Post Partum
PPBS	Post prandial blood sugar
PPD	Tuberculin test
PR	Per rectum
Pre op	Before surgery
Preg	Pregnancy
PRN, prn	As necessary or as needed
prob	Probable
PROM	Passive range of motion
Pt	Patient
pt.	Pint
P.T.	Physical Therapy
PT	Prothrombin Time
PTA	Physical Therapy Assistant
PTT	Partial Thromboplastin Time
PVC	Premature ventricular contractions
PWB	Partial Weight Bearing
q	Every
q3h, q4h	Every 3 hours; every 4 hours

ACCEPTABLE ABBREVIATIONS	
q am	Every morning
QAPI	Quality Assurance Performance Improvement
QC	Quad Cane
qd	Once a day
qh	Every hour
qhs	At bedtime
qid	Four times a day
qns	Quantity not sufficient
QOD, qod	Every other day
QOL	Quality of Life
QOW, qow	Every other week
q pm	Every evening
qs	Quantity sufficient
qt	Quart
R	Rectal
R, Resp	Respiration
RBC	Red blood count
RBS	Random blood sugar
Rec	Recovery
Reg	Regular
Rh	Rhesus blood factor
RHV	Routine home visit

ACCEPTABLE ABBREVIATIONS	
R - L	Right to left
RL	Ringers Lactate
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
Rm	Room
RML	Right middle lobe
RN	Registered Nurse
R/O	Rule out
ROM	Range of motion
ROS	Review of systems
RSO	Right salpingo oophorectomy
RSR	Regular sinus rhythm
Rt., rt	Right
r/t	Related to
R.T.	Respiratory Therapy
RTC	Return to Clinic
RTH	Return to hospital
RUE	Right Upper Extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RW	Rolling Walker

ACCEPTABLE ABBREVIATIONS	
Rx	Prescription
s̄	Without
S	Subjective
S & A	Sugar and Acetone Test
S & K	Sugar and Ketone Test
SAQ	Short Arc Quads
SB	Stillborn
SBA	Stand-by assist
SBP	Systolic Blood Pressure
SCTA	Sterile Cotton tipped Applicator
Seg	Segment
SGOT	Serum Glutamic-Oxaloacetic Transaminase
SGPT	Serum Glutamate Pyruvate Transaminase
SH	Social history
SKTC	Single Knee to Chest
sl	Sublingual
SLR	Straight Leg Raises
SLS	Single Leg Stance
sm	Small
SMA	Serum Multiple Analysis
SN	Skilled Nurse
SNF	Skilled Nursing Facility

ACCEPTABLE ABBREVIATIONS	
S/O	Significant Other
SOB	Shortness of Breath
SOC	Start of Care
Sp	Specific
SPC	Single Point Cane
Spec	Specimen
Sp. gr.	Specific gravity
S/P	Status post
spont	Spontaneous
SQ	Subcutaneous
SR	Sustained release/side rails
s/s	Signs/symptoms
SSD	Social Security Disability
SSE	Soap suds enema
SSI	Social Security Income
ST/SP/SLP	Speech Therapist
ss, ss	One-half
Subq	Subcutaneous
Surg	Surgery
T, Temp	Temperature
T & A	Tonsillectomy and adenoidectomy
T & C	Type and crossmatch

ACCEPTABLE ABBREVIATIONS	
Tab	Tablet
TAH	Total abdominal hysterectomy
TB, TBC	Tuberculosis
tbs	Tablespoon
TCDB	Turn, cough, deep breathe
tid	Three times daily
TIA	Transient ischemic attack
tntc	Too numerous to count
TAO	Triple Antibiotic Ointment
TO	Telephone order
tol	Tolerate
TOT	Total assist
TPN	Total parenteral nutrition
TPR	Temperature, pulse, respiration
tsp	Teaspoon
TUR	Transurethral Resection
TURP	Transurethral Resection of Prostate
TW	Talked with
TWE	Tap water enema
Tx	Therapy, treatment
U/A, UA	Urinalysis
UD	Unit Dose

ACCEPTABLE ABBREVIATIONS	
UE	Upper Extremity
UGI	Upper gastrointestinal
umb	Umbilicus
ung	Ointment or unguent
unk	Unknown
UPIN	Unique Physician Identification Number
URI	Upper respiratory infection
UT	Urinary tract
UTA	Unable to assess
UTI	Urinary tract infection
Vag	Vaginal
VC	Volunteer Coordinator
Vd	Void
V.D.	Venereal disease
VDRL	Test for venereal disease
via	By way of
V.O.	Verbal order
Vol	Volume
VS	Vital signs
W	White
WBC	White blood count
wc	Wound care

ACCEPTABLE ABBREVIATIONS	
W/C	Wheel chair
WD	Well developed
W/D	Warm and dry
WFL	Within functional limits
Wk	Week
WN	Well Nourished
WNL	Within normal limits
wt.	Weight
X	Times
yo	Year old
yr	year
4WRW	Four Wheel Rolling Walker

Symbols	
0	No, none
=	Equals
+	Positive/plus
-	Negative/minus
♀	Female
♂	Male
>	is greater than
<	is less than
↓	lowering, decrease
↑	rising, increase
2º	secondary
ʒ	dram
oz	ounce
#	number
@	at
+ or &	and
✓	check
◦	degree

Roman Numerals	
1.	I.
2.	II.
3.	III.
4.	IV.
5.	V.

COMPARATIVE USE OF DATABASES

PURPOSE

To establish guidelines for use of and contribution to external databases.

POLICY

Agency's information management system will attempt to reference external databases for comparative purposes as well as providing the means for Agency to contribute to databases when required by law or regulation. Throughout these exchanges of information, the system will maintain the confidentiality of patient identity.

PROCEDURE

1. Agency will maintain confidentiality of patient identity throughout information comparison with external reference databases. (May be obtained through National Hospice & Palliative Care Organization, State's Hospice Organization), and other sources for hospice data.

2. Agency may assess its scope of care and the availability of external reference databases for comparative data opportunities.

3. Agency may identify appropriate comparative data opportunities for identifying deviations from expected trends and establish a system to access data for performance improvement activities.

4. Agency may identify appropriate comparative data opportunities as well as those required by law or regulation and contribute as indicated.

PURPOSE

To ensure the confidentiality, security and integrity of information in accordance with applicable federal and state laws and regulations.

