

Chapter 5 RECORDS MANAGEMENT

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Chapter 5

RECORDS MANAGEMENT

12 VAC 35-105-870

Introduction

Consumer records are maintained by Richmond Behavioral Health Authority for the purpose of effective case planning and proper documentation of services and progress. These records contain vital and confidential information about individuals receiving services from the agency. This information serves to document all aspects of the services a consumer receives, including current functioning, medical history, diagnosis, family support, drug use, treatment/service plans, progress in treatment, and reason for termination. Other information includes evidence of case reviews, requests for information and consumer authorizations, as well as information about collaterals, when appropriate. While records are the property of the RBHA, they are stored in the Medical Records Department and kept primarily for the benefit of the consumers.

The Medical Records Department is decentralized into three coordinated functional units under the direct authority of a Medical Records' Supervisor. This individual shall be designated as the official custodian of health information for the organization as a whole.

The following procedural guidelines serve to implement the records management policy. In order to protect the identity of clients and insure the confidentiality of all consumer-related information, the following procedures will be adhered to by all staff.

Privacy Notice Policy

It is the policy of Richmond Behavioral Health Authority to maintain, post and distribute as necessary a Privacy Notice as defined in 45 CFR Parts 160 and 164, Standard for Privacy of Individually Identifiable Health Information Final Rule.

Procedures

Implementation

- On or before April 14, 2003, the agency's Privacy Notice was given and explained to all current individuals served by the agency. This distribution was documented in a *Privacy Notice Acknowledgement* form signed by the individual served or their parent/ guardian/ legally authorized representative, and filed in their medical record.
- By April 14, 2003, the agency's Privacy Notice was posted at all sites of service, and on the agency's website.
- Individuals coming into service on or after April 14, 2003, shall receive the agency's Privacy Notice and acknowledge receipt via signature on the Orientation Checklist form.
- A hard copy of the agency's Privacy Notice will be available upon request from anyone.
- Every three years individuals being served are notified on how to obtain a copy of the agency's Privacy Notice.

Characteristics and Content of Privacy Notice

- The agency is not permitted to use or disclose PHI beyond what is stated in the Privacy Notice.
- When the agency's privacy practices, policy or procedures change, the Privacy Notice must be revised to reflect these changes, posted and made available on site.
- The agency's Privacy Notice is written in plain language, defining how the agency will use and disclose the individual serve's PHI, and the individual serve's rights with regards to their PHI.
- The header of the notice must contain the specific wording: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."
- An Effective Date indicating the date the Privacy Notice went into effect, not the date written or printed, is listed as such and cannot be prior to the date the notice is published.
- The notice must inform individuals of all the uses and disclosures that the agency is required or permitted to make under all applicable laws. No statement should limit the agency's ability to use or disclose information that is required by law or necessary to avoid serious and imminent threat to health and safety.
- All the uses and disclosures of PHI the agency is permitted or required to make under HIPAA without individual authorization are clearly described. Each use and disclosure is described separately.
- All the uses and disclosures of PHI, including at least one example of each that the agency is permitted to make for treatment, payment and health care operations is clearly described.
- The Privacy Notice states that any uses and disclosures of PHI other than those defined above, can only be done with the individual's authorization, which the individual has the right to revoke in writing.
- The Privacy Notice includes the individual's rights with regards to PHI and indicates how they may exercise those rights. These rights include:

- ✓ Right to request restrictions on specific uses and disclosures of PHI, which the agency may refuse to grant.
 - ✓ Right to receive confidential communication of PHI.
 - ✓ Right to inspect and copy their PHI.
 - ✓ Right to challenge, amend, correct or explain their PHI.
 - ✓ Right to receive an accounting of disclosure of PHI not for the purpose of treatment, payment and health care operations, or authorized by individual
 - ✓ Right to receive a paper copy of the agency's Privacy Notice upon request.
 - ✓ Right to give or not give consent to the disclosure of information the agency maintains about them with the exception of circumstances defined by federal and state law.
- The Privacy Notice states that the agency has a legal requirement to maintain privacy of PHI, provide a notice of their duties and privacy practices, and to abide by the terms of the notice.
 - The Privacy Notice explains that the agency reserves the right to change or revise its privacy practices regarding previously collected, documented or received PHI, and how it will provide individuals served with a revised notice.
 - A Complaint Process is outlined in the event an individual served believes their privacy rights have been violated. The process includes a contact person's name and phone number, that there would be no retaliation for filing a complaint, and the right to file a complaint with the Secretary of HHS.

Privacy Officer/Security Officer

In accordance with the Health Insurance Portability and Accountability Act (1996), the agency has designated a Privacy Officer (Quality and Standards Director) and Security Officer (MIS Director) whom are responsible for the development, implementation, and maintenance of privacy/security policies and procedures. The Privacy Officer and Security Officer will be direct contact persons responsible for receiving complaints, as well as the agency's Consumer Affairs/Human Rights Coordinator, due to the overlap with the Human Rights Regulations. The Consumer Affairs/Human Rights Coordinator is designated as the person to investigate complaints.

Use of Protected Health Information

For the purpose of providing treatment, arranging payment, and for healthcare operations, the agency uses individually identifiable healthcare information about consumers within the agency and with business associates. The minimum necessary information will always be used, disclosed or requested, as per the policy stated within this Chapter.

Protected Health Information (PHI) is defined as "individually identifiable health information" maintained in any medium (electronic, paper, and oral). It includes all health information that is created or received by a health care provider, and relates to the past, present or future physical or mental health or condition of the individual. Health information becomes "individually identifiable" if it identifies the individual or can be used to identify the individual, with any of the following identifiers, as an example (full list can be found in 45 CFR):

- Names
- Address
- Birth dates and admission/discharge dates

- Telephone and FAX number
- E-mail address
- Social Security #
- Medical Records #
- Health plan #
- License #
- Vehicle identifiers (license plate #)
- Photographic images

De-Identification of PHI

Whenever it is not necessary to include PHI for the purposes of carrying out treatment, payment or healthcare operation, the information will be de-identified by removing individual identifiers. As needed, the information can be re-identified by replacing PHI.

Requests for Restrictions on Use of PHI

Consumers have the right to request a restriction with regards to the use or disclosure of information in the medical record, in writing. This should be submitted to the primary Case Manager/Clinician with copy forwarded to the Privacy Officer. Although any request will be given serious consideration, the agency is not required to accept the restriction if it hinders the provision of effective services or interferes with healthcare operations. Consumers will be notified in writing as to the decision in reference to the request. A restriction may also be terminated at any time, by written notice by the consumer or by written notice by the agency. Termination of a restriction is only effective with respect to PHI created or received after the consumer was notified of the termination.

Requests for Confidential Communication

Consumers also have the right to request the manner in which the agency staff should communicate with the individual, such as requesting that bills not be sent to their home address. This should be submitted to the primary Case Manager /Clinician with copy forwarded to the Privacy Officer. The agency will accommodate reasonable requests, but may deny requests that hinder the treatment, payment or healthcare operations.

Business Associates

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), it is agency policy to identify “business associates” and implement and maintain Business Associate Agreements with identified Business Associates. Business associates are individuals or agencies that carry out a function on behalf of RBHA.

Procedure

- Annually, all individuals or agencies that carry out a function on RBHA’ behalf will be identified by Quality Assurance staff and senior Management, including external and internal (to the City) entities
- At any time that an individual or agency is engaged to carry out a function on behalf of RBHA, an assessment of the need for a Business Associate Agreement will be made

- In consultation with the RBHA's Attorney's office, Business Associate Agreements, or addendums to existing contracts or Memorandums of Understanding, will be created and implemented with each Business Associate.
- The Business Associate Agreement will contain all required elements as set forth in HIPAA (45 CFR)

Complaint Policy

It is the policy of Richmond Behavioral Health Authority (RBHA) to provide an identified point of contact for consumers and employees to make complaints regarding violations of privacy and confidentiality of health information, (as per HIPAA and the Human Rights regulation). RBHA recognizes that privacy and confidentiality of health information of individuals and families served, and those who serve as legally authorized representatives are critical. RBHA also recognizes that individuals who receive services, and/or legally authorized representatives, have the right to have their health information protected from improper use and disclosure. The agency will not threaten, intimidate, or retaliate against any individual filing a complaint.

The Privacy Officer and/or Security Officer may receive complaints directly, as may the Human Rights Coordinator. All complaints will be forwarded to the Human Rights Coordinator for investigation and resolution. The Human Rights Coordinator will ensure that the Privacy Officer is informed of any complaint received directly by the Human Rights Coordinator, and the Privacy Officer will be available for consultation as needed. The Human Rights Coordinator will investigate, address staff sanctions, and mitigate harm in consultation with the Privacy Officer.

The Human Rights Coordinator will also involve the appropriate members of the administration in the investigation of the complaint. The Human Rights Coordinator will review findings of the investigation with the appropriate Divisional Director, Chief Executive Officer, and the Privacy Officer/Security Officer as appropriate.

Procedure

- Reports should be made promptly and in "good-faith." (Refer to Human Rights Policy for additional specifics on reporting and investigation requirements)
- Reports can be made anonymously and/or confidentially.
- If the individual requires assistance in making their complaint in written form, the Human Rights Coordinator or designee will provide the necessary assistance.
- Upon receiving a complaint, the Human Rights Coordinator will:
 - Document the receipt of the complaint
 - Document the date, time, and name of the person making the complaint and identifying them as consumer, authorized representative.
 - Notify the Divisional Director and/or Chief Executive Officer, as well as the RBHA Privacy Officer, and involve them in the investigation of the complaint
 - Perform, coordinate, or monitor the investigation of the complaint
 - Document or ensure documentation of the investigation of the complaint
 - Communicate the outcome of the complaint to the appropriate individuals including, at a minimum, the Privacy Officer, Divisional Director and the Chief Executive Officer.

- If individuals are not satisfied with the results of the investigation, they have the right to proceed with external reporting to the federal Department of Health and Human Services and/or the Local Human Rights Committee.
- The Human Rights Coordinator will make one of three possible findings, in a recommendation to the Chief Executive Officer;
 - Founded: The suspected violation was found to have occurred.
 - Unfounded: The suspected violation was found not to have occurred.
 - Undetermined: It cannot be determined whether or not the violation occurred. Use of this disposition is not encouraged.
- Upon completion of the investigation the Human Rights Coordinator will:
 - Provide a written report to the Privacy Officer
 - In consultation with the Privacy Officer, determine steps to mitigate harm
- The documented complaint and resolution will be maintained by the Privacy Officer for a period of no less than 6 years.

