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ORIGINAL PAPER

The Impact of Electronic Communication on Confidentiality in Clinical Social Work Practice

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Abstract Clinical social work practice has been significantly impacted by the evolution of electronic communication through the development of cyber technology. The increased methods for electronic communication raise questions about the impact of electronic communication on patient confidentiality. This paper will review the way that clinical social work ethics have addressed the use of electronic communication with clients, insurers, or other professionals. The history of confidentiality is briefly reviewed. The Health Insurance Portability and Accountability Act will be discussed as a new context for confidentiality in clinical social work practice.

Keywords Clinical social work · Electronic communication · Ethics · HIPAA

Introduction

When health care professionals are interviewed they often will say that one of their most important, if not their single most important, ethical obligations is to maintain in confidence the information that is revealed to them by their clients in the context of the professional relationship. The first Code of Ethics of the National Association of Social Workers (NASW), drafted in 1960, stated simply that social workers would "respect the privacy" of the people they serve. This statement implied that clients of LCSWs[1] would have an absolute right to privacy, a right which arose from the requirements of the service relationship. While the clinical and moral justifications for client confidentiality have not changed (Luepker 2012), the federal laws and rules in the Health Insurance Portability and Accountability Act (HIPAA) have, in many ways, influenced the view of confidentiality that clinical social workers have used for many years.

Nevertheless, health care professionals, including clinical social workers, have never had absolutely confidential relationships, even if they believed they did, and such relationships may, in fact, be problematic. There is an inevitable tension between the client's right to privacy in professional relationships and society's need to know certain information; under some conditions, relationships of absolute privacy may become a shield for antisocial behavior. [The terms "privacy" and "confidentiality," as used here, are related but not identical. The term privacy refers to the rights of the individual, while confidentiality is a feature of relationships in which information is revealed and a participant in the relationship pledges to maintain that information in secrecy (Beauchamp and Childress 2009)]. While confidentiality in clinical social work treatment is a goal to be sought, there are limits to what can be kept confidential.

Confidentiality in relationships between clinical social workers and their clients has had increasing protection in specific ways at the state and federal levels. New York and

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[1] For purposes of convenience, the term LCSW will be used in this paper to designate all clinical social worker practitioners, although there are at least 11 different such titles and designations in the various states.

Washington states, for example, have special protections for information related to the client's HIV status. On the federal level, in *Jaffe vs. Redmond* (1996), the United States Supreme Court handed down a precedent-setting decision in a case involving an LCSW protecting her client's confidential communications. The decision established the psychotherapist-client privilege (a relationship of confidentiality) in the Federal Rules of Evidence.

However, no laws have had the impact on privacy and confidentiality that the federal privacy and security standards found in HIPAA have had. HIPAA was enacted in 1996, with rules published in 2002, 2005, 2009, 2011, and 2013.

This article is intended to help clinical social workers learn what the HIPAA regulations require of them and their clients with respect to confidentiality; consider the impact of modern technology on confidentiality when used for the electronic storage and transmission of data; and evaluate the changes to confidentiality when treatment is delivered electronically, as well as the impact of other electronic communications with clients, including the implicit self-disclosure in the use of social media.

History

In the early 1960s, around the time the first NASW Code was written, various states passed laws requiring the reporting of child abuse or neglect by professionals in many categories. This trend, for the needs of society to intrude upon the privacy of the client's relationship with a health care professional, was accelerated by the revolutionary impact of the Tarasoff case in the 1970s (Beauchamp and Childress 2001). The decision in this case by the California Supreme Court was that professionals could be held liable for failure to protect a third party who was in danger from the actions of a client, and that revealing confidential information from the treatment might be one way that the responsibility to protect could be met.

There have been many other court precedents and new state laws since the Tarasoff decision. Some have confirmed Tarasoff; some have expanded upon it; and others have contradicted it. One consequence is that LCSWs now need to know the specific requirements of the states in which they are licensed and practice.

These changes all affected, and primarily reduced, the confidentiality that clients of health care relationships could expect. But no one could have prepared the authors of that original NASW Code for the impact on confidentiality of current trends, in which treatment is so often paid for by third parties, and information is stored and transmitted electronically. The growth of electronic counseling and psychotherapy has taken place with relatively little regulation regarding the protection of patient confidentiality, including guidelines for electronic record keeping, emails, texting, avatar therapy, and videoconferencing therapy, among other cybertechnologies.

For the most part, clinical social workers in 1960 could assure their clients that what they revealed in treatment would be kept in confidence. Since then, the passage of licensing (scope of practice) laws in every state has meant that LCSWs are regulated in the states in which they are licensed and practice. This "contract" between the state and the LCSW means that treatment information once held in confidence may have to be revealed for the protection of individuals or the country. LCSWs now need to be experts on the limitations of client confidentiality, regardless of its value to the treatment, and they need to discuss the limitations with the client, especially when insurance is used to pay for the treatment (Phillips 2013). As Reamer points out (2006, p. 160) the current NASW Code contains 18 separate standards in the section on confidentiality. The current Code of Ethics of the Clinical Social Work Association (1997) contains a similarly extensive section requiring LCSWs to discuss limitations of confidentiality with clients.