POLICY

I. The Agency will ensure that all patient identifiable information in the clinical record will remain confidential and will be secured and controlled whether in hard copy or in electronic format in compliance with the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as well as other Federal and State regulations and their revisions, as applicable.

II. Protected Health Information (PHI) is defined as any of the following that could identify an individual:

A. Name

B. All geographical identifiers small than a state

C. Dates (other than year) directly related to an individual

D. Phone numbers

E. Fax numbers

F. Email addresses

G. Social Security numbers

H. Medical record numbers

I. Health insurance beneficiary numbers

J. Account numbers

K. Certificate/license numbers

L. Full face photographic images and any comparable images

M. Any other unique identifying numbers, characteristic, or code except the unique code assigned by the investigator to code the data

III. All employees, contractors, Board of Directors members and IDT members will treat the following information concerning patient/client care/service with the utmost confidentiality:

A. Paper, electronic and computerized information

B. Telephone and cell phone communications

C. Verbal communications

D. Faxed information

PROCEDURE

I. Access to Information

A. The Agency shall provide all current employees with training on the HIPAA Privacy Rule.

1. All new employees shall receive privacy training during their orientation.

2. If the Agency changes its policies and procedures related to confidentiality, security and integrity of information, all employees shall receive retraining.

3. All privacy orientation and retraining shall be documented in the employees' personnel files.

a. The Privacy Officer shall maintain a record of privacy training given to the employees as defined in the Privacy Rule.

B. Before assuming job responsibilities, all staff will be educated regarding the confidential nature of medical records and proprietary or other confidential information, either hard copy or electronic format, and be informed of the resulting disciplinary action for willful, unauthorized disclosure of confidential information.

C. Agency staff will have access to the minimum amount of patient/client protected health information necessary to perform their duties as described below:

1. Clinical staff - access to all information 24 hours a day, 7 days a week.

2 Administrative staff - access to all information 24 hours a day, 7 days a week.

3 Quality assessment/improvement staff - access to all information during office hours.

4 Billing staff - access to information needed to process claims during office hours.

5 Clerical staff responsible for chart maintenance or data entry - access to information for inclusion in medical record for copying, filing, data entry, and for retrieval to use.

6 Visiting staff - at the request of administration, access to all information during office hours.

D. If an employee has more than one job title, s/he shall have access only in the capacity s/he is functioning at the time.

E. Any discussion, whether by telephone or cell phone communications or verbal information involving patient or caregiver information, will be conducted discreetly to avoid accidental disclosure to unauthorized persons.

F. Patient/client computer data will be accessed, entered, or retrieved by authorized persons only.

G. All employees who have access to the system will be given network and patient database username and passwords. These passwords are not to be shared with any person. Passwords will be changed by the user at least annually, or every 90 days if the Agency contracts with a Health and Human Services (HHS) agency, or following a breach of security. Passwords will be deleted at termination of an employee.

H. Measures such as locking file cabinets or locking the medical record room will be used for protection of records from access and/or retrieval by unauthorized personnel after office hours.

I. Other sources that may have access, without patient consent, are:

1 Medicare/Medicaid,

2 Fiscal intermediaries,

3 Payor sources,

4 Regulatory agencies, accrediting bodies,

5 Contracted consultants.

J. Any information needing to be faxed or emailed will have a cover sheet stating the confidential nature of the information or a similar statement in the email. The following information will not be faxed:

1 Occurrence Reports,

2 Employee Drug Screening Reports,

3 Employee or Patient/Client HIV testing results.

K. Information collected during performance improvement activities may be shared in statistical reporting formats.

L. Patient/Client information boards (e.g., patient lists, schedules) will not be displayed in office common areas.

M. The Agency will:

1. Avoid placing medical records in unattended areas accessible to unauthorized individuals.

2. Store medical records in a manner that minimizes the possibility of damage from fire and water.

3. Implement guidelines as to when release and/or removal of medical records is allowed (see Medical Record Information Release and Removal policy).

4. Implement guidelines regarding copying the medical record which include:

   a. Which portions of the record may be copied and for what purposes;

   b. Staff accountability for protection of copies in their possession; and

   c. Control of the destruction of record copies.

5. Maintain confidentiality during and after normal business hours

N. The Agency will secure written contracts that include confidentiality clauses from but not limited to:

1 Contracted agents to complete the regulatory reporting requirements,

2 Contracted billing companies who are billing via electronic claims.

3 Business associates

O. Any employee found to be in violation of this policy will be subject to discipline up to and including termination of employment.

P. To further protect patient information, all employees and Board of Directors members will sign a confidentiality/privacy statement upon hire or appointment.

II. Breach Notification for Unsecured Protected Health Information (PHI)

A. A breach occurs when protected health information is acquired, accessed, used, or disclosed in a way that compromises the protected health information.

B. The patient will be notified within 60 calendar days from discovery when a breach of protected health information occurs. The breach notification must include:

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

2 A description of the types of *unsecured* protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

3 Any steps individuals should take to protect themselves from potential harm resulting from the breach;

4 A brief description of what the Agency involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and

5 Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

C. The Agency must send written notification:

1 To patients via first-class mail, at their last known address or electronically when patients have agreed to this form of communication.

2 If patients are deceased, notification should be mailed to patients' next of kin or personal representatives.

3 In an emergency situation in which imminent misuse of the health information may occur, the Agency may notify individuals by telephone or other means, in addition to providing written notice.

4 If written notice is impossible to provide due to incomplete or outdated contact information, a substitute form of notice must be provided. When there is insufficient contact information for fewer than ten (10) individuals, notice may be given by telephone, another type of written communication, or other means. When sufficient contact information is unavailable for ten (10) or more individuals, such notice shall:

a. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the web site of the agency involved, or

b. Conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside; and

c. Include a toll-free telephone number that remains active for at least 90 days that individuals can use to learn whether their unsecured protected health information may be included in the breach.

D. The Agency also has a duty to notify the media of a breach affecting more than five hundred (500) individuals residing in one State or jurisdiction. In this situation, the Agency must notify "prominent media outlets" serving the particular State or jurisdiction. Notice must be in written form and given no later than sixty (60) days after discovery of the breach.

E. The Secretary of HHS must also receive notice of breaches

1. When five hundred (500) or more patients are involved, the Agency must mail written notification to the Secretary at the same time as it is sent to the individuals affected.

2. For breaches involving fewer than five hundred (500) patients, providers must maintain documentation of these breaches throughout the year. This documentation must be sent to the Secretary no later than sixty (60) days after the end of the calendar year.

