

Medical Records Extraordinaire: Balancing Documentation & Privacy

EXCERPTS TAKEN FROM

TITLE X – INFORMATION SECURITY
SECTION 3532. DEFINITIONS

www.uscis.gov/graphics/Title_X.pdf

&

PROGRAM GUIDELINES FOR
PROJECT GRANTS FOR
FAMILY PLANNING SERVICES

*The guidelines can be downloaded directly from OPA website at
http://opa.osophs.dhhs.gov/titlex/2001guidelines/ofp_guidelines_2001.html.*

(b) DEFINITIONS for Security

- (1) the term 'information security' means protecting information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide---
- a. integrity which means guarding against improper information modifications or destruction, and includes ensuring information non-repudiation and authenticity;
 - b. confidentiality, which means preserving authorized restrictions on access and disclosure, including means for protecting personal privacy and proprietary information;
 - c. availability, which means ensuring timely and reliable access to and use of information; and
 - d. authentication, which means utilizing digital credentials to assure the identify of users and validate their access;

The above relates to HIPAA security, similar terminology and references.

- (2) the term 'information system' means any equipment or interconnected system or subsystems of equipment that is used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information, and includes
- a. computers and computer networks
 - b. ancillary equipment
 - c. software, firmware, and related procedures
 - d. services, including support services, and
 - e. related services;

similar references made in HIPAA

- (3) Overseeing agency compliance with the requirements of this subchapter, including any authorized action to enforce accountability for compliance with such requirements--
- a. reviewing at least annually, and approving or disapproving agency information security programs; and
 - b. coordinating information security policies and procedures with related information resources management policies an procedures

10.3 MEDICAL RECORDS

Projects must establish a medical record for every client who obtains clinical services. These records must be maintained in accordance with accepted medical standards and State laws with regards to record retention. Records must:

- o Complete, legible and accurate; including documentation of telephone encounters of a clinical nature
- o Signed by the clinician and other appropriately trained health professionals making entries, including name, title and date
- o Readily accessible
- o Systematically organized to facilitate prompt retrieval and compilation of information
- o Confidential
- o Safeguarded against loss or use by unauthorized persons
- o Secured by lock when not in use, and
- o Available upon request to the client

▪ **Content of Client Record**

The client's medical record must contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results. The required content of the medical record includes:

- Personal data
- Medical history, physical exam, laboratory test orders, results, and follow-up
- Treatment and special instructions
- Scheduled revisits
- Informed consents
- Refusal of services, and
- Allergies and untoward reactions to drug(s) recorded in a prominent and specific location

The record must also contain reports of clinical findings, diagnostic and therapeutic orders and documentation of continuing care, referral and follow-up. The record must allow for entries by counseling and social service staff. Projects should maintain a problem list at the front of each chart listing identified problems to facilitate continuing evaluation and follow-up. Client financial information should be kept separate from the client medical record. If included in the medical record, client financial information should not be a barrier to client services.

▪ **Confidentiality and Release of Record** [this section relates to HIPAA the most and is much more specific than HIPAA (thus HIPAA is considered a minimum standard)]. A confidentiality assurance statement must appear in the client's record. The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality [59.11]. HIV information should be handled according to law, and kept separate whenever possible. When information is requested, agencies should release only the specific information requested (referred to as minimum necessary in HIPAA). Information collected for reporting purposes may be disclosed only in summary, statistical, or other form which does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care.

According to the program guidelines for family planning projects, the word “**must**” indicates mandatory program policy, “**should**” indicates recommended program policy related to components of family planning and project management and “**can**” or “**may**” indicate suggestions for considerations by individual projects.

8.3 HISTORY, PHYSICAL ASSESSMENT, AND LABORATORY TESTING

History

At the initial comprehensive clinical visit, a complete medical history must be obtained on all female and male clients. Pertinent history must be updated at subsequent clinical visits. The comprehensive medical history must address at least the following areas:

- Significant illnesses; hospitalizations, surgery, blood transfusion or exposure to blood products, and chronic or acute medical conditions;
- Allergies;
- Current use of prescription and over-the-counter medications;
- Extent of use of tobacco, alcohol and other drugs;
- Immunization and Rubella status;
- Review of systems;
- Pertinent history of immediate family members; and
- Partner history
 - Injectable drug use
 - Multiple partners
 - Risk history for STDs and HIV
 - Bisexuality

Histories of reproductive functions must include at least the following

For Female Clients	For Male Clients
Contraceptive use past and current (including adverse effects)	Sexual history
Menstrual history	Sexually transmitted diseases (including HBV)
Sexual history	HIV, and
Obstetrical history	Urological conditions
Gynecological conditions	
Sexually transmitted diseases (including HBV)	
HIV	
Pap smear history (date of last pap, any abnormal pap, treatment)	
In utero exposure to diethylstilbestrol (DES)	

Clinics must provide and stress the importance of the following to all clients:

Blood pressure evaluation, breast exam, pelvic examination which includes vulvar evaluation and bimanual exam, pap smear, colo-rectal screening in individuals over 40, and STD and HIV screening as indicated.

If a client chooses to decline or defer a service, this should be documented in their record.

Counseling must include information about the possible health risks associated with declining or delaying preventive screening, tests, or procedures.