HIPAA has raised the bar for LCSWs who choose to transmit information using electronic means; LCSWs should become "covered entities" prior to the electronic transmission of client information. It is important for all LCSWs to be familiar with those regulations, even if they currently do not use electronic transfer of information. Many experts in the field agree that electronic information transfer will gradually be adopted by the courts as the legal standard required for the protection of client privacy by health care professionals.

HIPAA and Clinical Social Work Practice

LCSWs have a solid basis for the confidentiality principles which HIPAA attempts to create because HIPAA rules are consistent with social work codes of ethics. When HIPAA rules went into effect in 2003, the requirements for LCSWs regarding privacy of patient information was formalized. The modern developments of social work licensing, reliance on third party payers, use of advanced technology, and HIPAA regulations all came together to revise the way that confidentiality practices are observed by LCSWs.

Electronic communication of client information was not regulated in law or rule prior to the advent of HIPAA in 1996, and the rules that followed to implement HIPAA. Many legal experts agree that HIPAA regulations for the protection of patient privacy will gradually be accepted as the standard of practice for all LCSWs, whether or not they are technically considered to be covered entities. To be

sure, the HIPAA regulations require a commitment by clinical social workers to learn new material regarding protection of confidentiality, and share it with their clients. As Barsky (2010, p. 123) points out:

> Anyone involved in providing health-care services needs to be aware of the impact of the Health Insurance Portability and Accountability Act on client confidentiality. This law was established to facilitate transmission of information between health-care providers, managed care systems, and insurance providers. Health care is defined broadly to include physician-medical care and mental health services, so it does apply to many of the services provided by social workers.

LCSWs and Confidentiality in the Internet Age

Communications that take place in the LCSW's office have the benefit of the strong confidentiality protections in law, through privilege and social work codes of ethics. Other principles in clinical social work that protect the confidentiality of client information include disguising any patient material presented, keeping identifiable material from disclosure, and, as a general rule, preventing third parties, including family members, from conversing with the LCSW about the patient. These are all widely held beliefs about ethical practice (Luepker 2012).

However, there have always been some exceptions to these principles. Freud took walks with patients in public areas as part of several analyses, a practice that would not be seen as HIPAA-compliant today. Similarly, LCSWs practicing today may not be aware of the problems of casual conversations with colleagues about their patients. Even comments about clients that are social in nature, not related to the treatment, and that are made to trusted colleagues, can nevertheless violate HIPAA rules.

Privacy practices began to be reconsidered about the time that managed care came into existence, approximately 20 years ago. Third-party payments through insurers have undermined confidentiality by requiring increasing amounts of treatment information. The use of the computer, cellular telephone, and facsimile transmission (fax) changed the ease with which information could be communicated, and its vulnerability to breaches of privacy when transmitted through such "open server" systems as AOL and Yahoo, and more recently, Comcast and Gmail. Many LCSWs are not fully aware of the confidentiality risks of sending, or even storing, client information electronically (Groshong et al. 2013).

Just as the use of electronic communications was on the rise, the insurance companies began accepting mental health treatment and, consequently, the number of people outside the treatment relationship who could gain access to patient information grew exponentially.

Confidentiality may be compromised for any clients who have had claims submitted for them or have submitted claims directly to third party payers. A mental health diagnosis alone constitutes a release of patient information when given to a third party payer. For over 30 years, any patient who received a mental health diagnosis might find that s/he was denied life or health insurance as a result. Actuarial tables often gave these codes a rating of 250 points, regardless of the seriousness of the disorder, and 400 points was the cutoff for life insurance. (One publication, *For the Record: Protecting Electronic Health Information,* National Academy Press, 1997, charts over 30 government agencies that had access to client information prior to the implementation of HIPAA standards.)

While client information has been disclosed in many ways for the past 50 years, the increased access to it through electronic transmission in the past 20 years has rapidly grown. All LCSWs should be concerned about the disclosure of client information and become familiar with HIPAA regulations and the way they try to protect that information.

As a result of HIPAA rules, there are six major changes to the ways that clinicians must manage client privacy when sending information electronically. The confidentiality obligations incurred through HIPAA are permanent and can never be eliminated; once the HIPAA "bell has sounded," it can never be un-rung. The changes are:

- Prepare and provide Notice of Privacy Practices at first session
- Have any non-covered entity sign a Business Associate Agreement
- Have Policies and Procedures that are the basis for all privacy and security practices, including breaches of Protected Health Information
- Record Keeping must include Medical Record and may include a separate file for Psychotherapy Notes
- Back up electronic records regularly
- Do a GAP analysis of privacy practices and a Risk Assessment of security practices.

