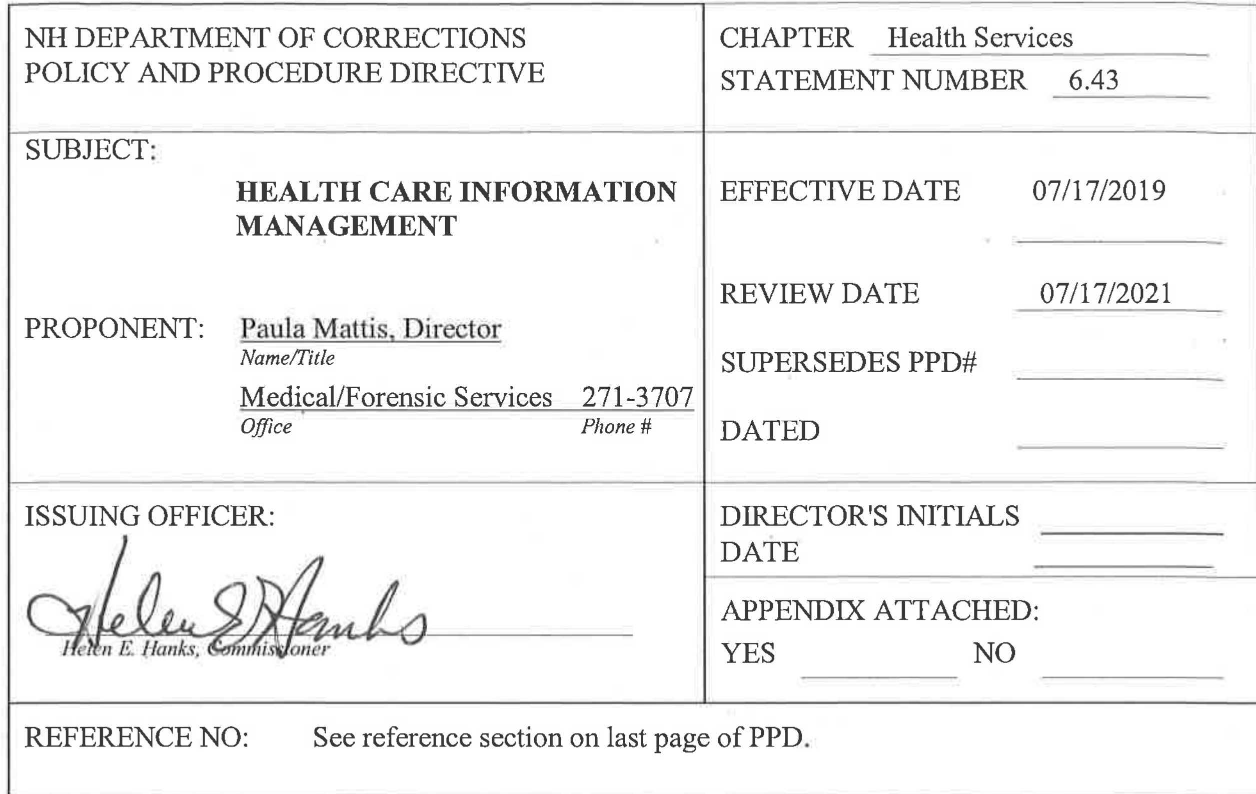

NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER Health Services STATEMENT NUMBER 6.43
SUBJECT: **HEALTH CARE INFORMATION MANAGEMENT** PROPONENT: Paula Mattis, Director *Name/Title* Medical/Forensic Services 271-3707 *Office* *Phone #*	EFFECTIVE DATE 07/17/2019 REVIEW DATE 07/17/2021 SUPERSEDES PPD# _____ DATED _____
ISSUING OFFICER: *Helen E. Hanks, Commissioner*	DIRECTOR'S INITIALS _____ DATE _____ APPENDIX ATTACHED: YES _____ NO _____
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:

To provide guidelines and procedures for the content, handling, utilization, maintenance, and retention of health care records for the Division of Medical and Forensic Services. Health information management serves a multitude of purposes including providing data and information for patient care planning, continuity of patient care, quality assessment review, and legal defense as well as business record keeping.