Staff Sanctions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities have and apply appropriate sanctions against members of their workforce who fail to comply with Privacy Policies and Procedures of the entity, or the requirements of the Rule (45 CFR SS 164.530(e)(1)). Accordingly, it is the intention of Richmond Behavioral Health Authority (RBHA) to ensure the confidentiality and integrity of consumer and/or employee protected health information (PHI) as required by law, professional ethics, and accreditation and/or licensure requirements. This policy establishes agency policy, guidance, and standards for workforce performance expectations in carrying out the provisions of HIPAA, and the corrective action(s) that may be imposed to address privacy violations.

Consumer and/or employee PHI information will be regarded as confidential, and may not be used or disclosed except to authorized users for approved purposes. Access to PHI is only permitted for direct consumer care, approved administrative and/or supervisory functions, or with approval of the Privacy Officer (Quality and Standards Director), Chief Executive Officer, or Divisional Director.

Permitted Use and Disclosures

RBHA is permitted to use or disclose PHI in the following instances:

- To the individual who is the subject of the PHI;
- In compliance with acknowledgement of Privacy Notice receipt to carry out treatment, payment or health care operations;
- Without authorization, if authorization is not required and has not been sought;
- In compliance with valid authorization;
- Pursuant to a Business Associate Agreement.

Required Disclosures

RBHA is required to disclose PHI in the following instances:

- To an individual, when requested under and as required by SS164.524 (Access of individuals to PHI) or SS164.528 (Accounting of disclosure of PHI) of the HIPAA Regulations;
- To specific private entities that provide services under contractual agreements (health benefits, life insurance, Workers Compensation, etc.) in order to provide such services;
- When required by the Privacy Officer, Divisional Director or Chief Executive Officer to investigate or determine compliance with HIPAA and Human Rights requirements.
- As otherwise required by law.

Minimum Necessary

When using or disclosing PHI, or when requesting PHI from another covered entity, RBHA will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Sanction Exemptions

Sanctions will not apply to disclosures by employees who are *whistleblowers* or *crime victims*.

Disclosure by Whistleblowers:

- The employee is acting in good faith on the belief that RBHA has engaged in conduct that is unlawful or otherwise violates professional or clinical standards; or,
- That the care, services and conditions provided by RBHA potentially endangers one (or more) RBHA consumers, employees or a member of the general public; or,
- The disclosure is made to a federal or state health oversight agency or public health authority authorized by law to oversee the relevant conduct or conditions of the covered entity; or,
- The disclosure is made to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by RBHA; or
- The disclosure is made to an attorney retained by or on behalf of the employee or business associate for the purpose of determining legal options regarding disclosure conduct.

Disclosure by Crime Victims:

- A covered entity is not considered to have violated the use and disclosure requirements if a member of its workforce who is the victim of a criminal act discloses PHI to a law enforcement official about the suspected perpetrator of the criminal act, and the disclosed PHI is limited to identification and location purposes.

Mitigating circumstances include conditions that would support reducing the sanction in the interest of fairness and objectivity.

Mitigation

RBHA will mitigate, to the extent practicable, any harmful effect that is known to be the result of the use or disclosure of PHI in violation of HIPAA or Human Rights regulations, including such disclosures by business associates.

Retaliation

RBHA will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against an individual who:

- Exercises his rights or participates in the RBHA complaint process; or,
- Files a complaint with the Secretary of Health and Human Services; or,
- Testifies, assists, or participates in an investigation, compliance review, proceeding or hearing; or,
- Opposes any act or practice unlawful under HIPAA, providing that the individual acted in good faith, believing that the practice was unlawful, the manner of opposition is reasonable, and does not involve disclosure of PHI in violation of HIPAA regulations

Levels of Violations

Employees found to have violated PHI disclosure provisions will be disciplined in accordance with Richmond Behavioral Health Authority's *Employee Handbook*, up to and including termination of employment. The type of sanction will depend on the intent of the individual and severity of the violation. The offenses listed below, while not all inclusive, are organized according to the severity of the violation.

Group I: Improper and/or unintentional disclosure of PHI or records.

This level of breach occurs when an employee unintentionally or carelessly accesses, reviews or discloses consumer or employee PHI to himself or others without a legitimate need-to-know. Examples include, but are not limited to: employees who discuss consumer information in a public area; an employee leaves a copy of consumer medical information in a public area; an employee leaves a computer unattended in an accessible area with consumer information unsecured.

Group II: Unauthorized use and/or misuse of PHI or records.

This level of breach occurs when an employee intentionally accesses or discloses PHI in a manner that is inconsistent with RBHA policies and procedures, but for reasons unrelated to personal gain. Examples include, but are not limited to: an employee looks up birth dates, address of friends or relatives; an employee accesses and reviews the record of a consumer out of curiosity or concern; an employee reviews a public personality's record.

Group III: Willful and/or intentional disclosure of PHI or records.

This level of breach occurs when an employee accesses, reviews or discloses PHI for personal gain or with malicious intent. Examples include, but are not limited to: an employee reviews a consumer record to use information in a personal relationship; an employee compiles a mailing list for personal use or to be sold.

Definition of Designated Record Set

The purpose of this guidance is to identify groups of records called "designated record sets" that persons served have the right to access and amend.

Definitions

Designated record set is a group of records maintained by or for a health care provider, that is:

- The medical records and billing records about individuals maintained by or for a covered health care provider; or
- Used, in whole or in part, by a health care provider to make decisions about individuals.

For purposes of this definition, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a health care provider.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

- Is created or received by a health care provider; and
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
- That identifies the individual; or
- With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected health information includes individually identifiable health information that is:

- Transmitted by electronic media;
- Maintained in the internet, extranet, leased lines, dial-up lines, private networks and those transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media; or
- Transmitted or maintained in any other form or medium.

Psychotherapy Notes are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. 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.

Parameters of Designated Record Set

Any item, collection, or grouping of information that includes protected health information (PHI), which is maintained, collected, used, or disseminated by or for a health care provider, and is used by the health care provider to make decisions about individuals. The Designated Record Set includes the following:

- Current, Overflow, Closed and/or Private Provider charts
- Financial and Billing records
- Any of the following information if not summarized in the medical record***:
 - Contents of Logs or Data Notebooks
 - Raw test data from psychological tests
 - Audiotapes
 - Videos/photographs
 - Telemedicine
 - Coding Worksheets

***If the above information is used to make decisions about a person served and it is not summarized in the medical record, then it needs to be considered as part of the Designated Record Set.

Exclusions from the Designated Record Set

Exclusions to the Designated Record Set include:

- Psychotherapy notes
- Health information that is not used to make decisions about individuals or information that the person served does not have a right of access based on state or federal law. Some examples follow:
 - Copies of reports/documentation/forms wherein the originals are maintained in an 'official' record maintained by the organization
 - Copies produced from original records maintained by the organization should be limited and should not be disclosed outside the health care provider.
 - Copies of health information that are maintained in more than one location must be protected but only the original document should be included in a designated record set.
 - If the same protected health information is maintained in more than one location, the health care provider is required to produce the information only once.
- Quality Improvement records/Utilization Review
- Risk Management records
- Research documentation (Note: When protected health information is created or obtained by a covered health care provider/researcher for a clinical trial, the Privacy Rule permits the patient's access rights in these cases to be suspended while the clinical trial is in progress, provided the research participant agreed to this denial of access when consenting to participate in the clinical trial.)
- Information compiled in reasonable anticipation of, or for use in civil, criminal, or administrative action or proceeding (e.g., Incident Reports - used to identify problems and implement corrective action)

Minimum Necessary

The Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA) requires covered entities to take reasonable steps to limit the use or disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

RBHA will adhere to the standards set by HIPAA and the ethical principles of the agency to insure that only information that is required to fulfill the stated purpose of the services, and that required by law, will be disclosed.

Exceptions to the Minimum Necessary Standard

The minimum necessary standard does not apply in the following circumstances:

- Disclosures to or requests by healthcare providers for treatment purposes
- Disclosures to the individual who is the subject of the information
- Uses or disclosures made pursuant to an authorization requested by the individual
- Uses or disclosures required for compliance with the standardized HIPAA transactions

- Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the rule for enforcement purposes
- Uses or disclosures that are required by other law

Use and Disclosure of PHI *Internal* to the Agency

RBHA will insure the Minimum Necessary Standard is met by:

- Identifying the persons or classes of persons in the workforce who need access to PHI.
- Identifying the category(ies) of PHI to which access is needed.
- Developing and implementing procedures to insure that disclosure of PHI is limited to the amount reasonably necessary to achieve the purpose of the disclosure.
- Maintaining standards of good practice to assure reasonable precautions are taken to prevent inadvertent and unnecessary disclosure, such as limiting discussion in public areas.
- Developing and implementing procedures for review of requests for access.

Persons or Class of Persons Who Need Access to PHI and Category(ies) of PHI to Which Access is Needed

In order to appropriately comply with Minimum Necessary Standards and effectively maintain healthcare operations, access will be determined by a role-based assessment and context-based assessment:

- Complete access to a consumer's PHI will be available to the direct service provider, his/her immediate supervisor, and other providers on the same service unit/team
- *Emergency Services/ Crisis Intervention* staff will have access to all consumers' PHI
- *Medical Records* staff will have complete access to all consumers' PHI
- *Reimbursement* staff will have access to all consumers' PHI, as needed, to handle transactions
- *MIS* staff will have complete access to all consumers' PHI
- *Data Entry* staff will have access to all consumer's PHI, as needed, to complete data entry

As CMHC develops the capability of electronically restricting access, implementation of access controls will be handled through the MIS department. Until such time, agency staff will be trained on the amount of access that their job requires be required to sign acknowledgement of understanding of the agency's policies regarding limiting access, and the agency will provide monitoring to assure compliance.

Procedures to Insure Disclosure of PHI is Limited to the Amount Reasonably Necessary to Achieve the Purpose of the Disclosure

Internal to the agency, there are numerous and varied ways in which PHI is used and disclosed for treatment and healthcare operations. To insure adherence to the standards, the following questions will be considered to determine appropriate safeguards are in place:

- What PHI is necessary to complete the task?
- What PHI can be omitted and healthcare operations continue unimpeded?
- Who will have access to the information disclosed in the healthcare operation under review?