III. Audit Processes

A. The Agency will cooperate with the Office for Civil Rights (OCR) and/or federal regulatory inspections, audits or investigations related to compliance with the Health Insurance Portability and Accountability Act. The Agency will perform annual audits that evaluate HIPAA compliance.

PURPOSE

To define a mechanism for safeguarding medical records and confidential information.

POLICY

The Agency will implement measures to safeguard medical records and confidential information against loss, destruction, tampering and unauthorized use.

PROCEDURE

I. Agency will:

A. Avoid placing medical records in unattended areas accessible to unauthorized individuals.

B. Assure medical records on decks or computers can't be read by unauthorized individuals.

C. Store medical records in a manner that minimizes the possibility of damage from fire and water.

D. Implement guidelines as to when release or removal of medical records is allowed (see policy on Medical Record Information on Release and Removal).

E. Implement guidelines regarding copying the medical record which include:

1. Consulting with the Privacy Officer before information is disclosed;

2. Which portions of the record may be copied and for what purposes the disclosure is made;

3. Documentation of the disclosure;

4. Staff accountability for protection of copies in their possession;

5. Control of the destruction of record copies.

F. Maintain confidentiality during and after normal business hours.

G. Educate staff, upon hire and annually thereafter, on steps to prevent unauthorized disclosure of medical record information.

H. Ensure retrievability of baseline data if the original medical records are destroyed.

I. Implement measures to maintain confidentiality when sending patient information by telecopier (fax) and email. Telecopier (fax) cover sheet will include a statement similar to the following and it shall appear in all email transmissions:

> "The information contained in this telefax**/email** message is legally privileged and confidential information intended only for the use of the individual or entity **to which it is addressed**. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copy of this telefax**/email** is strictly prohibited. If you have received this telefax**/email** in error, please immediately notify us by telephone and return the original message to us at the address **listed** via the United States Postal Service. Thank you."

J. Implement measures to maintain confidentiality and security when using an electronic record, Point of Care device, laptop, personal digital assistant (PDA), USB flash drive, memory card, or home computer, including but not limited to:

1. All employees using an electronic record, Point of Care device, laptop, PDA, USB flash drive, memory card, or home computer will sign a confidentiality/security agreement form after being oriented to the electronic device. The form will include the employee's printed or typed name as well as a signature.

2. All persons using an electronic record, Point of Care device, laptop, PDA, USB flash drive, memory card, or home computer will either be given a network and patient database username and password or they will password protect the program being used. These

passwords are not to be shared with any person. Passwords will be changed by the user at least annually or every 90 days if the Agency contracts with a Health and Human Services (HHS) agency, or following a breach of security.

3. Access to patient information on an electronic record, Point of Care device, laptop, PDA, USB flash drive, memory card, or home computer will be limited to individuals with a legitimate "need to know" in order to effectively perform their specific job duties and responsibilities.

4. In the event an employee using electronic record, Point of Care device, laptop, PDA, USB flash drive, memory card, or home computer is terminated, suspended or has an extended leave of more than 30 days, the user access will be inactivated or, if a laptop, data will be removed to an Agency file. The Agency will make every effort to remove confidential information from a personal Point of Care device, laptop, PDA, USB flash drive, memory card, or home computer. Reactivation will only occur upon notification from the Administrator or supervising nurse.

5. In the event the electronic record, Point of Care device, laptop, PDA, USB flash drive, memory card, or home computer is not available, all entries will be made on the appropriate paper documents. Paper records should be carried in locked containers.

6. If using digital signatures, the above security measures must be taken and the signature must not be in an encrypted format.

7. Any concerns related to an electronic record, Point of Care device, laptop, PDA, USB flash drives, memory card, or home computer will be submitted as identified to the QAPI Committee and a report of findings will be submitted to the Board for review.

K. Security measures to be taken by authorized Agency staff using laptop and other portable media or devices may include but not be limited to:

1. Use of password management procedures (for changing and safeguarding passwords) for all portable or remote devices that store EPHI;

2. Installation of personal firewall software on all laptops that store or access EPHI or connect to networks on which EPHI is accessible;

3. Installation, use and regular update of virus-protection software on all portable or remote devices that may access EPHI;

4. Use of session termination (time-out), lock-down or other locking mechanisms for inactive or unattended laptops or other inactive portable or remote devices;

5. Prohibition of the placement of laptops or other portable media or devices in unattended areas accessible to unauthorized individuals (ex. Never leave in plain view in an unattended vehicle, hotel, public workstation, or Wireless Access Point);

6. Prohibition of transmission of EPHI (including email, Facebook, Twitter, text messaging, etc.) over open networks, such as the Internet, where appropriate, and

7. Prohibition of storage or creation of confidential information on free cloud services or social media sites.

L. If the Agency uses a Cloud Service Provider (CSP), the Agency must have a Professional Service Agreement with the CSP that will be creating, receiving, maintaining, or transmitting electronic protected health information (ePHI) on its behalf. The Professional Service Agreement must establish the permitted and required uses and disclosures of ePHI by the business associate performing activities or services for the Agency, based on the relationship between the parties and the activities or services being performed by the business associate. The Professional Service Agreement also contractually requires the business associate to appropriately safeguard the ePHI, including implementing the requirements of the Security Rule.

M. The preceding training/education and security measures will also be implemented to maintain confidentiality/security when using other kinds of devices and tools such as Smart Phones, Wireless Access Points (WAPs), Memory Cards; CDs, DVDs, backup media, Smart cards, and Remote Access Devices (including security hardware).

N. Contracted Services using electronic documentation, including electronic or digital signatures, will implement measures to maintain confidentiality/security of patient information and will provide the agency proof of such upon request.

O. If the Agency contracts with a Health and Human Services (HHS) agency, in addition to those requirements cited above, the Agency will meet the requirements for data security and privacy as outlined in the HHS Data Use Agreement (DUA), required when contracting and/or re-enrolling with an HHS agency.

PURPOSE

To establish a standardized medical record.

POLICY

Agency will maintain active and inactive medical records in a format that facilitates easy retrieval of data/information.

Agency will maintain standardized medical record forms as well as a format, for documenting all care provided to patients.

PROCEDURE

1. MEDICAL RECORD FORMS

   1.1 Each medical record form will be reviewed and updated as needed to comply with federal / state regulations.

   1.2 Forms will be updated as needed to comply with federal / state / accreditation body regulations and will be submitted to the Director for final approval.

