



<b>Policy Title: Health Home Record Retention, Storage, and Destruction Requirements</b>	<b>DOH Policy Name: N/A</b> <b>DOH Reference Number: N/A</b> <b>Effective Date: N/A</b>
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## POLICY STATEMENT

Under HIPAA, covered entities are required to retain the required documentation for six years from the date of creation or the date when it was last in effect, which is later. It is important to note that State Laws supersede HIPAA requirements.

Each Care Management Agency (CMA) partnered with the Bassett Community Health Navigation Health Home (BCHNHH) has responsibility for the retention and appropriate destruction of these records that are identified. Each CMA has responsibility to ensure workforce members receive training on and follow the disposal policies and procedures, as necessary and appropriate for each workforce member.

Each CMA should develop a retention and destruction schedule for those records. The destruction method should be of a nature to render the destroyed document unreadable, undecipherable, reference BHN destruction policy. The destruction schedule and method should include all media for maintaining records and provide for the possibility that some records may be duplicated on various media.

## SCOPE

This policy applies to all CMA's partnering with the Health Home (HH).

## OBJECTIVES

Assure retention, storage, and destruction of records meets the requirements set by the following laws and regulations:

- [Title: Section 405.10 - Medical records | New York Codes, Rules and Regulations \(ny.gov\)](#)
- [45 CFR 164.306\(a\)\(4\), 164.308\(a\)\(5\), and 164.530\(b\) and \(i\)-...](#)
- 28 U.S.C. s.1732; 44 U.S.C. s. 3312
- NY- Title 405.10
- Part 50 of Chapter II of this Title
- Public Health Law, section 18(4).
- Release of the Legal Medical Record
- Patient Access to Protected Health Information



## DEFINITIONS

### Record

1. A group of records maintained by or for a covered entity that is:
  - a. The medical and billing records about individuals maintained by or for a covered healthcare provider;
  - b. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
  - c. Used, in whole or in part, by or for the covered entity to make decisions about individuals.
2. For purposes of this policy, 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 covered entity.

**Destruction-** as defined by HIPAA as unreadable, undecipherable

**Retention-** written or electronic record of medical record

## ROLES AND RESPONSIBILITIES

### Health Home Administration Responsibilities

Responsible for the administration of this policy.

### CMA Supervisor Responsibilities

Review and provide guidance on their respective policies and procedures for upholding this policy. While ensuring education and training are completed for their agencies workforce.

## PROCEDURES

### General Considerations: New York

- Medical records shall be retained in their original or legally reproduced form for a period of at least **6 years** from the date of discharge or **3 years** after the patient's age of majority (18 years), whichever is longer, or at least **6 years** after death.
  - Consideration may warrant additional retention for age of majority (18 years) plus 3 yrs. after the child's 18<sup>th</sup> birthday or a minimum of 6 yrs. after the last date service was received, whichever date occurs later.
- Recommendation, statistics, and vital records (i.e., births and deaths) must be readily retrievable for not less than **10 yrs**.

### Non-original Records

- Federal law allows retention of non-original records & gives them the same evidentiary status as originals. *28 U.S.C. s.1732; 44 U.S.C. s. 3312.*
- **New York** requires healthcare providers who maintain patient records to be retained in their original or legally reproduced form for a period of at least **6 years** from the date of discharge or **3 years** after the patient's age of majority (18 years), whichever is longer, or at least **6 years** after death. **NY- Title 405.10**



### Storage Guidelines

- There are no specific federal guidelines for storage of records.
- CMA's may store records onsite or off-site if the medical record is maintained under the direction of a qualified individual and protected from loss, damage or unauthorized use.
  - If records are maintained electronically, the date and time of an entry to a medical record must be recorded by the computer's internal clock.
  - CMA must have policy regarding the storage of records onsite and off-site to aid in protection from loss, damage, or unauthorized use.
- Storage of records must protect the privacy and confidentiality of persons information this includes but is not limited to:
  - The use of a locking mechanism to secure records and protected health information (PHI).
  - The use of a secured area for storage of said locking mechanism.
  - Maintain signed confidentiality agreements from anyone with access to medical records and the secured area.
  - Maintenance of a list of people with access to medical records when staff are not present to monitor the records.
- New York requires entities to have a system of coding and indexing medical records.
- The CMA shall ensure the confidentiality of patient records. Original medical records, information from or copies of records shall be released only to staff involved in treating the patient and individual as permitted by Federal and State laws.
- The CMA shall allow patients and other qualified persons to obtain access to their medical records and to add brief written statements which challenge the accuracy of the medical record documentation to become a permanent part of the medical record, in accordance with the provisions of Part 50 of Chapter II of this Title and the provisions of Public Health Law, section 18(4). See policies-Release of the Legal Medical Record Patient Access to Protected Health Information

### Destruction of Records

- No specific federal guidelines, however, HIPAA covered entities must keep record of destroyed record to include the following:
  - Destruction date
  - Destruction method
  - Inclusive dates
  - Description of destroyed medical information
  - Signatures of witnesses to the destruction

### COMMUNICATION/TRAINING/IMPLEMENTATION

The policy will be provided via email to identified Manager's and Supervisor's.  
Each CMA is responsible for the training and education of their workforce.

### Quality Management & Performance Improvement

The HH and CMA leadership are responsible for compliance with this policy. Review of and enforcement of this policy will be reviewed annually with responsible parties.