Procedures are also in place to ensure that the minimum necessary is disclosed:

- Staff will be trained in HIPAA standards
- Supervisors will be available for consultation
- The agency's Privacy Officer and Security Officer will be available for consultation and will be responsible for handling any complaints
- Periodic audits will be conducted by *Quality and Standards /Medical Records staff*

Precautions to Prevent Inadvertent and Unnecessary Disclosure

Staff will be trained about the need to take reasonable precautions to prevent inadvertent and unnecessary disclosure, such as disclosure that can occur if discussions were held in areas with public access.

Procedures for Review of Request for Access

Quality and Standards/ Medical Records staff will periodically audit procedures to assure compliance with all confidentiality and Minimum Necessary standards. Corrective action will be taken as needed and appropriate.

Use and Disclosure of PHI External to the Agency

Authorization to Release Information

The Authorization form indicates the specific information to be disclosed or requested. Only the minimum necessary information needed to accomplish the intended purpose will be disclosed or requested. The form contains an explanation of confidentiality and Privacy Rule standards for the consumer's information. Consumers must give informed, voluntary consent to any disclosure of PHI, except as allowed by law, and may revoke the authorization at any time.

Routine and Non-routine Requests and Disclosures

For routine and recurring requests and disclosure, individual review of each request is not necessary. RBHA Medical Records' Supervisor will limit information that is disclosed or requested to the minimum necessary to achieve the purpose of the disclosure. If a covered entity is requesting information, staff may rely on the judgment of the party requesting the disclosure as to the minimum necessary amount of information that is needed. However, if the agency staff member has concerns that more than the minimum necessary is requested to be disclosed, the staff member may, in consultation with his/her supervisor, make his/her own minimum necessary determination for disclosure.

For non-routine requests or disclosure, agency staff, with the guidance of the Medical Records' Supervisor, shall determine the minimum necessary that is needed to achieve the purpose of the disclosure. Some guidelines are:

- The medical record in it's entirety will not *routinely* be copied
- Portions of the medical record will not *routinely* be copied
- If a request or disclosure is for treatment information, a summary of consumer contact may be prepared which includes:
 - the consumer's name,
 - date of birth,

- service dates,
- purpose for seeking services,
- diagnosis and assessment information,
- type and duration of services received,
- outcomes of services received, and
- discharge summary information and referral, if appropriate.

Substance abuse information will only be shared if the Authorization for Disclosure and/or Request of Health Information form specifically states that information is to be disclosed or is in accordance with 42 CFR.

Medical information such as diagnosis of TB, AIDS, HIV or other infectious disease will only be shared if the Authorization for Disclosure and/or Request of Health Information forms specifically states that information is to be disclosed.

RBHA staff will not routinely check all options on the Authorization for Disclosure and/or Request of Health Information form, for information to be disclosed or requested. RBHA staff must be very specific as to what is being requested or disclosed, applying the minimum necessary standard.

Third party information is to be considered part of the Designated Record Set, and may be disclosed in accordance with this policy and applicable law.

Monitoring

RBHA will monitor adherence to the Minimum Necessary Standards on a regular basis. Some examples of monitoring procedures are:

- Supervisors review requests and disclosure with supervisees during probationary employment period
- Periodic supervisory review throughout employment
- Regular, ongoing supervisory review if performance issues are present

Quality and Standards/ Medical Records staff will periodically conduct audits to limit use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.

Who May Authorize Disclosure of Information

No consumer-related information will be released to any agency or person without the written authorization of the consumer, except as authorized or required without the authorization of the consumer. In the case of a deceased consumer, the executor or administrator of the deceased consumer's estate may authorize release of information. If no executor has been appointed, a spouse, adult son or daughter, either parent, adult brother or sister, or other relative in descending order of blood relationship may authorize release of information. Documentation of executorship or kinship is required. (Code of Virginia Section 8.01-413.)

When services are provided to families, safeguards will be taken to protect the confidentiality of individual family members. Each participant in a specific service incident (e.g., session) shall have equal rights to

obtain and release information obtained during that incident. Information regarding family members will be kept in a separate file upon request.

In the event that a consumer has a legal representative who has been authorized to sign for the release of information, the representative's signature will be required, and their legal authority and identity must be verified.

While minors may consent to outpatient mental health treatment, they cannot authorize the disclosure of their records. This must be done by a custodial parent, guardian or surrogate under the Code of Va. 54.1-2969. Neither the minor themselves nor a non-custodial parent may authorize disclosure of confidential information. This is true even if the minor sought services without parental knowledge or consent.

Minors also may consent to outpatient substance abuse treatment. Due to federal rules, they alone may authorize the disclosure of confidential information. Their parents may not, even if the parents are part of the treatment. The substance abuse rule applies to anyone who is receiving services from a substance abuse program regardless of diagnosis or someone with a DSM IV diagnosis of substance abuse or addiction, receiving any agency services. The inclusion of some mental health cases in the federal substance abuse rules results from the fact that the agency receives federal substance abuse funds.

If the minor lacks the capacity to give informed consent, procedures for obtaining substitute decision-making should be followed.

In the case of minors in residential programs, the concurrent authorization of a parent with legal custody must also be obtained to disclose records.

*For situations that do not seem to be addressed by the above, the staff member will seek assistance from their Program Supervisor.

** Situations where following the above guidelines poses serious risk for a consumer or a third party, the staff member will consult with their Program Supervisor to determine whether emergency exceptions to these rules might apply.

Documentation of Disclosures

Whenever information is disclosed by the RBHA staff, a cover letter must accompany it, clearly indicating one or the following:

"Re-disclosure of this information is prohibited except with specific written authorization or as permitted by law or regulation. The consumer has authorized Richmond Behavioral Health Authority to release this information but does not authorize the re-disclosure of this information. This information is provided under the express condition that the recipient will protect the confidentiality of the client and will not re-disclose this information."

In the case of a consumer receiving substance abuse services, the receiving agency will be notified in writing that it is a violation of federal law to re-disclose such information. RBHA will clearly mark such information as follows:

"This information has been disclosed to you from records the confidentiality of which is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further

disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise permitted by these regulations. A general authorization for the release of medical information or other information is not sufficient for this purpose."

The cover letter will also document what information has been disclosed. A copy of the cover letter and the signed authorization will be filed together in the medical record. All requests for information will be answered within ten (10) working days.

The agency will not honor authorizations for disclosure of information signed more than 90-days prior to their receipt, unless other conditions for the disclosure are specified on the authorization form, or which do not have any of the following: appropriate signature, specific information required, and purpose for which the information is sought. If any of these are lacking, the additional necessary information will be sought from the requesting agency. The Authorization for Disclosing and/or Requesting Health Information Form, which meets these requirements, is available for use by staff.

General Notice to Consumers

All consumers, but especially the court-ordered consumer, must be made aware that while the relationship is protected by a significant degree of confidentiality, there are some circumstances (e.g., under subpoena) in which the staff member might be ordered or obliged to breach confidentiality.

Notifying Consumers of Risks Involved with Disclosure

In the event the consumer authorizes and requests disclosure of the entire medical record or portions of the medical record to another agency that the clinician or case manager deems potentially damaging to the consumer, the clinician/case manager will contact the consumer and explain the implications of such disclosure and advice against it. If the consumer still wishes such potentially damaging portions of their medical record disclosed, this will be done and notations will be made in the medical record that the consumer was advised that such disclosure was potentially damaging.

Revocation of Authorization

At any time, a consumer may revoke authorization previously given to disclose or request information. The revocation must be done in writing, and submitted to the primary service provider or other agency staff. The revocation will not be valid on disclosures or requests that have already been acted upon in accordance with the original signed authorization. Upon written notice of the intent to revoke authorization, agency staff will mark across the authorization form indicating the date of revocation

Non- Authorized Disclosure of Information

Information will never be disclosed without authorization except in these specific circumstances:

- As required by law (e.g. Court-ordered warrant)
- Public Health activities (e.g. communicable diseases are reported by medical services, not by RBHA)
- Judicial and Administrative proceedings (e.g. order from a court or administrative tribunal)
- Law Enforcement purposes (e.g. limited information requested about suspects, fugitives, material witnesses, missing persons; witness to criminal conduct on premises)

- To avert a serious threat to Health and Safety (e.g. in response to a statement made by a person served to harm self or others)
- Children or incapacitated adults who are victims of Abuse, Neglect or Exploitation
- Health Oversight activities (e.g. the DMHMRSAS)
- Military Services (e.g. in response to appropriate military command to assure the proper execution of the military mission)
- National Security and Intelligence activities (e.g. as authorized by the National Security Act or in relation to protective services to the President of the United States)
- State Department (e.g. medical suitability for the purpose of security clearance)
- Correctional Facilities (e.g. to correctional facility about an inmate)
- Workers Compensation to facilitate processing and payment
- Coroners and Medical Examiners for identification of a deceased person or to determine cause of death
- To the Department of Health and Human Services in connection with an investigation of us for compliance with federal regulations

Only the minimum necessary information as is deemed appropriate for the purposes of the requesting person or agency will be released. Every occurrence of non-authorized disclosure of information will be recorded in the consumer's medical record and on the Disclosure Log, by the disclosing staff member.

Emergency Situations

In emergency situations seriously and imminently threatening the physical well-being of the consumer or public safety, information may be disclosed without written authorization upon the authorization of the appropriate Program Supervisor, Division Director, Privacy Officer, and/or Chief Executive Officer. Only such information as is deemed necessary to meet the emergency will be disclosed and the circumstances of such disclosure (i.e., reason for disclosure, information disclosed, and person to whom information is disclosed) will be documented in the consumer's medical record. In the case of substance abuse, the nature of an emergency will be limited to a bona fide medical emergency.

Child or Adult Abuse, Neglect, and/or Exploitation

The Code of Virginia mandates that all professional staff of this Agency who has reason to suspect that a child is an abused or neglected child, or that an incapacitated adult is an abused, neglected, or exploited adult, report such suspicion to the Virginia Department of Social Services. Failure to report such suspicion is punishable by fine. In reporting suspected abuse or neglect, only information that is the basis of suspicion and records relating directly to that suspicion may be disclosed. Under no circumstances may copies of any other consumer medical records be disclosed. The circumstances of such disclosure (i.e. reason for disclosure, information disclosed, and person to whom information was disclosed) will be documented in the consumer's medical record.