   1.3 Staff will be educated regarding forms.

2. MEDICAL RECORD

2.1 ACTIVE MEDICAL RECORD:

Admission Information
Hospice Election Form and Consents
Physician Certification
Initial Nursing Assessment
IDT Plan of Care
Bereavement Assessment
Supplemental/Verbal Orders
Medication Profiles
Team Conferences
Nursing Visit Notes
Communication Notes
Home Health Aide Visit Notes
Medical Social Services
Visit Notes
Communication Notes
Counselor/Chaplain
Visit Notes
Communication Notes
PT, OT, ST
Visit Notes
Communication Notes
Lab Reports
Miscellaneous
Hospital Discharge Summaries
Copy of Advance Directive (if applicable)
Consent/Authorization
Provision of Services Form
Referral Form

3. THINNED MEDICAL RECORD:

- The material which is removed from the active medical record will be compiled into a "thinned medical record."
- The active medical record will be flagged with the dates thinned.
- Only the following medical record forms will be considered for thinning from the active medical record:
  - visit notes (older than 2 months)
  - communication notes (older than 2 months)
  - plans of treatment (older than 6 months)
  - supplemental/verbal orders (older than 6 months)
  - team conferences (older than 6 months)
  - lab results (older than 6 months unless reports substantiate skill)

4. DISCHARGED MEDICAL RECORD:

Medical record contents and all thinned material will be combined into the same order as an active medical record when a patient is discharged from Agency.

PURPOSE

To ensure each medical record, whether paper, electronic or combination, contains information which identifies the patient, describes problems and needs of the patient, justifies patient care, and accurately describes care provided, results, and continuity among disciplines.

POLICY

Agency will initiate and maintain an individual and accurate medical record for each patient receiving care in compliance with all federal and state laws and regulations. The record may be in a paper, electronic or combination format.

The record will include, at minimum, the initial and subsequent assessments, the initial and updated plans of care, identification data, consent and authorization and election forms, pertinent medical history, and complete documentation of all services and events including evaluations, treatments, and progress notes.

PROCEDURE

1. Each medical record will contain the following:

    1.1 Patient identification information:

    - Name
    - Gender
    - Address
    - Phone number
    - Date of birth
    - Legal authorized representative (if any)
    - Height/weight as appropriate to patient care

- For emergency contact:
  - Family member/caregiver's name
  - Family member/caregiver's telephone number
- Name/s of physician responsible for care
- Source of referral

1.2 Patient's needs information, as documented in both initial and comprehensive assessments, and updated comprehensive assessments, which reflects:

- Patient history
- Dietary restrictions/nutritional requirements
- Home suitability/adaptability
- Safety measures required to protect the patient from injury
- Care provided by Agency and contracted personnel
- Date care provided
- Staff member who provided care
- An updated medication profile to include medication, allergies, and/or sensitivities
- Actual or potential drug/food interactions
- The dose, time, date, and any adverse drug reactions of every dose of medication administered by Agency staff
- Identification of individual administering the medication

- Patient's mental status
- Survivor risk factors

1.3. Justification of care information:

- Identity of others known to be involved in patient's care
- Instructions given to patient upon discharge from another facility (if any)
- Admission/discharge dates from a hospital or other institution, if applicable
- Transfer summaries/records (if any) received from transferring agencies
- Change in Attending Physician designation, as appropriate
- Description of the patient's functional limitations
- Description of the patient's activity restrictions
- A statement of any change in patient's condition or level of care
- A statement of the conclusions or impressions drawn from the assessment data
- Primary and secondary diagnoses related to the patient's care as assessed upon admission and updated during the course of care
- Physician's narrative and face to face encounters
- Physician certification and recertification of terminal illness

1.4. Documentation of care provided:

- Initial and updated plans of care
- Identification of problems, needs, actions and goals
- Outcome measures data elements
- Ongoing education of patients/caregivers
- Evidence of consent for care on admission and during the course of care
- Legible, complete, individualized, diagnostic, therapeutic orders, including, but not limited to, types of care and equipment needed, frequency of visits, and instructions for a timely discharge or referral
- Physician's orders that include medications, dietary information, treatment, and activity orders
- Actions/interventions/procedures
- Patient/family response to care/service provided
- Care provided through contracted services
- Signed/dated clinical notes by individual who provided care/service

1.5. Documentation/Communication for Continuity of Care:

- Conclusions of patient medication monitoring
- Results of all diagnostic and therapeutic procedures and tests performed
- Patient's response to care

- Any referrals to internal or external providers/agencies and coordination of care with all referrals who may be providing service/care
- Advance Directives, including name of Medical Power of Attorney, if applicable
- Notification to the prescribing physician of patient discharge
- A discharge summary when patient dies or is discharged
- Any summaries of care provided through contracted services

1.6. Written consent from patient/caregiver:

- Admission and informed consent documents; signed copy election of hospice benefit statement
- Consent for treatment
- Financial authorization
- Release of information and other documents for protected health information
- Services to be provided and estimated frequencies

1.7. Acknowledgments of the following:

- Patient's/client's receipt of a copy of the Human Resource Code, Chapter 102, Rights of the Elderly
- Patient's/client's receipt of the agency's policy relating to abuse, neglect and exploitation of a patient/client,
- Patient/client agreement to services provided by the agency
- Signed copy of Patient Rights and Responsibilities

- Right to confidentiality

2. If Agency is using an Electronic Health Record (EHR) system for a patient/client Agency may:

   2.1 Incorporate and file in the patient/client's EHR a signed paper record by preserving its electronic duplicate in the EHR; or

   2.2 Maintain the patient/client's record as a combination of a signed paper record and an EHR.

3. If Agency preserves an electronic duplicate of a signed paper record in a patient/client's EHR, agency is not required to retain the signed paper record. Agency should have a system for verifying the accuracy of an electronically duplicated paper record before destroying it.

4. If Agency is utilizing an EHR system, Agency must provide surveyor access to all of its records as requested and readily provide the equipment and information necessary to assist the surveyor in the review process.

5. There are no circumstances where a separate patient record is not required.

AUTHORIZATION AND AUTHENTICATION OF MEDICAL RECORD ENTRIES

PURPOSE

To identify the authors of medical record entries.

To assure security of the identification of authors of electronic signatures for electronic records or point of care devices.

POLICY

All medical record entries whether paper, electronic or combination format will be made by appropriate staff and authenticated as true and accurate by the author of the entry.