II. APPLICABILITY:

To all staff that have authorized access to the electronic health record (EHR) or in the course of their work will come in contact with patient health care information.

III. POLICY:

It is the policy of the New Hampshire Department of Corrections (NHDOC) that a complete, confidential, and integrated electronic health care record (EHR) shall be maintained for each patient while in the care and custody of the NHDOC.

IV. PROCEDURE:

A. Staff responsibilities and utilization of the EHR.
   1. Staff shall only utilize the EHR in an approved manner following specific workflows and conventions as specified in the EHR manual. This manual is available to all authorized EHR users by going to the NHDOC intranet home page, clicking on Medical and Forensic Services, EHR project, TechCare manual.
   2. Staff shall only utilize the EHR in the course of their job duties.
   3. Staff in the following service areas are required to use the EHR for documentation of services provided to NHDOC patients:
      a. Medical services

b. Behavioral health services (mental health, sexual offender and substance use disorder treatment services)
c. Dental services
d. Officers assigned to the Secure Psychiatric Unit (SPU).

B. Staff are prohibited from using the EHR in any manner that is not authorized by NHDOC. Some examples of prohibited use include but are not limited to:
   1. Sharing of health information with DOC staff not involved in the treatment team.
   2. Accessing or utilizing EHR for patients not being treated or followed by the staff person in the course of their job duties.
   3. Sharing a patient's health information with external parties without an appropriate release.
   4. Logging into the EHR using another employee's account.

C. The Director of Medical and Forensic Services shall determine access to the EHR in order to maintain confidentiality of the health information record.

D. Routine access to the EHR and the information contained therein shall include:
   1. Direct Care Staff:
      a. Medical and psychiatric providers
      b. Dental providers, hygienists, and assistants
      c. Pharmacists and pharmacy technicians
      d. Nursing staff
      e. Physical therapists
      f. Nutritionists
      g. Recreation therapists
      h. Master's level clinicians: social workers, licensed mental health counselors
      i. Licensed Alcohol and Drug Counselors (LADC)
      j. Comparable contracted staff in the previous categories
      k. Comparable staff employed under the auspices of grants approved by the NHDOC
      l. SPU educational staff
      m. Security staff assigned to the SPU
      n. Students in DOC approved internships/residencies
   2. Administrative Staff:
      a. Commissioner of the Department of Corrections
      b. Assistant Commissioner of the Department of Corrections
      c. Deputy Directors of the Division of Medical and Forensic Services
      d. Chief Nursing Officer
      e. Assistant Nursing Director
      f. Operations Administrator
      g. NHDOC information technology staff
      h. EHR vendor staff
      i. Quality improvement staff
      j. Comparable contracted staff in the previous categories
      k. Staff employed to conduct surveys for the purpose of accreditation or to fulfill grant and/or statutory requirements.

E. Limited access to health care information for the purpose of determining appropriate housing and programming; eligibility for health care services and welfare benefits; protecting the health/safety of the patient, other patients, department staff, and/or the community; responding to grievances or in response to legal requirements may be approved by the Director of Medical and Forensic Services, or designee. Examples include:
      a. Warden of each DOC prison

b. DOC Director of Community Corrections
c. DOC Investigations Unit
d. DOC Classifications
e. Outside health/behavioral health consultants
f. Law enforcement agencies, public safety officials and others including individuals and the media when necessary or prudent in the event that dangerous patients are no longer in custody
g. New Hampshire Office of Reimbursements pursuant to RSA 126-A
h. Case counselors/case managers to aid in reentry and discharge planning
i. Public Health for reportable communicable diseases
j. Department of Justice staff in the Office of the Attorney General assigned to the NHDOC for contract adherence, litigation, and/or resolution of complaints, disputes, or grievances
k. New Hampshire Division of Children, Youth and Families as related to investigations of child abuse and neglect cases
l. In response to business agreements or memorandums of understanding signed by the appropriate DOC authority
m. Patient (See patient review of EHR.)