Disclosure of Intent to Commit a Crime

Confidentiality does not apply to the disclosure of intent to commit a crime that poses serious, imminent physical danger. In the event that intent to commit such a crime is disclosed to a staff member, the staff member will consult with the appropriate Program Supervisor, Division Director, Privacy Officer, or Chief Executive Officer, and the appropriate authorities and/or potential victim will be notified. Confession of past crimes within a confidential relationship will only be reported if the crime is of such a nature that public

welfare continues to be jeopardized by not disclosing the crime. This will generally be when the crime is against persons and is compulsive in nature (e.g., child molestation, arson).

Any decision to disclose information without consumer authorization will be made by the appropriate Program Supervisor, Division Director, Privacy Officer, or Chief Executive Officer. The circumstances of such disclosure (i.e. reason for disclosure, information disclosed, and person to whom information was disclosed) will be documented in the consumer's medical record.

State Facilities (and Human Service Providers)

Note: Disclosure of information in accordance with this section is NOT applicable to consumers receiving substance abuse services.

Information required to prepare and implement a comprehensive individualized treatment plan, including a discharge plan, can be disclosed to state facilities when a consumer refuses to authorize disclosing such information. Information disclosed may include that which is necessary to develop a pre-discharge plan that specifies the services to be provided the released patient in the community to meet the individual's needs for treatment, living, nutrition, physical care and safety, and to link the individual with appropriate service providers and human service agencies.

Information needed to secure services specified in the pre-discharge plan may be disclosed without authorization to those service providers and human services agencies identified in the pre-discharge plan.

The consumer's refusal to authorize disclosure of information and any information disclosed under this provision shall be documented in the consumer's medical record. The consumer will be informed of this unauthorized release of information as soon as this is clinically appropriate and logistically possible. If the consumer cannot be informed of this disclosure within two weeks, a letter will be sent notifying the consumer of this fact. The circumstances of such disclosure (i.e. reason for disclosure, information disclosed, and person to whom information was disclosed) will be documented in the consumer's medical record.

Crimes Committed on Premises

Crimes committed on premises will be reported to police when the offense is of such a nature as to jeopardize the safety of staff, consumers, general public, or the integrity of the program. Crimes must be reported in a manner which will not disclose that the perpetrator is an Agency consumer, unless an authorization to disclose information has been previously signed by the consumer allowing communication between the Agency and police.

Examples of crimes that will be reported are:

- Bomb threats
- Selling/distributing drugs on premises
- Stealing drugs from the pharmacy
- Assault upon any person (minor altercations in psychosocial or day support programs may not be reported)
- Threatening any person with a dangerous weapon
- Fire setting

In the event that a staff member becomes aware of the commission of such a crime, the staff member will inform his Program Supervisor of the incident immediately. The Program Supervisor will consult with the appropriate Division Director and/or Chief Executive Officer and the appropriate authorities will be notified. In the event that the Program Supervisor is not available, the staff member will inform the appropriate Division Director and/or Chief Executive Officer directly.

Less serious violations may need to be handled as therapeutic issues. In the event that a staff member becomes aware of a less serious violation, he will notify his Program Supervisor of the incident as soon as possible. Examples that violate agency policy may include:

- Illicit drugs brought onto agency premises
- Weapons brought onto agency premises (except in the possession of law enforcement personnel)

The Program Supervisor will then seek consultation from the appropriate Division Director and/or Chief Executive Officer regarding whether to report the less serious violation. Through consultation with the Program –Supervisor and appropriate Division Director, it may be determined that other actions may be taken that are consistent with program policies.

In all instances in which a crime is committed, the appropriate Program Supervisor, Division Director, and Chief Executive Officer must be notified. Nothing in this policy shall be interpreted as prohibiting the reporting of illegal behavior to the appropriate law enforcement agency.

Disclosure of Information to Courts

In the event of a court-ordered evaluation, a confidential relationship does not exist, and the consumer will be informed before the evaluation that the results of the evaluation and the contents of any interviews, etc., will be available to the Court and could be used against him. No Authorization for Disclosing and /or Requesting Health Information form will be required to disclose such records to the Court; but, as a matter of practice, staff is advised to obtain a written authorization from the consumer. Without the authorization of the consumer, the circumstances of such disclosure (i.e. reason for disclosure, information disclosed, and person to whom information was disclosed) will be documented in the consumer's medical record.

Since the purpose of a court-ordered evaluation is to aid the Court and the purpose of court-ordered treatment is to aid the consumer, confidentiality in the former would defeat its purposes and confidentiality in the latter is essential to its purposes. In order to form an appropriate therapeutic relationship, the consumer must have reasonable assurance of confidentiality. Therefore, in the case of court-ordered treatment, an authorization should be obtained from the consumer to disclose information

Precautions to Prevent Inadvertent and Unnecessary Disclosure

All staff and persons associated with RBHA are responsible for taking reasonable precautions to protect the privacy and security of PHI. There are instances when consumers may request that staff accompany them to court or staff may feel obliged to provide support to consumer during a court

proceeding. **Staff shall not appear in court without a subpoena in order to avoid common breaches of confidentiality, improper and/or unintentional disclosures of PHI.**

Accounting of Disclosures

Consumers may request an accounting of non-authorized disclosures of their PHI by submitting the Client Request for Accounting form to the Medical Records' Department Supervisor or Privacy Officer. A response will be returned to the consumer within 60 days of the request. Accountings can be requested for up to 6 years prior to the request, back to November 2001 at the earliest.

Privileged Communication

The concept of privilege is distinct from that of confidentiality and applies only to testimony in a judicial or quasi-judicial proceeding. Virginia law recognizes no "doctor/patient" privilege in criminal matters. In civil matters, privilege exists for licensed counselors, psychologists, social workers, and physicians with the following exceptions:

- Where the physical or mental conditions of the client is at issue in the action;
- In matters related to child abuse and neglect; and
- When the court deems disclosure necessary to the proper administration of justice.

Privilege is ordinarily asserted by the consumer or his attorney. If they are not present, the staff member should assert privilege by respectfully stating that he believes the information in question is privileged communication under Code of Virginia 8.01-399 et. seq. and allow the court to rule if he must answer questions. If a jury is present and the court orders the staff member to testify, he should request that the judge hear his testimony outside the presence of the jury before ruling that the testimony be admitted into evidence.

Under no circumstances should a staff member testify regarding substance abuse treatment unless the court has conducted a hearing and issued an order pursuant to 42 CFR 2.61 et. seq. During such a hearing the staff member should be represented by counsel. If in the course of testimony, and lacking written consent of the consumer, a staff member is asked or ordered by a judge to reveal substance abuse related client information, he/she should respectfully inform the judge that specific federal law applies to such information and request the opportunity to seek legal counsel.

Information Provided to Third Party Payers

Only the following information will be provided to third party payers:

- The consumer's name and the contract or policy number.
- The date the consumer was admitted or began receiving services from the agency.
- The date of onset of the consumer's condition.
- The date services were terminated.
- The diagnosis with brief information substantiating the diagnosis.
- A brief description of the services provided the consumer, including type of therapy, medications ordered and administered, and the number of hours spent in individual, group, or family treatment or other rehabilitation activities.
- Status of the consumer, as inpatient or outpatient.
- The consumer's relationship to the contract subscriber or policyholder.

If the third party payer is unable to settle a claim on the basis of the information provided, a physician employed by the third party payer may request additional information stating the reason therefore. An explicit authorization to disclose this information does not need to be sought from the consumer.

Access of Auditors, Accreditors, and Researchers to Records

Implicit in the consumer's application for service is the permission for all necessary agency staff, practicum students, and clinical supervisors to have access to records. If, in order to do business, the agency undergoes audits or accreditation studies, authorized auditors and accreditors may be permitted access to whatever records are necessary for their legitimate audits or accreditation studies. The auditor or accreditor will be bound by confidentiality.

Consumer Access to Records

- If a consumer wishes to inspect her/his own records, a Client Request to Access Records form must be obtained from and submitted to the Medical Records' Supervisor, by the primary service provider (i.e. Case Manager/Clinician) after the following has occurred:
 1. The primary Case Manager/Clinician will review the request with their supervisor and primary psychiatrist.
 2. If, upon review of the record by the consumer's psychiatrist, case manager or clinician, Program Supervisor, or Privacy Officer, it is determined that no harm would come from the consumer's review of his medical record, the consumer will be given access to his record. This will always be done in the presence of a professional staff member who will be able to explain or interpret the contents of the record.
 3. In the rare case that the clinician or case manager, Program Supervisor, or Privacy Officer believe that it would be harmful for the consumer to have direct access to his medical record, they will consult with a psychiatrist, who will review the record.
 4. If the psychiatrist concurs, he/she will so note in the medical record and access to the medical record will be denied the consumer
 5. An acknowledgement of the request must be sent to the consumer within 5 days of request, and a response returned within 15 days of the request. The Response to Exercise Individual Rights form will be used to respond, by the Medical Records' Supervisor.
 6. The consumer may obtain copies of any portion of the record. Copies of medical records will be furnished for a fee.
 7. If the request for access to the medical record had been denied to the consumer, at the consumer's request, the medical record may be reviewed by any duly licensed mental health professional, physician or attorney of the consumer's choosing.

Request for Amendment to the Medical Record

Consumers have the right to request an amendment to their medical record if they dispute information. In the event that a consumer disputes information in his medical record, the primary service provider will make known to the consumer his right to challenge, correct, or have explained to him information in his medical record.

- A Request to Amendment to the Record form must be completed by the consumer and forwarded to the Medical Records' Supervisor who will then consult with the Privacy Officer.
- A response must be returned within 60 days of the request, using the Response to Exercise Individual Rights form.
- In response to a consumer's dispute of information in his medical record, the medical record may be changed if the Medical Records' Department Supervisor and Privacy Officer determine such change is warranted. This would ordinarily be the case if factual information such as a birth date is disputed.
- Any amendments to the medical record must be included in any subsequent disclosure, and individuals/agencies that have previously received the information must also be notified of the amendment.
- If the medical record is not amended as a result of a consumer's request, the consumer may include a statement of up to 200 words in length setting forth his/her position. This statement must be sent to all previous and subsequent recipients of the disputed information.
- The medical record will also be clearly marked indicating that its contents are disputed by the consumer.
- In addition, the agency may include in the medical record a rebuttal statement to the individual's disagreement with the information in the medical record, and a copy will be given to the consumer.
- If the agency is notified by another treatment provider of an amendment to a consumer's medical record, whose copy we have included in the agency's medical record, then the amendment will be added to the medical record.
- A copy of all of the above written communications will be included in the consumer's medical record.