PROCEDURE

I. Medical record entries may be made by Agency health care professionals, para professionals, clerical staff as appropriate, and/or contracted health care providers.

II. Medical record billing or operations entries may be made by trained Agency staff members responsible for these functions.

III. Medical record entries will be written in ink. typed, or computer-generated.

IV. Each medical record entry will be dated and signed with the complete name and title/credential of the person making the entry. Initials are acceptable only when requested.

V. Electronic signatures may be used by employees (who have been oriented to the process) for electronic records or point of service devices. The Agency will maintain a list of all employees using electronic signatures. Employees will sign a confidentiality/security form that includes the printed or typed name and an original signature to facilitate positive identification of the signature per policy and procedure, Safeguarding Medical Record Information.

VI. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended or corrected.

A. Regardless of whether an entry is from a paper record or an electronic health record, documents containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and

2. Clearly indicate the date and author of any amendment, correction or delayed entry, and

3. Clearly identify all original content, without deletion.

B. Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished as follows:

1. Using a single line strike through so the original content is still readable, and

2. The author of the alteration must sign and date the revision.

   a. Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

   b. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name.

C. Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles specified above remain fundamental and necessary. Records from electronic systems containing amendments, corrections or delayed entries must:

1. Distinctly identify any amendment, correction or delayed entry, and

2. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

3. The system must have the capability to track corrections or changes to an entry in the Electronic Health Record (EHR) after the entry is entered or authenticated, and/or prevent alterations of EHR entries after they are authenticated.

VII. An original physician's order is sent/faxed to the physician for signature, and a copy is retained in the patient's medical record or file. A manual or electronic log is maintained to ensure timely receipt of signed orders. If orders are not returned, the Agency may call the physician, re-fax the order or hand carry a copy of the order to the physician's office.

VIII. Agency staff will verify, upon return of physician's orders, that the orders are complete, accurate, signed and dated.

PURPOSE

To establish timely parameters for all medical record information.

POLICY

Agency will ensure timely provision of care to meet patient's needs in compliance with all federal and state laws and regulations.

PROCEDURE

I. All Agency staff, and physician/physician office staff as appropriate, will be oriented to the following parameters:

A. Initial health assessment by the RN will be completed within 48 hours after receipt of the physician's referral for hospice care, unless the physician, patient, or representative requests otherwise.

B. Initial POC will be established prior to the initiation of services, and will be signed prior to billing.

C. The IDT, in consultation with the attending physician, will complete the Comprehensive Health Assessment no later than 5 calendar days after the start of hospice care. The Assessment is updated at least every 15 days or as changes occur.

D. The IDT POC will be developed within 15 days of the start of care, and updated at least every 15 days.

E. Admission paperwork will be turned in within 2 business days of admission to Agency.

F. All clinical and progress notes will be written the day service is rendered.

G. Daily progress notes are turned in twice a week.

H. Supplemental verbal orders may be obtained before care is provided and are written within 24 hours of receiving the orders. Orders will be signed by the physician within 30 days.

I. Physician signatures are obtained on IDT Plan of Care at the interdisciplinary team meeting.

J. Documentation for the medical records of discharged patients is completed within 30 days of the discharge, either from a single discipline or Agency.

K. An Admission Medical Record is assembled by the seventh working day after admission.

II. A tracking system will be implemented to track all physician orders.

III. All medical record information will be incorporated into the patient's medical record within14 business days of providing service.

IV. The Agency's quality assessment performance improvement activities may monitor effectiveness of the medical records parameters and will reevaluate the parameters if negative trends are identified.

MEDICAL RECORD REVIEW/UTILIZATION REVIEW

PURPOSE

To ensure appropriate documentation through timely medical record review.

POLICY

Qualified individuals will review a representative sample of medical records quarterly in order to ensure that the documentation is complete, accurate and timely.

PROCEDURE

1. At quarterly intervals, a random sampling of services furnished to patients contained in both active and closed records will be selected for review.

2. This sampling should contain all disciplines offered by Agency.

3. The medical record documentation will be reviewed and analyzed on appropriate forms.

4. The results will be analyzed through the QAPI Committee's performance improvement process, presented to the Board of Directors, and presented to appropriate Agency staff.

PURPOSE

To define the process for release or removal of medical record information from the Agency's jurisdiction and safekeeping as well as the Agency's need for copying medical record information. To define the process for amending and accessing patient/client protected health information.

POLICY

The Agency will observe confidentiality when releasing medical record information and when arranging for record removal from the licensed premises by court order, subpoena, or statute. Agency staff will observe confidentiality when copying and/or removing copied medical record information. Agency staff will observe confidentiality in the process of allowing a patient/client access to or amendment of their protected health information.

PROCEDURE

I. Release To Non-Agency Entities

A. All requests for release of information to entities not covered by HIPAA will be submitted in writing to the Privacy Officer.

B. Two copies will be made of the requested information.

1. One copy is packaged for hand delivery or pick-up by the requesting entity. If it must be mailed, it is mailed by certified mail with "return receipt requested." It is labeled "confidential."

2. One copy is for Agency records.

C. The original request and authorization will be filed in the medical record.

D. In situations related to communicable or occupational disease(s) that are reportable to the state health department by law, a signed patient consent form will not be required.

E. The billing department will invoice the requesting entity or expect payment at time of pick-up.

F. Any request to release information to an entity other than the patient's physician, laboratories, contracted entities providing patient care, health care facilities receiving the patient for care, or payor sources, requires authorization in writing specifying the information to be released and the patient's/legal guardian's signature.

II. Patient/Client Request To Access Protected Healthcare Information

A. Patients/clients must request access to their protected health information in writing, including a reason, and are informed of such upon admission.

B. The Privacy Officer will be responsible for assisting patients and accepting patient requests for access.

C. The Privacy Officer or designee shall act upon the request: no later than 30 calendar days from receiving the individual's request. See 45 CFR 164.524(b)(2).

D. If the Agency is unable to provide access within 30 calendar days, for example, where the information is archived offsite and not readily accessible, the Agency may extend the time by no more than an additional 30 days. To extend the time, the Agency must, within the initial 30 days, inform the individual in writing of the reasons for the delay and the date that they will provide access. Only one extension is permitted per access request.

E. The Agency is not required to provide access to patient/client's protected health information that is excepted from access, or to which access may be denied, under 45 C.F.R. Section 164.524 (a)(1), such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

F. If the Agency denies the request, in whole or in part, it must provide the individual with a written denial.

G. If the Agency provides an individual with access, in whole or in part, to protected health information, the Agency must comply with the following requirements:

1. The Agency must provide the access requested by individuals, including inspection or obtaining a copy, or both, of the protected health information about them in designated record sets. If the same protected health information that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the covered entity need only produce the protected health information once in response to a request for access.