F. DOC responders may provide necessary information to paramedics/EMTs responding to medical emergencies to ensure that any individual requiring emergency care receives appropriate and necessary treatment to sustain life and/or prevent any adverse health outcome.
G. Inquiries from the Governor's Office shall be referred to the Commissioner or designee.
H. No health care information shall be released to any member of the media without a signed ROI.
I. Consent for release of information
   1. In order to preserve confidentiality of patient health care information, the written consent of the patient or court appointed guardian is required prior to the release of any health care information.
      a. If patient is under 18, a parent or court appointed guardian is required to sign a release of information.
      b. If a patient is 18 or older, that patient shall give written consent for release of information.
      c. If a patient 18 or older has a court-appointed guardian over person that guardian is responsible for signing a release of information for health care information.
   2. In the event that health care information is sought on a deceased patient, the administrator of the patient's estate shall present proof of appointment and the information shall be provided. Absent an administrator of the estate, NH RSA 560:22 allows for the surviving spouse or next of kin to obtain medical records as provided in RSA 332-I:13.
   3. The NHDOC shall maintain a form that meets all legal requirements for an individual to authorize release of health care information called "Authorization for Release of Information". An electronic version is incorporated into the EHR in the Forms section. A paper version shall also be maintained (Attachment 1).
      a. The Authorization for Release of Information shall be signed in ink and may be checked for validity by comparing the signature against the admission record to verify authenticity.
J. Patient access to health care information
   1. Review of personal health care information contained in the EHR
      a. Patients shall be able to view their personal health care information by

appointment only via a Resident Request Request.

b. Since all reviews must take place under the direct supervision of health information staff, and to minimize disruption to departmental operations, appointments shall be for half-hour periods only.

c. At the SPU, the Administrator of the SPU shall determine who will provide the supervision of the patient during the review.

d. The Medical Records Supervisor can authorize extensions to the time period if appropriate. Patients are restricted to review of their health record once every six months. The Medical Records Supervisor may authorize exceptions to the six-month rule for documented court appearances or other documented reasons.

2. Patient requests for copies of their EHR information

   a. To receive paper copies of the EHR, patients must submit an itemized list of copies to be made on a Resident Request Slip accompanied by an authenticated Cash Withdrawal Slip. Patients must have sufficient funds in their accounts to pay for the copies. Copies will be made at the rate of $.30 per page.

   b. To fulfill these requests, copying will occur Monday through Fridays, exclusive of holidays. Generally, requests will be fulfilled in five business days barring unforeseen circumstances.

   c. Health information staff are the only employees authorized to make reproduction of all or any portion of the EHR for patient requests.

   d. Copies will be sent to the patient's housing unit in a sealed envelope marked "CONFIDENTIAL".

   e. Patients requesting copies of their entire or portions of the EHR after release will be provided a DOC release of information (ROI). The release must be completed and returned to Medical Records, New Hampshire State Prison for Men, P.O. Box 14, Concord, NH 03302-0014.

   f. The Authorization for Release of Information shall be signed in ink and may be checked for validity by comparing the signature against the admission record to verify authenticity.

   g. If a patient is known to have a guardian, the guardian's signature is required on the ROI.

   h. The fee for obtaining portions of or the entire health care record will be specified on the Acknowledgement of Request for Receipt of Records—Fee (Attachment 2). This fee shall be mailed to the address specified on the form. Upon receipt of this fee, Financial Services will notify the Health Information Department that payment was received.

   i. Upon receipt of the notice from Financial Services, the Health Information Department shall copy the information onto a disk and forward to the person and address specified in the ROI.

K. Requests from authorized parties other than the patient

1. Attorneys (excluding the Attorney General's Office when representing the DOC), insurance companies, and patient authorized representative(s) must provide an original, Health Information Portability and Accessibility Act (HIPAA) compliant release of information signed, in ink, by the patient and/or guardian.

   a. Upon receipt of a properly executed, HIPAA compliant release, the health information staff shall send the requestor an Acknowledgement of Request for Receipt of Records—Fee form. (Attachment 2)

   b. The fee for obtaining portions of or the entire health care record shall be specified on the Acknowledgement of Request for Receipt of Records--Fee.

This fee shall be mailed to the address specified on the form. Upon receipt of this fee, Financial Services will notify the Health Information Department that payment was received.

   c. Health information staff will copy the requested health care information on to a disk and will forward this to the requestor.
   d. Health information staff shall scan the Acknowledgement of Request for Receipt of Records into the EHR.