Acceptance of Subpoenas, Preparation and Response

The agency will comply with all properly executed subpoenas for records. Subpoenas for records will be accepted by the Chief Executive Officer for the person named on the subpoena, or a person designated by the Chief Executive Officer to accept subpoenas.

If the subpoena is for a record of persons served in the Substance Abuse program or substance abuse is documented in the medical record, a court order or a signed authorization to disclose information must be completed in conjunction with the subpoena duces tecum.

The agency may also file a motion to quash based on the content of the record and on behalf of the client unable to seek counsel. If there is a motion to quash by direct service staff, staff will consult the Program Supervisor and/or Division Director who will consult with the Medical Records' Supervisor and/or Chief Executive Officer and move to have the subpoena quashed in order that the Court may rule on the merits of the subpoena.

Subpoenas Duces Tecum for Records

Upon acceptance of a subpoena for records, the Medical Records' Supervisor or designee in the Medical Records Department will complete an entry on the Acceptance of Subpoena Log. After logging, a subpoena for records will remain in the Medical Records Department.

If the case is still open, then the Medical Records' Supervisor will implement the following procedures:

- Verify that the direct service staff is present; if not present, the supervisor will be contacted.
- Inform the direct service staff, or supervisor, that a subpoena duces tecum was received. Instruct the direct service staff to call the consumer to inform them their record has been subpoenaed to court. The consumer must be informed he/she has a right to take action. A notice regarding this should come from the requesting party (or their attorney) inform them about the subpoena duces tecum. (** See Notice To Patient and Notice To Providers outlined at end of this section)
- Medical Records' staff will forward the chart to the direct service staff for review. The direct service staff will need to clarify any oppositions regarding what should be sent according to the subpoena, and in consideration of specific Substance Abuse Confidentiality Law (42 CFR; see above)
- Once the review is completed by the direct service staff, the medical record is returned to the designated medical records' staff for copying.
- Medical Records' staff will number all pages of the record in ink on the bottom of each page, and maintain a record of the number of pages of each subpoenaed record.
- Medical Records staff will photocopy the entire chart or specific information requested.
- Medical Records Supervisor or designee will deliver the medical record to the court or requesting attorney on or before the due date indicated on the subpoena duces tecum. If the Notice To Provider indicates the subpoena for medical records is of a non-party or a pro se party, medical records staff should follow outlined instructions.
- In the event the subpoena requests the original record, Medical Records Supervisor should present to (but not leave) the court the original medical record. Medical Records Supervisor should request that a photocopy of the medical record be made and retained by the court. If

the court requires the original it should be entrusted only to appropriate court staff, such as Clerk of the Court, and should NOT be given to a Probation Officer, Attorney or Protective Services Worker, etc. unless this is specifically ordered in the subpoena.

**The notice accompanying the Subpoena Duces Tecum will read:

NOTICE TO CONSUMER

The attached request for subpoena means that a name of party requesting the subpoena has asked the court to issue a subpoena to your doctor or other health care provider requiring them to produce your medical records. Your doctor or other health care provider is required to respond by providing a copy of your medical records. If you believe your records should not be disclosed and object to their disclosure, you have the right to file motion with the clerk of the court to quash the subpoena. You may contact the clerk's office to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, it must be filed as soon as possible before the provider sends out the records in response to the subpoena. If you elect to file a motion to quash, you must notify your doctor or other health care provider(s) that you are filing the motion so that the provider knows to send the records to the clerk of court in a sealed envelope or package for safekeeping while your motion is decided.

The notice that will come to the provider, notifying the agency of a pending subpoena will read:

NOTICE TO PROVIDERS

If you receive notice that your patient has filed a motion to quash (objecting to) this subpoena, or if you file a motion to quash this subpoena, send the records only to the clerk of the court which issued the subpoena using the following procedure: Place the records in a sealed envelope and attach to the sealed envelope a cover letter to the clerk of the court which states that confidential health care records are enclosed and are to be held under seal pending the court's ruling on the motion to quash the subpoena. The sealed envelope and the cover letter shall be placed in an outer envelope or package for transmittal to the court.

Subpoenas for Individuals

Subpoenas for individuals should ordinarily be accepted only by the Chief Executive Officer or designee. Subpoenas for individuals cannot be quashed as the Subpoena Duces Tecum. Any questions or problems concerning the acceptance of subpoenas should be directed to the appropriate Division Director or Program Supervisor. The following guidelines will assist in accepting subpoenas for individuals:

- Prior to acceptance of a subpoena for an individual, determine whether or not there are five working days from the date of service to the date of appearance of the subpoenaed individual.
 - If there are at least five working days between the date of service and date of appearance, accept the subpoena.

- If there are less than five working days from the date of service to the date of appearance, there is an issue as to whether or not timely delivery of the subpoena to the named individual can be accomplished. Make a reasonable effort to locate the named staff member, and notify her/him of the need to serve an outstanding subpoena.
 - If the staff member is located and agrees, the subpoena may be accepted.
 - If the staff member cannot be located, or the staff member does not agree to allow someone to accept the subpoena, advise the deputy that timely deliverance of the subpoena to the named individual cannot be assured and that, therefore, the subpoena cannot be accepted.
- Upon acceptance of a subpoena, the staff member accepting the subpoena will:
 - Will complete an entry on the Acceptance of Subpoena Log.
 - Directly notify the person named on the subpoena of all relevant information, with appropriate notations made on the log. Leaving a voice-mail, e-mail, or information in the staff member's mail box is **NOT** sufficient.
 - Deliver the subpoena to the named individual.
- If a subpoena was accepted in the absence of the named individual, and there were less than five working days between the date of service and the date of appearance, and the named individual cannot be contacted within one working day of acceptance of the subpoena, then the person accepting the subpoena will then be responsible for contacting either the staff person and/or the court with regard to the appearance.

Acceptance of Warrants

In the event that a public safety officer presents a warrant for arrest of a consumer, or a search warrant, staff will consult with the appropriate division Director who will seek consultation with the Chief Executive Officer regarding the need to pursue legal consultation with the agency attorney.

Observation and Recording

In order to provide the most effective clinical supervision and training, the use of audio and videotape and live observation of services for supervisory and peer review, as well as training, is strongly encouraged. In order to assure consumer confidentiality, the following guidelines will be followed:

Taping or live observation of consumers will only be done with the written consent of the consumer. The Observation and/or Recording Consent form is used for this purpose.

- Consumers will always be made aware when taping or observation is being done.
- Tape review will be restricted to staff and trainees of Richmond Behavioral Health Authority unless specific authorization is obtained for use for other purposes (e.g., case coordination with another agency).

- Observation will be restricted to staff and trainees of Richmond Behavioral Health Authority. There is one exception: If the consumer consents to the use of tape or observation for training purposes, this authorization extends only to training provided by Richmond Behavioral Health Authority staff for professional or student audiences.
- When training activities are conducted, every effort will be made to protect the confidentiality of the consumer and any trainee who recognizes the consumer will be asked to leave during that portion of the training activity.
- The consumer may withdraw authorization at any time.

Publication, Photograph and Broadcast

Richmond Behavioral Health Authority occasionally disseminates directly, or upon request of the news media, information about its programs that includes, with the appropriate authorization, still and videotaped photographs. At times, these photographs include recognizable likenesses of consumers. In order to assure appropriate documentation of the consumer's permission for the Agency to use such photographs, the authorization form, is to be completed prior to the consumer being photographed. It is the responsibility of the staff member arranging to have the photographs taken to obtain written consent for taking the photographs, and consumer authorization to disclose the photographs. In no circumstances is a photograph to be used for any purpose if any recognizable single consumer in the photograph has not signed the authorization form. Each consumer being photographed must sign the authorization form, and each consumer in the photograph must authorize its use by signing an authorization form, or it will not be disclosed. In the case of a minor, either the child or the parent may sign, unless the minor specifically declines permission for photographs to be taken.

Freedom of Information

All non-confidential records, policies, procedures, and related public records will be available for public scrutiny and fees for copying these materials will be charged as following:

\$0.50 per page up to 50 pages and \$0.25 a page thereafter for copies from paper or other hard copy generated from electronic storage, \$1.00 per page for any copies from microfilm, plus all postage and shipping costs and a \$10.00 search and handling fee.

12 VAC 35-105-880 Documentation Policy

Record-Keeping Guidelines

The Medical Records' Department is a support service of Richmond Behavioral Health Authority (RBHA) whose primary purpose is to contribute the quality of consumer care through the development and maintenance of a comprehensive reporting system. A reporting system is an essential requirement for the effective functioning of behavioral health agencies. It is also a prerequisite for assuring accountability, appropriate service planning and coordination.

A separate case record will be maintained on each consumer receiving services from the Richmond Behavioral Health Authority. The Problem-Oriented Record (POR) system is used to assure a uniform

recording system. Case records are filed according to the Terminal Digital Filing System in our three medical record rooms, where confidentiality is maintained. Records may be removed from the record room using a “sign-out” system. Only authorized staff providing services or who are reviewing and monitoring service delivery shall have access to consumer records. All records must be returned to the prospective record rooms by the end of the normal working day.

The primary service provider of each consumer shall be identified in the record. The primary service provider shall be responsible for maintaining the consumer records for respective consumer cases, and coordinating all services with any internal and external providers. Primary service providers shall maintain and update the consumer’s record in accordance with State behavioral health standards for PORs and agency procedures (see Chapter 4 for documentation instructions).

Medical records are permanent documents of the reporting system. The record keeping guidelines have been developed to promote the integrity of RBHA’s Consumer Medical Records, which are periodically examined by regulatory, funding, and legal agencies.

Some of the documentation guidelines include:

- The consumer’s full name and identification number shall be on each page.
- Entries shall include: the date, setting(office, field, etc.), service delivered, time spent, whether contact is face to face, telephone or client related
- All entries are made only on RBHA forms approved by the Forms Control Committee. If telephone messages must be part of the consumer record, the content of the message should be noted on the progress note.
- Typed or hand written in black ink.
- Words should be chosen carefully to leave no room for misunderstanding
- Never argue, complain, belittle, criticize or blame others to defend oneself in the record
- Legible, accurate and clear, avoiding discrepancies and /or contradictions with previous entries.
- Dated with the month, day and year the activity or service occurred.
- Chronological order; all time gaps in a record shall be justified
- All entries in the consumer’s record shall be current, dated, and authenticated by the person making the entry.