2. The Agency must provide the patient/client with access to the protected health information in the form and format requested by the individual, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by the covered entity and the patient/client.

3. If the protected health information that is the subject of a request for access is maintained in one or more designated record sets electronically and if the individual requests an electronic copy of such information, the covered entity must provide the individual with access to the protected health information in the electronic form and format requested by the individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by the covered entity and the individual.

4. The Agency may provide the patient/client with a summary of the protected health information requested, in lieu of providing access to the protected health information or may provide an explanation of the protected health information to which access has been provided, if:

   a. The individual agrees in advance to such a summary or explanation; and

b. The individual agrees in advance to the fees imposed, if any, by the covered entity for such summary or explanation.

H. The Agency may deny an individual access without providing the individual an opportunity for review, in the following circumstances:

1. The protected health information is excepted from the right of access by Procedure E of this section.

2. A covered entity that is a correctional institution or a covered health care provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of protected health information, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate.

3. An individual's access to protected health information created or obtained by a covered health care provider in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered health care provider has informed the individual that the right of access will be reinstated upon completion of the research.

4. An individual's access to protected health information that is contained in records that are subject to the Privacy Act,5 U.S.C. 552a (/uscode/text/5/552a), may be denied, if the denial of access under the Privacy Act would meet the requirements of that law.

5. An individual's access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

I. The Agency may deny patient/client access, provided that he or she is given a right to have such denials reviewed, in the following circumstances:

1. 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 individual or another person;

2. The protected health information makes reference to another person (unless such other person is 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; or

3. The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

4. If access is denied, the patient/client has the right to have the denial reviewed by a licensed health care professional who is designated by the Agency to act as a reviewing official and who did not participate in the original decision to deny.

J. If the Agency is using an electronic health records system that is capable of fulfilling a request for protected health information by the patient/client, the Agency will provide the patient/client with their electronic health record in electronic form within 15 business days after receipt of a written request, unless the patient/client agrees to accept the record in another form.

K. A standard electronic format for the release of requested health records will be utilized by the Agency when available from the state.

M. The Agency shall not charge a fee for retrieving, handling or processing the patient's/client's request for access to his/her information. However, the Agency may charge a reasonable fee to the patient/client for preparing a summary at his/her request.

N. The Agency may charge a reasonable fee to others for copying, labor and supplies.

1. The Agency shall expect payment upon delivery or may invoice the requesting party for the information.

III. Patient/Client Request To Amend Protected Healthcare Information

A. Patients/clients must request amending their protected health information in writing, including a reason, and are informed of such upon admission.

B. The Privacy Officer will be responsible for assisting patients and accepting patient requests for amendments.

C. The Privacy Officer or designee shall act upon the request: no later than 60 calendar days from receiving the individual's request. See 45 CFR 164.526(b)(2).

D. If the Agency is unable to act on the request for amendment within the time required, the Agency may extend the time for such action by no more than 30 days, provided that:

1. The Agency provides the individual with a written statement of the reasons for the delay and the date by which the Agency will complete its action on the request; and

2. The covered entity may have only one such extension of time for action on a request for amendment.

E. The Agency may deny the patient's/client's request if it determines that the protected health information or record:

1. Was not created by the Agency, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;

2. Is not part of the designated record set;

3. Would not be available for inspection under 164.524; or

4. Is accurate and complete.

F. If the Agency denies the requested amendment, in whole or in part, it must provide the patient/client with a timely written denial in plain language and it must contain:

1. The basis for the denial,

2. The patient's/client's right to submit a written statement disagreeing with the denial and how he or she may file such a statement;

3. A statement that, if the patient/client does not submit a statement of disagreement, the patient/client may request that the Agency provide the patient's/client's request for amendment and the denial with any future disclosures of the protected health information that is the subject of the amendment; and

4. A description of how the patient/client may complain to the Agency pursuant to the complaint procedures established in 164.530(d) or to the Secretary pursuant to the procedures established in 160.306. The description must include the name, or title, and telephone number of the contact person or office designated in 164.530(a)(1)(ii).

G. If the patient/client provides a written statement rebutting the denial:

1. The Agency may rebut that and provide a copy to the patient/client.

2. The original request, denial letter, statement of disagreement and rebuttal shall be included with any disclosures of the disputed health information.

3. If the patient/client agrees with the denial, the Agency does not have to include the original request or denial letter with any disclosures of the disputed health information.

H. If the Agency agrees to the patient's/client's request:

1. The patient/client is told of the decision and may amend his/her protected health information;

2. The Agency shall request identification of and permission to contact other health care entities and/or individuals that need to be told of the amendment; and

3. The Agency shall contact those entities as well as its own Business Associates.

I. If the Agency is contacted by another health care provider or plan that the patient's/client's protected health information has been amended:

1. The amendment is made part of the medical record; and

2. The Agency shall notify any of its Business Associates that use/rely on the information and they shall make changes as required in the written agreement with the Agency.

IV. Release To Agency Staff

A. Any information in the patient's medical record that is pertinent to the planning or delivery of patient care may be copied by designated Agency staff. The Agency retains the right to review and limit the information to be copied in individual patient/client cases.

B. The following designated staff may utilize copies of medical record information in planning or providing patient care:

1. Nursing staff

2. Hospice Aide staff

3. Physical therapists

4. Occupational therapists

5. Speech therapists

6. Medical social workers

7. Dieticians/nutritionists

8. Pastoral counselors

9. Bereavement Coordinator

10. Volunteer Coordinator

C. Agency staff will implement the following measures to ensure confidentiality of copied/original medical record information:

1. Only information that relates to the patient receiving care will be taken into that residence.

2. Medical record information will not be left unattended in an unlocked vehicle.

3. Medical record information with patient identification will not be visible to the public.

V. Medical Record Information Removal

A. All requests for removal of information will be submitted in writing.

B. All information to be sent will be copied for Agency and labeled "copy."

C. The original information will be packaged for delivery and labeled "confidential."

D. The information will be delivered in one of the following ways:

1. Hand-delivered by Agency staff,

2. Picked up by requesting entity, or

3. Certified mail with return receipt requested.

E. The original request and authorization will be filed in the medical record.

F. When the original is returned, the copy will be retained for Agency records.

G. Protected health information is retained by the Agency for seven years from the last date it's in effect.

PURPOSE

To ensure medical record information retention and destruction is in accordance with federal and state laws and regulations.