2. Records requested for the benefit of the patient, per a signed release of information, for continuity of care and coordination of benefits post-release will not incur a charge. Examples include, but are not limited to, community mental health centers, hospitals, federal or state welfare programs, substance use disorder facilities, extended care facilities, correctional facilities.
   a. Upon receipt of a properly executed, HIPAA compliant release, signed by the patient and/or guardian the health information staff shall send the requestor an Acknowledgement of Request for Receipt of Records—Continuity form (Attachment 3) along with the health care information requested per the ROI.
   b. Health information staff shall scan the Acknowledgement of Request for Receipt of Records--Continuity into the EHR.
3. Court orders and subpoenas
   a. All court orders and subpoenas for health information shall be reviewed by the Attorney General's Office to determine appropriateness and compliance with laws.
   b. Once a court order or subpoena for health information is reviewed and authorized by the Attorney General's Office, the party requesting a portion of or the entire health record shall be sent an Acknowledgement of Request for Receipt of Records—Fee form. (Attachment 2)
   c. In petitioning for involuntary commitment or guardianship, a court order shall be sufficient in order for the patient's record to be taken to court for reference in the proceedings. A paper copy shall be printed to satisfy this requirement.
   d. Attorneys and physicians appointed by the court to represent patients in involuntary commitment and guardianship hearings shall receive a disk of the health care record. Health information staff complete an Acknowledgement of Request for Receipt of Records—Continuity form (Attachment 3).

L. Adding Data or Information to the EHR
   1. EHR entries shall only be made by qualified and authorized personnel involved in treatment, observation, or oversight of the health care of the NHDOC patient.
   2. Health care information from external medical/behavioral health care providers shall be scanned into the EHR by health information staff only if the external providers are licensed and qualified to provide health care services in their discipline and/or specialty.
   3. Point of care documentation is expected. All clinical documentation, both contact and non-contact, shall be entered into the EHR at the conclusion of the episode of care.
   4. Scanning of health care information from external sources shall occur daily, Monday through Friday.

M. Facsimile transmission/receipt of health care information
   1. Health care records will be transmitted via facsimile only when urgently needed for patient care.
   2. Health care information received via facsimile is acceptable for inclusion in EHR.

3. Facsimile releases of information will generally not be accepted. Facsimile releases of information will be accepted from other correctional facilities and other healthcare facilities/providers in the case of emergencies.
4. If a fax is received in error, the sender shall be notified immediately. After informing the sender of the error, the faxed document will be returned via regular mail or destroyed upon request of the sender.
5. If a faxed transmission fails to reach the recipient, the number shall be verified prior to again sending the information. If a notification is received that health information staff sent a fax in error a request should be made to return the information by mail.

N. Exclusions from the EHR
1. Per New Hampshire RSA 332-1:2, 1(g) audit trail data is not considered to be part of a patient's health care information or the medical record designated record set. Audit trail data resulting from EHR usage is not available to individuals held in corrections facilities within the state of New Hampshire.
2. Letters, summaries, or any written documents from patients, family members and interested others, who are not qualified health care professionals shall not be included in or considered part of the EHR.
3. Information from external medical personnel or community health care facilities that is unsolicited from DOC staff shall not be included in the EHR.

O. Retention of health care records
1. Any health care records that are in paper format are maintained in the NHDOC warehouse ordered by calendar year.
2. Paper records will be stored until scanned into FileHold if the patient is still in NHDOC custody.
3. Paper records of patients no longer in NHDOC custody will be maintained for 10 years after they have been released from custody or the patient has died.
4. Patient health care records in the EHR will be locked after the patient dies.

P. FileHold
1. FileHold is the storage application used for paper health care records including NHDOC paper records and paper or scanned documents received from external health care facilities that were in existence prior to activation of the EHR.
2. Health care records in paper format shall be scanned into FileHold with priority given to patients currently in NHDOC custody.

References:

Standards for Mental Health Services in Correctional Facilities, 2015
National Commission on Correctional Health Care
MH-H-02, MH-H-03, MH-H-04

Standards for Health Services in Prisons, 2018
National Commission on Correctional Health Care
P-A-07, P-A-08

42 CFR 160-164

NH RSA 332-I:1-13

Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976),

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