All services and/or activities are to be documented in the record, including all face to face and significant telephone contacts directly with the consumer and/or on behalf of the consumer. Telephone conversations are to be noted as such, including date of contact, who initiated the call, discussion content and response.

Entries are to be made chronologically to reflect the date the service or activity occurred. Late entries should have two dates: the date of actual service/activity and the date the entry is actually made in the chart and designated as a "late entry".

Only authorized abbreviations and symbols are to be used. (Refer to Table of Standardized Client Record Abbreviations at end of chapter) Medications and staff names are not to be abbreviated.

An entry should be made in each blank on forms used; enter N/A (not applicable) when no other entry is appropriate. Excess space before or after an entry should be filled with a straight line to the margin; this practice preempts challenges to the timeliness of entries.

Each entry is to be signed by the individual making the entry. The signature is to include the complete full name and credentials (e.g. LCSW, LPC, QMHP, QMRP, etc.)

Corrections are to be made in a manner which supports the reliability and credibility of the record. Simply put a single line through each word or line to be deleted, label error, initial and date. Proceed with the correct entry. Correction fluid which obliterates the original entry is not to be used.

Records of Individuals Seen in Non-Consumer Status

The only official records which may be kept regarding individuals seen at the agency in a Non-Consumer Status (e.g., Triage forms, Prevention Groups, Mutual Support Groups, etc.) will identify attendance at such groups. Even if the individual signs an Authorization to Disclose Health Information, which allows our disclosure of information, only information regarding her/his participation will be released. Without such consent, the agency will not acknowledge the individual's participation or non-participation. Questions regarding clarification of this procedure should be directed to the Medical Records' supervisor.

12 VAC 35-105-890 Individual's Service Record

- A. Richmond Behavioral Health Authority has established a single, separate primary record for each individual or family admitted for service. A separate record shall be maintained for each family member who is receiving individual treatment.
- B. All individuals admitted to Richmond Behavioral Health Authority shall have identifying information on the face sheet in the individual's service record. Identifying information on the standardized face sheet include the following:
 1. Identification number unique for the individual;
 2. Name of the individual
 3. Current residence, if known
 4. Social security number
 5. Gender
 6. Marital status

7. Date of birth
8. Name of legal guardian
9. Name, address, and telephone number for emergency contact
10. Adjudicated legal incompetency or legal incapacity, if applicable;
11. Date of admission to service

C. In addition to the face sheet, an individual's service record shall contain, at a minimum:

1. Screening documentation
2. Assessments
3. Medical evaluation, as applicable to the service
4. Advance Directive, if available
5. Individualized services plans and reviews
6. Progress notes; and
7. A discharge summary, if applicable

12 VAC 35-105-900 Record Storage and Security

Consumer Record Security and Tracking

It is required that both originals and copies of consumer records be secured against loss, defacement, tampering, and use by unauthorized persons and that the location of each consumer record is known at all times. For these reasons, the following procedures are established.

Procedures for Storage and Handling of Records

The following procedures have been developed for the storage and handling of records.

Storage of Open Records

Records of active consumers will be located at one of the three secure medical record's areas at which the consumer receives services and accessible to appropriate staff. To ensure that records are organized and available to staff, records are filed as soon as they are made available. It is the responsibility of each Medical Records' technician to develop a plan for storing consumer information and to obtain the approval of the RBHA Medical Records Supervisor for the plan. Exceptions to this procedure must be approved by the Quality and Standards Director and/or Chief Executive Officer.

Storage of Closed Records

All records for cases that are closed will be located in the Closed Records Room in the main Medical Records Department and multi-volumes for cases that are closed are placed in a secured office on the lobby level.

Sign-Out of Closed Records

Closed records are obtained by request to the Medical Records Department. Upon receipt of a request for a closed record, Medical Records' Technicians will provide the closed record within four (4) hours.

Sign-Out of Open Charts

Authorized staff members may go to the secured medical record areas and request the open record needed. Only those staff members with a legitimate need for administrative or service delivery purposes shall have access to information regarding consumers, including consumer records. In the absence of Medical Records staff, if a record is removed from the secure record areas, staff shall initiate a Consumer Record Charge Out Slip and out guide. Staff locates the record, insert out guide in its place, and removes the record. If chart space is already marked with an out guide, staff shall use the information provided on the Consumer Record Charge Out Slip to locate the record. Monthly, the out guides will be inventoried by the Medical Records Department staff. On or about the fifteenth of the month, all out guides should be reviewed and records located.

Transferring Records

The agency is responsible for knowing the location of all consumer records at all times. The Intra-agency Chart Tracking form is utilized to:

1. Document records that were requested, but not found and the return of that record.
2. Document records being received and the return of records that were misfiled or lost.

Staff transporting records to another area/floor and returning a record the same day; do not record on the Intra-agency Chart Tracking Form. For same day transportation and return, use Client Record Charge Out Slip.

The Intra-agency Chart Tracking form shall be located where records are kept. These forms will be maintained as a log and 2 years worth will be kept, 1 year on site, to aid in locating misplaced charts.

Transporting of Records

It is the policy of Richmond Behavioral Health Authority that all medical records remain in designated secure areas at all times. In the event that the Medical Records' staff is required to transport records to court, then records should be secured in a confidential bag or briefcase.

Records, or photocopies of any portion of a record, may be removed from RBHA facility only under the following circumstance:

- For Court and Commitment Hearings in which record information must be available to the staff member.

Retention of Active Records Overnight

All records must be returned to the appropriate secure record area at the end of the workday. No records may be kept in offices overnight even if they have been specifically designated as "Sensitive Client Records."

If an authorized staff member knows that he/she will need a record immediately the next day, he/she may file the record overnight in the Medical Records Department file holding area, after following the appropriate "sign-out" procedure. Work on records should be completed within 24 hours of the first overnight hold. If record work cannot be completed within this time frame, the record must be returned to the secure record area.

Sensitive Client Records

Certain consumer records are designated "sensitive" so that there is limited staff access to these records. Examples of records that might be designated as sensitive are those of City or RBHA employees and their families, or well-known individuals. The designation of a chart as "sensitive" will be made by the consumer's Primary Case Manager/Clinician in conjunction with the Medical Records' Department Supervisor, Program Supervisor and/or Division Director. Once so designated, the sensitive record will be kept in a secure manner in a designated central area for sensitive charts as long as it is an open and active case. Once closed, the Medical Records Department Supervisor will determine whether the sensitive record should be filed in the Closed Records section or in the designated central area. In any case, the sensitive record will be kept in a locked and secure section of Medical Records' Department.

Security of Records

All service and support staff share equally in the responsibility of assuring that consumer information is secure at all times and that these procedures are followed. The Medical Records' Supervisor is in charge of a secure record area and is further responsible for assuring compliance with these procedures.

Access to Record Areas

The number of staff on each floor who has access to the keys to secure record areas is limited. At each records area, this will be limited to primary service providers, division directors, program supervisors, quality and standards staff, who have a need for access; the appropriate staff in the Administrative Division, and the Assessment/Emergency and Medical Services staff. The Medical Records Department Supervisor is in charge of the medical record areas and will be responsible for the distribution of keys to the medical records' and emergency services staff to secure record areas. Every effort must be made to limit the number of staff who receives these keys. A list of individuals who receive keys must be maintained by the Medical Records' Department Supervisor. Secure record areas must be locked when not under the supervision of assigned staff.

Assuring Security in Areas Other Than Designated Record Storage Areas

In addition to confidential information included in consumer records, there are several other areas in which availability of confidential information must be carefully regulated.

Reception Areas

All written material with consumer names (daily schedule, phone log, accounts payable, etc.) must be locked up after reception coverage has ended for the day.

Master keys must be kept out of sight at all times and be locked up after reception coverage has ended for the day.

Consumer names, discussion of consumers and their families, etc., by staff in reception area must be done in such a manner that others in the waiting area do not overhear such discussions.

Consumers and other non-staff will not be allowed in the receptionist area.

Mailbox and Facility Holding File Areas

Although placing consumer files in mailboxes is discouraged, when deemed necessary to store consumer files and other consumer-related material in staff mailboxes "reasonable care" must be taken to see that these areas are secured at all times and after hours.

Staff Offices

No consumer records may be kept in a staff member's office overnight. Any other material with consumer's name (correspondence, appointment schedules, etc.) should not be in plain view on desk-tops. All offices (desks – if in a cubicle) shall be locked overnight.

Business Staff Areas

Copies of confidential correspondence, psychological reports, etc., which are discarded must be destroyed by shredding.

Copies of confidential correspondence, reports, etc., that are kept in this area must be locked up after office hours in files, desks, etc.

The Medical Records Department, Business Office and Data Processing areas are a major concern due to the log books, notebooks, notes, etc., that include consumer names and information. These materials must be locked and out of sight after office hours.

Offices that can be locked must be locked at night. This includes the financial and accounting offices. Confidential material within these offices should also be locked up at night in desks, files, etc.

Monitoring of Security Procedures

Overall responsibility for monitoring the record security system lies with the Medical Records Department Supervisor. Such monitoring will be coordinated with the Quality and Standards Division and MIS Division Directors. Periodic checks of the record files will be made to determine staff use of out guides and to assure adequate tracking of records at all times. Staff offices will be checked periodically to assure that established procedures are followed. Any problem revealed by such monitoring will be reported to the appropriate Division Director on the Medical Record Incident Form.

Reporting of Security Breaks

Disclosure of consumer record information, except as authorized in these guidelines, will not be tolerated. Examples of various types of security breaks are listed below:

- Consumer record material is seen by unauthorized individuals, i.e., anyone other than RBHA staff or individuals named in specific releases of information.
- Secure record area is left unlocked overnight or on the weekend.
- Records are removed from their primary storage area, other than under the authorized conditions listed above.
- Records are kept in staff offices, other than under the authorized conditions listed above.
- Non-RBHA staff is in the designated secure record area at anytime.