POLICY

Agency will maintain all adult medical records for a minimum of seven (7) years after discharge of the patient and for any additional time as deemed necessary in the event of an audit, litigation or other dispute until after settlement.

In the case of a child, the medical record will be maintained until the age of majority eighteen (18) years, plus seven (7) years beyond the age of majority.

In the case of a patient who has Medicare as the secondary payer, records will be retained for ten (10) years.

If the patient is mentally retarded or mentally handicapped, the medical record will be maintained until the patient reaches the age of majority eighteen (18) years, plus six (6) years, until the patient is twenty-four (24) years of age.

In the event that Agency ceases to exist, all charts will be maintained in safekeeping for at least seven (7) years.

In the case of an employee exposure to communicable diseases, the post exposure records will be retained for thirty (30) years.

The agency will not destroy patient records that relate to any matter that is involved in litigation if the agency knows the litigation has not been finally resolved.

The final disposition/responsibility for the patient's medical record will rest with Agency Administrator and Board of Directors.

The State will be notified in writing of closure of the agency, the location of the medical records and the name/address of the medical record custodian.

PROCEDURE

A. Process: Retention Of Information

1. An inactive patient/client medical record may be stored as a signed paper record, an electronically signed computer record or a combination.

2. Agency may preserve and retain a signed paper record electronically, including on microfilm, optical disc, or computer disk.

3. Agency may maintain a signed paper record by preserving its electronic duplicate in the electronic record for an inactive patient/client. If the electronic record is readily accessible and systematically organized, the signed paper record, after it is duplicated does not have to be retained.

4. The contents of inactive medical records in paper format will be combined in chronological order into one document.

5. Inactive patient/client medical records in paper format will be stored in alphabetical order by year of discharge.

6. Medical records whether in paper, electronic or combination format will be stored so as to protect them from damage, loss, and/or theft.

7. Inactive medical records will be accessible during normal working hours. If a medical record is removed, the appropriate sign-out form is completed and all medical records are returned by the end of business day.

8. Inactive patient information stored in a computer data system will be protected from accidental deletion and remain accessible to identified staff during normal working hours.

B. Process: Protection Of Protected Health Information (PHI) Of Deceased Patients

1. The Agency shall honor the privacy of a deceased patient's/client's PHI for as long as the information is stored/maintained but at least for six years.

2. The deceased patient's/client's rights regarding his/her PHI may be exercised by someone with legal authority to act on behalf of the patient/client.

3. The Agency shall verify the identity of the individual with legal authority to act on behalf of the deceased patient/client per Agency's protocol.

C. Process: Destruction Of Information

1. When a patient is discharged from active care, all non-original/copied information carried by Agency staff to facilitate patient care will be returned to the office for destruction.

2. When a patient is discharged from active care, and after final billing, information stored in the computer system will be purged at an appointed time.

3. At the time identified by policy, inactive patient medical records will be removed from storage by Agency staff and destroyed in a manner so as to ensure that information cannot be retrieved (shredding, contract with disposal company, etc.).

PURPOSE

To ensure compliance with Texas Health and Human Services (HHS) privacy and security requirements for receipt, maintenance, use, disclosure, or access to confidential information.

POLICY

I. If the Agency contracts with an HHS agency and is required to sign an HHS Data Use Agreement (DUA), the agency will meet the requirements for privacy and security as outlined in the DUA and with this policy.

II. The Agency will cooperate with HHS agencies or federal regulatory inspections, audits or investigations related to compliance with the DUA or applicable law.

DEFINITIONS

I. “Authorized Purpose” means the specific purpose or purposes described in the Scope of Work of the Base Contract for the Agency to fulfill its obligations under the Base Contract, or any other purpose expressly authorized by HHS in writing in advance.

II. “Authorized User” means a Person:

A. Who is authorized to create, receive, maintain, have access to, process, view, handle, examine, interpret, or analyze Confidential Information pursuant to this DUA;

B. For whom the Agency warrants and represents has a demonstrable need to create, receive, maintain, use, disclose or have access to the Confidential Information; and

C. Who has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information as required by this DUA.

III. "Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Agency or that the Agency may create, receive, maintain, use, disclose or have access to on behalf of HHS that consists of or includes any or all of the following:

A. Client Information;

B. Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information;

C. Sensitive Personal Information defined by Texas Business and Commerce Code Ch. 521;

D. Federal Tax Information;

E. Personally Identifiable Information;

F. Social Security Administration Data, including, without limitation, Medicaid information;

G. All privileged work product;

H. All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

PROCEDURE

I. The Agency will not, without prior written approval of HHS, disclose or provide access to any Confidential Information on the basis that such act is Required by Law without notifying HHS so that HHS may have the opportunity to object to the disclosure or access and seek appropriate relief. If HHS objects to such disclosure or access, The Agency will refrain from disclosing or providing access to the Confidential Information until HHS has exhausted all alternatives for relief.

II. The Agency prohibits disclosure of the Agency's work product done on behalf of HHS pursuant to the DUA, or to publish HHS Confidential Information without express prior approval of the HHS agency.

III. The Agency will not attempt to re-identify or further identify Confidential Information or de-identified information, or attempt to contact any individuals whose records are contained in the Confidential Information, except for an Authorized Purpose, without express written authorization from HHS or as expressly permitted by the Base Contract.

IV. The Agency prohibits offshoring, or the use, disclosure, creation, maintenance or transmission of HHS Confidential Information outside of the United States of America, without express written permission from the HHS agency.

V. The Agency will not permit, or enter into any agreement with a Business Associate to, create, receive, maintain, use, disclose, have access to or transmit Confidential Information, on behalf of the Agency without requiring that Business Associate first execute the (HHS) Form Subcontractor Agreement which ensures that the Business Associate will comply with the identical terms, conditions, safeguards and restrictions as contained in the DUA for PHI and any other relevant Confidential Information.

VI. If the Agency receives a request for access, amendment or accounting of PHI by any Individual subject to the DUA, it will promptly forward the request to HHS; however, if it would violate HIPAA to forward the request, the Agency will promptly notify HHS of the request and of the Agency's response. Unless the Agency is prohibited by law from forwarding a request, HHS will respond to all such requests, unless HHS has given prior written consent for the Agency to respond to and account for all such requests.