When any security break involving consumer information occurs, the following procedures are to be followed:

- Staff member discovering the break will report it to the appropriate Program Supervisor and/or Division Director who will immediately report it to the Medical Records Department Supervisor.
- The Medical Records Department Supervisor will investigate the break and determine what action is necessary to correct the situation.
- In all cases of violations of consumer record security, the Medical Records Department Supervisor will keep the Quality and Standards Director informed. In consultation with the Chief Executive Officer, a decision will then be made as to whether or not other parties are to be informed, (e.g., Commonwealth's Attorney, Division of Police, etc.), and what action is to be taken.

12 VAC 35-105-910 Retention of Individual's Service Records

Retention and Disposition of Case Records

Responsibility for Retention and Disposition of Records

Ongoing implementation of the retention and disposition of records shall be the responsibility of the Medical Records Department Supervisor.

Converting Records to Microfilm or CD-Rom

Richmond Behavioral Health Authority is currently developing a plan to include on an annual basis, case records of consumers who have been closed without contact since the calendar year two (2) years previous will either be converted to microfilm or CD-Rom. Converting of records will meet or exceed standards for archive retention as established by the State Library Board of Virginia in accordance with provisions of Virginia Public Records Act. Two copies of all records will be produced. One will be stored in a secure manner in the Closed Record Room. The second will be a "backup" that will be stored at the agency Archives.

In the event that a program or facility ceases to operate, all case records will be converted and stored in an alternate and secure space. Should all programs and facilities of the Board cease to operate, all records will be retained in a designated alternate location for ten (10) years following the termination of the program.

Review/Audit of Converted Records

A sample of converted records will be reviewed for completeness and quality prior to destruction of the paper originals.

Destruction of Original Records

Original case records which have been converted to microfilm or CD-Rom and reviewed as indicated above will be destroyed by shredding in accordance with the Code of Virginia The Certificate of Records Destruction (RM-3 form) must be sent to the Medical Records Department Supervisor and MIS Division once the original records are destroyed. A statement indicating the original records were reformatted according to Library of Virginia guidelines and standards must be on the form. Records may be destroyed ten (10) years following the last date of treatment or contact; or five (5) years following age of majority for a minor; or five (5) years following death, whichever is longer. However, records of persons under a disability may be destroyed ten (10) years following the last date of treatment or contact; or five (5) years after a person is considered to be legally competent and no longer considered to be "under a disability", whichever is longer. The disability ends when the court finds the person to be competent. RBHA does not have procedures in place to document which consumers have court appointed guardians or a process of being notified when the court has ended a client's disability. Therefore, RBHA will maintain all records for an average lifespan (75 years) beyond the last date of treatment or contact.

Destruction of Confidential Information

All confidential information that is to be discarded will be shredded. The Medical Records' Department Supervisor will develop procedures for the protection of items to be shredded.

Guidelines for Disaster Recovery of Records

The following guidelines and information is provided by the Library of Virginia for offices having records damaged by water or floods.

The first process is to organize the recovery process by determining whether or not a commercial recovery service is needed. The decision should be based on the extent, type, and location of the damaged record, the amount of records/materials to be removed and the ability or difficulty to gain access to the building.

Maintain security by limiting the number of staff/persons into damaged records area and use check-in sheets to monitor traffic.

Inhibit the growth of mold by placing fans in the records areas as soon as possible to circulate air and keep interior of the building as dry and cool as possible. If possible, move the records to a clean, dry place.

Categorize the records by priority:

Top priorities are records that are difficult or impossible to replace or replicate (permanent and/or vital records).

Secondary priorities are records that would cause extreme difficulty if destroyed or are difficult to replace and that provide significant operational or research resources.

Last priorities are records/material that would cause some inconvenience but can be replaced either in original or reproduced format, or that may, if necessary, be considered expendable.

The Recovery Process

Paper Record:

If the records are slightly damp and space is available, spread them out and let air dry. Circulate air with fans at low temperatures. Although records may dry rigid and rippled, consider reformatting to photocopy or microfilm as part of the recovery process.

Very Wet or Saturated Paper Records:

Handle wet papers with care and as little as possible. Pack in storage boxes. Do not remove records from the file drawer. Store drawers in refrigerated trucks as quickly as possible. RBHA will develop a plan to address shipping drawers to a freeze-dry facility.

Magnetic Tapes/Fixed Discs:

Soiled discs or tapes will damage equipment. Consult with vendors who specialize in recovery services for media.

Microfilm:

If microfilm is damaged, leave in cartons. Use rubber bands to secure labels. Immerse film in clean water in a lidded container. Do not agitate container during transportation or storage. The Medical Records Department Supervisor and the MIS Director will collaboratively consult with film and/or equipment companies that offer restoration services:

Disaster Recovery Services

American Freeze Dry, Inc. (609) 546-0777
411 White Horse Pike
Audubon, New Jersey 08106

BMS Catastrophe, Inc. (800) 433-2940
Corp HQ, 303 Arthur Street
Ft. Worth, TX 76107

Document Reprocessors (800) 437-9464
5611 Water Street
Middlesex, NY 14507

M.F.Bank- The Restoration Company (800) 843-7284
3120 Medlock Bridge Road, Building 1

Norcross, GA 30071

Servpro of Chesterfield, Inc.
Servpro of Richmond

(804) 378- 2323
(804) 740- 6151

12 VAC 35-105-920 Review Process for Records

The Quality and Standards Division has developed and implemented a monthly statistical sampling review process to evaluate both current and closed records for completeness, accuracy, and timeliness of entries. Additionally, this division routinely conducts compliance reviews to ensure that the services provided to RBHA consumers meets best practice standards, are medically necessary, and appropriate.

A summary of findings is distributed to the appropriate service director who will then be requested to provide a corrective action plan to the Quality and Standards Division, no later than two (2) weeks post the review.

EXTERNAL REVIEWER/AUDITOR/CORRECTIVE ACTION PLAN PROTOCOLS

During an initial or ongoing review or investigation, Richmond Behavioral Health Authority (RBHA) shall cooperate with third-party payers, federal, state, and local regulations governing reviewer access to documents, records, staff, and consumers that are needed in order to conduct inspections and complaint/incident investigations. RBHA will implement a corrective action plan for each area found to be in noncompliance with regulations.

External reviewer/Auditor Process:

The process outlined below shall be used once a reviewer/auditor requests information about a consumer or primary service provider by a) telephone, and/or b) enters the main site or a satellite location of RBHA:

1. The Director of Quality and Standards (Q & S) should be contacted immediately to receive the request directly from reviewer and facilitate access to documents, information, records, staff and consumers.
2. The Director of Q & S shall immediately notify the Chief Executive Officer or designee, the Division Director or designee of details of each informal and/or formal contact and/or announced or unannounced visit from an external auditor/reviewer. Informal contacts should be kept to a minimum.
3. Exit Interviews with external reviewers and auditors are strongly encouraged and shall include the following RBHA staff:

Chief Executive Officer
Division Director
Staff (appointed by Chief Executive Officer and/or Division Director)
Quality and Standards Director

4. The Director of Quality and Standards shall forward a written overview of the Exit Interview Conference to the Chief Executive Officer and Division Director.

External Auditor/Review Report and Request for Corrective Action Plan (CAP) Process:

1. Upon receiving a report of findings from any external auditor/reviewer, the Director of Quality and Standards shall immediately alert and forward the report of findings to the Chief Executive Officer and Division Director.
2. **RBHA has the right to request a conference with the reviewer and the reviewer's supervisor should they desire further discussion of the findings, which will be determined by the Chief Executive Officer.** Acting upon the directive of the Chief Executive Officer or designee, the Director of Quality and Standards will coordinate this conference.
3. If compliance with a regulation cannot be determined by DMHMRSAS, DMAS, third party insurer, etc., the Director of Quality and Standards in collaboration with the Chief Executive Officer and Division Director shall comply with requests for additional information and submit within 10 business days of the issuance of the report. As deemed warranted by the RBHA Chief Executive Officer, the Director of Quality and Standards will request extensions prior to due date.
4. To avoid violation of due dates, the Division Director and the Director of Quality and Standards shall immediately collaborate and collectively implement the corrective action plan for each deficiency or regulation found to be in noncompliance to include:
 - a. Description of the corrective actions to be taken
 - b. Date of completion of each action; and
 - c. Signature of the RBHA representative
5. When practicable, a corrective action plan (CAP) will be submitted to the reviewing agency for approval within 15 business days of the issuance of findings report, unless it is determined by the Chief Executive Officer that a request for an extension prior to due date is warranted.
6. The Director of Quality and Standards shall collaborate closely with the Division Director to monitor implementation of pledged corrective action plan and evaluate service quality as well as effectiveness on a systematic and ongoing basis.

Standardized Client Record Abbreviations

<u>Abbreviation</u>	<u>Definition</u>
a	Before
@	At
A	Assistance
A.A.	Alcohol Anonymous
AC	Aftercare
ac	Before meals
ACOA	Adult Child of an Alcoholic
A.C.S.W.	Academy of Certified Social Workers
ACT	Assertive Community Treatment
ADD	Attention Deficit Disorder
ADC	Aid to Dependent Children
ADL	Activity of Daily Living
ADHD	Attention Deficit Hyperactivity Disorder
adm	Admission
AIDS	Acquired Immunity Deficiency Syndrome
AKA	Also Known As
AM	Morning; before noon
antibx	Antibiotic(s)
AMA	Against Medical Advice
APA	American Psychiatric Association
appt	Appointment
apt.	Apartment
APS	Adult Protective Services
AR	Annual Review
ARC	Association of Retarded Citizens
AROM	Active Range of Motion
ASAP	As soon as possible

A..S.A.P.	Alcohol and Safety Action Program
ASPD	Antisocial Personality Disorder
Assist.	Assistance
audio	Audiology, audiological
A/V	Auditory/Visual
B	Bilateral
BDS	Behavior Development Survey
b/f	Boyfriend
BF	Black Female/African American Female
BM	Black Male/African American Male
b.i.d.	Two Times per Day
BIS	Behavior Intervention Services
B/P or BP	Blood Pressure
B.M.	Bowel movement
Bo or bro	Brother
BW	Birth Weight
c or w/ orw	With
ca	Cancelled
CA	Chronological Age
Caps	Capsules
Case Mgt.	Case Management
CBC	Complete Blood Count
CC	Chief Complaint
c.c.	Cubic Centimeter
CCC	Certificate of Clinical Competence of American Speech Language Hearing Association
CCC-A	Certificate of Clinical Competence - Auditory
CCC-SP	Certificate of Clinical Competence - Speech Pathology
CDI	Community Diversion Incentive
Clt. or Cl	Client
c/o	Complains of
C.F.R.	Center for Facial Reconstruction, MCV

C.H.	Children's Hospital
COA	Child of an Alcoholic
cog.	Cognitive
coke	Cocaine
cont.	Continued
CP	Cerebral Palsy
CPS	Child Protective Services
CSA	Comprehensive Services Act for Children and Youth
CSB	Community Service Board
CSH	Central State Hospital
CVTC	Central Virginia Training Center
CT	Crisis Therapy
CTT	Case Consultation Team
da	Daughter
DB	Decibel
D/C	Discharge
d/c	Discontinue
DD	Dual Diagnosis
detox	Detoxification
DOA	Dead on Arrival
Disp	Disposition
Div	Divorced
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services
DNKA	Did Not Keep Appointment
D/O	Disorder
D.O.A.	Date of Admission
DOB	Date of Birth
D.O.L.	Department of Labor
Dr.	Doctor
dr.	dram

DRS	Department of Rehabilitative Services
DSM IV	Diagnosis and Statistical Manual of Mental Disorders Fourth Edition
DSS	Department of Social Services
DT's	Delirium Tremens
DTR's	Deep Tendon, Reflexes
DUI	Driving Under the Influence
DV	Domestic Violence
DVH	Department of the Visually Handicapped
DWI	Driving While Intoxicated
Dx	Diagnosis
Dz	Disease
ECT	Electroconvulsive Treatment
EEG	Electroencephalogram
elix	Elixir
e.g.	For Example
E.L.	Expressive Language
EMR	Educable Mentally Retarded
EMS	Emergency Medical Services
ER	Emergency Room
enc.	Encourage
E.N.T.	Ear, Nose and Throat
ESH	Eastern State Hospital
ETOH	Alcohol
eval.	Evaluation
exam	Examination
f	Female
Fa	Father
F/F or f/f	Face to Face
FHx	Family History
FM	Fine Motor
FT	Family Therapy

f/t	Full Time
f/u	Follow-up
FOK	Fund of Knowledge
FV	Field Visit
G.A.	Gestational Age
GED	General Educational Development
GFa	Grandfather
g/f	Girlfriend
G.I.	Gastrointestinal
gm	Gram
GM	Gross Motor
Gmo	Grandmother
GRTC	Greater Richmond Transit Authority
gtt(s)	Drop(s)
GT	Group Therapy
G-Tube	Gastrointestinal Tube
GW	Green Warrant
ha	Headache
HAMHRS	Henrico Area Mental Health Retardation Services
HBI	Home Based Intervention
HI	Homicidal Ideations
HIV	Human Immunodeficiency Virus
H&P	History and Physical
HPI	History of Present Illness
H2O	Water
hosp	Hospital
hr.	Hour
hrs.	Hours
h.s.	At Bedtime
HV	Home Visit
hx	History

I	Independent
IC	Initial Contact
ICAP	Inventory for Client and Agency Planning
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility-Mental Retardation
ID	Identification
i.e.	Such as, that is
IEP	Individualized Education Program
I.F.S.P.	Individual Family Service Plan
ILC	Independent Living Center
IM	Intramuscular
Imp:	Impression
info	Information
inj.	Injection
IOP	Intensive Outpatient Program
IIH	Intensive In-Home
inpt.	Inpatient
IP	Identified Patient or Person
IQ	Intelligence Quotient
irreg	Irregular
I.R.W.E.	Income Related Work Expense
ISP	Individual Service Plan
IT	Individual Therapy
IV	Intravenous
IVH	Intra-ventricular, hemorrhage
I.V.N.A.	Instructive Visiting Nurses Association
J&DC	Juvenile and Domestic Relations Court
Kg	Kilogram(s)
KHz	Kilo-hertz
l	Liter
L	Left

L.	Lower
lab	Laboratory
lbs	Pounds
LFT	Liver Function Test
LOC	Level of Consciousness
L.C.S.W.	Licensed Clinical Social Worker
L.C.P.	Licensed Clinical Psychologist
LD	Learning Disability
LE	Lower Extremities
LEP	Life Enrichment Program
LiC03	Lithium Carbonate
liq	Liquid
LL	Lithium Level
L/M	Left Message
L.P.C.	Licensed Professional Counselor
LTMI	Long Term Mentally Ill
m	Muscle
M	Male
MCMII-II	Miller Clinical Multiaxial Inventory II
MCV	Medical College of Virginia
MD	Muscular Dystrophy
M.D.	Medical Doctor
ME	Middle Ear
Meds	Medications
mg	Milligrams
MH	Mental Health
MHCM	Mental Health Case Management
MHSS	Mental Health Supports Services
Micro	Micro-Images
MI	Mental Illness
M.I.M.	Marschack Interaction Method

min.	Minute
ml	Milliliter
MIS	Management Information System
MMPI-2	Minnesota Multiphasic Personality Inventory-2
Mo	Mother
m.o.	Month(s) Old
MR	Mental Retardation
MRCM	Mental Retardation Case Management
MSE	Mental Status Exam
MSW	Masters of Social Work
MT	Martial Therapy
NA	Narcotics Anonymous
N/A	Not Applicable or Not Appropriate
NEC.	Necrotizing Enterocolitis
neg.	Negative
NGRI	Not Guilty By Reason of Insanity
NGT	Nasogastric Tube
NKA	No Known Allergies
nl	normal
NOS	Not Otherwise Specified
N.P.O.	Nothing By Mouth
N/S	No show
N&V	Nausea and Vomiting
O2	Oxygen
OD	Overdose
OK	Okay
O/M	Oral-Motor
O/P	Outpatient
O.T.	Occupational Therapy
OTR	Registered Occupational Therapist
OV	Office Visit

Oz	Ounce
p	after; post
P.A.S.S.	Plan for Achieving Self Support
p.c.	After meals
P.C. or P/C	Phone Call, Phone Conversation , Phone Contact
PCP	Primary Care Physician
PE	Physical Examination
Ped.	Pediatric
per	Through, by, in accordance with
P.G.D.	Pediatric Group Practice, MCV
PGH	Piedmont Geriatric Hospital
Ph.D	Doctor of Philosophy
PHP	Partial Hospitalization Program
PIH	Pregnancy-Induced Hypertension
PIP	Parent Infant Program
PM	Evening; afternoon
p.o.	By mouth or orally
post	After
prn	As needed; whenever necessary
Prob	Problem(s)
PROM	Passive Range of Motion
p/t	Part Time
psych	Psychiatric
Psy. D	Doctor of Psychology
pt.	Patient
P.T.	Physical therapy
q	Every
QA	Quality assurance
qam	Every morning
qd	Every Day
q.i.d	Four Times a Day

q.h.	Every hour
qhs	At Bedtime
QMHP	Qualified Mental Health Provider
QMRP	Qualified Mental Retardation Provider
q.o.d.	Every Other Day
q.o.w.	Every Other Week
qw	At awakening
® or rt.	Right
RBHA	Richmond Behavioral Health Authority
Rd.	Road
RDS	Respiratory Distress Syndrome
re	regarding
rec.	Recommend, recommendation
rec'd	Received
Reg	Regular
res	Residential
R.L.	Receptive Language
R.N.	Registered Nurse
RNC	Registered Nurse Certified
R/O	Rule Out
ROM	Range of Motion
RT	Recreational Therapy
RTC	Return to Clinic or Center
RU	Reporting Unit
Rx	Prescription Drugs
s or w/o	Without
SA	Substance Abuse
SC	Service Coordination
SAR	Semi-Annual Review
S/E	Social Emotional

s/e	Side Effects
S.E.	Supported Employment
SED	Seriously Emotionally Disturbed
SFS	Specialized Family Services
sep	Separated
S/H	Self-help
SI	Suicidal Ideations
sibs	Siblings
sis	Sister
SJ	St. John's
SJV	St. Joseph's Villa
SL	Supportive Living
sl	Slightly
S.L.P.	Speech Language Pathologist
SMA	Blood Chemistry Profiles
SMH	St. Mary's Hospital
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
Soc.Sec.	Social Security
SOV	Scheduled Office Visit
SP	State Pharmacy
SS	Supportive Services
S&S	Signs and Symptoms
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Social Security Income
spec.	Specimen
S/P	Status Post
Stat	Urgent, immediate
SVTC	Southside Virginia Training Center
St.	Street

Subq.	Subcutaneous
Sx	Symptoms
SW	Social Worker
s/w	Spoke With
sz	Seizure
tab(s)	Tablet(s)
T	Transferred
TAT	Thematic Apperception Test
TB	Tuberculosis
TC	Telephone Contact
TDD	Telephone Device for the Deaf
TDO	Temporary Detention Order
TFC	Therapeutic Foster Care
thru	Through
t.i.d.	Three Times a Day
TFT	Thyroid Function Test
TSH	Thyroid Stimulating Hormone
TM	Tympanic Membrane
TMR	Trainable Mentally Retarded
TPN	Total Parenteral Nutrition
transp.	Transport
T.S.	Training Specialist
Tx	Treatment
U.	Upper
UDS	Urine Drug Screen
UE	Upper Extremities
u/s	Undersigned
unk.	Unknown
Vet.	Veteran
Villa	St. Joseph Villa
VCU	Virginia Commonwealth University

voc.	Vocational
VTCC	Virginia Treatment Center for Children
W	White
WAIS-R	Weschler Adult Intelligence Scale Revised
w/c	Wheel chair
WD	Withdrawal
WF	White Female
WISC-R	Weschler Intelligence Scale for Children Revised
wk	Week
W/L	Waiting List
WM	White Male
wn	Well Nourished
WNL	Within Normal Limits
WSH	Western State Hospital
wt.	weight
w/o	Without
WWRC	Woodrow Wilson Rehabilitation Center
x	Time(s)
YDT	Youth Day Treatment
y/o	Year Old
yrs.	Years

Symbols

&	And
–	Change
↓	Decreased
+/-	Emerging, inconsistent
=	Equal
–	Female
>	Greater than, e.g., 5 > 4
↑	Increased
→	Leading to
<	Less than, e.g., 4 < 5
–	Male
\$	Money
-	Negative
#	Number
	Parallel
%	Percent or Percentage
+	Positive
1°	Primary
?	Question, possibility
2°	Secondary

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