VII. The Agency and its Business Associates will maintain an updated, complete, accurate and numbered list of Authorized Users, their signatures, titles and the date they agreed to be bound by the terms of the DUA, at all times and supply it to HHS, as directed, upon request.

VIII. The Agency will only conduct secure transmissions of Confidential Information whether in paper, oral or electronic form. A secure transmission of electronic Confidential Information *in motion* includes Secure File Transfer Protocol (SFTP)

or Encryption at an appropriate level or otherwise protected as required by rule, regulation or law. HHS Confidential Information *at rest* requires Encryption unless there is adequate administrative, technical, and physical security, or as otherwise protected as required by rule, regulation or law. All electronic data transfer and communications of Confidential Information will be through secure systems. Proof of system, media or device security and/or Encryption must be produced to HHS no later than 48 hours after HHS's written request in response to a compliance investigation, audit or the Discovery of an Event or Breach. Otherwise, requested production of such proof will be made as agreed upon by the parties. De-identification of HHS Confidential Information is a means of security. With respect to de-identification of PHI, "secure" means de-identified according to HIPAA Privacy standards and regulatory guidance.

IX. The Agency prohibits the storage or creation of HHS Confidential Information on free Cloud Services or social media sites, unless there is an HHS-approved subcontractor agreement including an encryption-at-rest requirement with the service or site.

X. The Agency will provide electronic security measures to include locking a password after three failed attempts to enter the system, and requiring password re-entry after 15 minutes of inactivity in all computing devices that access or store HHS Confidential Information.

XI. The Agency will apply appropriate methods in the disposal or destruction of confidential information to ensure that information is unreadable or undecipherable (shredding, contract with a disposal company, etc.).

XII. ***Breach or Event Notification to HHS***

A. The Agency will cooperate fully with HHS in investigating, mitigating to the extent practicable and issuing notifications directed by HHS, for any Event or Breach of Confidential Information to the extent and in the manner determined by HHS.

B. The Agency's obligation begins at the Discovery of an Event or Breach and continues as long as related activity continues, until all effects of the event are mitigated to HHS's satisfaction (the "incident response period").

C. Breach Notice:

1. Initial Notice.

a. For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Client Information, within the first, consecutive clock hour of Discovery, and for all other types of Confidential Information not more than 24 hours after discovery, or in a timeframe otherwise approved by HHS in writing, the Agency will initially report to HHS's Privacy and Security Officers via email at: privacy@HHSC.state.tx.us

b. The Agency will report all information reasonably available to the Agency about the Event or Breach of the privacy or security of Confidential Information.

c. The Agency will name, and provide contact information to HHS for, the Agency's single point of contact who will communicate with HHS both on and off business hours during the incident response period.

2. 48-Hour Formal Notice. No later than 48 consecutive clock hours after Discovery, or a time within which Discovery reasonably should have been made by the Agency of an Event or Breach of Confidential Information, the Agency will provide formal notification to the State, including all reasonably available information about the Event or Breach, and the Agency's investigation, including without limitation and to the extent available:

a. The date the Event or Breach occurred;

b. The date of the Agency's and, if applicable, Business Associate's Discovery;

c. A brief description of the Event or Breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);

d. A brief description of the Agency's investigation and the status of the investigation;

e. A description of the types and amount of Confidential Information involved;

f. Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual and if applicable, the Legally Authorized Representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by the Agency at that time;

g. The Agency's initial risk assessment of the Event or Breach demonstrating whether individual or other notices are required by applicable law or the DUA for HHS approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;

h. The Agency's recommendation for HHS's approval as to the steps individuals and/or the Agency on behalf of individuals, should take to protect the individuals from potential harm, including without limitation the Agency's provision of notifications, credit protection, claims monitoring, and any specific protections for a Legally Authorized Representative to take on behalf of an individual with special capacity or circumstances;

i. The steps the Agency has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);

j. The steps the Agency has taken, or will take, to prevent or reduce the likelihood of recurrence of a similar Event or Breach;

k. Identify, describe or estimate of the Persons, Workforce, Subcontractor, or Individuals and any law enforcement that may be involved in the Event or Breach;

l. A reasonable schedule for The Agency to provide regular updates to the foregoing in the future for response to the Event or Breach, but no less than every three (3) business days or as otherwise directed by HHS, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and

m. Any reasonably available, pertinent information, documents or reports related to an Event or Breach that HHS requests following Discovery.

XIII. ***Investigation, Response and Mitigation***

A. HHS may direct the Agency to provide Breach notification to Individuals, regulators or third-parties, as specified by HHS following a Breach.

B. The Agency must obtain HHS's prior written approval of the time, manner and content of any notification to Individuals, regulators or third-parties, or any notice required by other state or federal authorities. Notice letters will be in the Agency 's name and on the Agency 's letterhead, unless otherwise directed by HHS, and will contain contact information, including the name and title of the Agency's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.

C. The Agency will provide HHS with copies of distributed and approved communications.

D. The Agency will have the burden of demonstrating to the satisfaction of HHS that any notification required by HHS was timely made. If there are delays outside of the Agency's control, the Agency will provide written documentation of the reasons for the delay.

E. If HHS delegates notice requirements to the Agency, HHS shall, in the time and manner reasonably requested by the Agency, cooperate and assist with the Agency's information requests in order to make such notifications and reports.

XIV. The Agency will conduct privacy and security training of the workforce within thirty (30) days of hire and annually thereafter for all staff who will handle HHS Confidential Information.

A. Training will include:

1. Privacy and security policies, procedures, plans and applicable requirements for handling HHS Confidential Information,

2. A requirement to complete training before access is given to HHS Confidential Information, and

3. Written proof of training and a procedure for monitoring timely completion of training.

B. The Agency will monitor for and correct any training delinquencies.

C. The Agency will permit only Authorized Users with up-to-date privacy and security training, and with a reasonable and demonstrable need to use, disclose, create, receive, maintain, access or transmit the HHS Confidential Information, to carry out an obligation under the DUA for an Authorized Purpose, unless otherwise approved in writing by an HHS agency.

XV. The Agency will sanction and maintain proof of appropriate sanctions against any staff members or Business Associates who fail to comply with an Authorized Purpose or who is not an Authorized User, and used or disclosed HHS Confidential Information in violation of the DUA, the Base Contract or applicable law.

XVI. Privacy and security policies, procedures and plans will be updated following major changes with use or disclosure of HHS Confidential Information within 60 days of identification of a need for update.