Basic HIPAA Concepts

HIPAA has a language all its own regarding privacy and security. Here are the basic concepts that are used in HIPAA laws and rules.

Protected Health Information (PHI)

Protected Health Information (PHI) is identifiable health information that is transmitted by an LCSW (or any other health care clinician). When such information is

transmitted electronically, it is sometimes called ePHI. LCSWs should be HIPAA compliant before PHI or ePHI is transmitted electronically in one of four covered transactions.

Covered Transactions and Covered Entities

The first time an LCSW engages in an electronic "covered transaction," the LCSW becomes a "covered entity" under the HIPAA regulations. A covered entity must always be HIPAA compliant, regardless of whether they are transmitting PHI electronically or not. There are four covered transactions: health care claims; eligibility for treatment; authorization for treatment; and/or health claim status (Groshong et al. 2013).

Policies and Procedures

Policies and Procedures are the basis for the privacy and security standards that each covered entity, i.e., each LCSW in private practice, uses to define his or her own privacy and security plans. An LCSW in private practice also needs to appoint himself or herself as the Privacy Officer of the practice, responsible for implementing the privacy and security policies and procedures that the LCSW has created. HIPAA has a "floor" for what the privacy and security standards should include, but an LCSW who is a covered entity may have higher standards for privacy and security than the requirements. The basic policy and procedure requirements in HIPAA are the privacy and security rules. Privacy rules apply to the privacy of information about a client in verbal, written, and/or electronic form. Security rules apply to the physical security of electronic information, both "at rest" in storage, or "in transmission," that is, sent electronically.

GAP Analysis and Risk Assessment

Prudent LCSWs will conduct a GAP Analysis to make sure all privacy requirements regarding PHI are in place, and a Risk Assessment to make sure all security requirements are in place. Most associations provide tools to conduct these reviews, as does the U.S. Department of Health and Human Services.

Notice of Privacy Practices

An LCSW who is a covered entity must provide a summary of his or her confidentiality policies and procedures to every new client at the first session, which is called the Notice of Privacy Practices (NPP). Clients must sign an "Acknowledgement of Receipt," indicating that they have received the NPP, and this Acknowledgement must be kept in the record for 6 years. (Contrary to a widely held belief, HIPAA has no requirement about how long the Medical Record must be maintained.) Prudent LSCWs will consult with or use an NPP that has been developed in consultation with an attorney well versed in health care law.

Treatment Payment and Operations Exemption (TPO)

HIPAA allows covered entities to share PHI through what is known as the "TPO exemption." This includes discussing a client with other covered entities for treatment purposes; sending client information for purposes of payment; and communicating with an insurer or hospital that can provide eligibility or other information about the client.

Business Associate Agreement

The Business Associate Agreement (BAA) is a document that must be signed by any non-covered entity who has access to the PHI of the LCSW. The BAA's main purpose is to have consent from non-covered entities that they will not disclose any PHI and will abide by the confidentiality policies and procedures of the LCSW. Examples of non-covered entities who may have access to PHI include billers, accountants, and computer technicians. By signing a BAA, a Business Associate agrees to abide by the privacy policies and procedures of the Covered Entity.

Medical Record

The Medical Record is not explicitly described in HIPAA, but the record of the client's treatment with the LCSW must contain:

- Billing information, fee arrangement, and record of payments
- Formal evaluations
- Collateral contacts, including release of information, if used, and contact information
- Records obtained from other providers, including release of information, if used
- Counseling session dates, start and stop times
- Modalities of treatment
- Frequency of treatment
- Medication prescribed, if known
- Description of diagnoses
- Functional status (tasks of daily life, ability to work, intimate relationships, etc.)
- Medical/physical problems, if known
- Out of office contacts, including phone calls, emails, texts
- Treatment plans and goals

- Symptoms
- Prognosis
- Progress in each session toward treatment goals
- The fee arrangement and record of payments
- Dates counseling was received
- Disclosure form, signed by licensed counselor and client or associate and client
- The presenting problem(s), purpose or diagnosis
- Notation and results of formal consults, including information obtained from other persons or agencies through a release of information
- Progress notes sufficient to support responsible clinical practice for the type of theoretical orientation/therapy the licensed counselor or associate uses.

All Medical Records should be backed up regularly and kept in an encrypted format. Information cannot be put in Psychotherapy Notes to avoid keeping it in the Medical Record (Groshong et al. 2013).

Psychotherapy Notes

Psychotherapy Notes are the place that LCSWs may keep their own experience and perceptions of the treatment, in other words, a more detailed description of the treatment, which has commonly been called process recording or process notes. Psychotherapy Notes belong to the therapist and are not subject to disclosure to the client or others, including legal proceedings (N.B.: Some attorneys believe this is unenforceable, but no case law exists to determine whether Psychotherapy Notes can be kept private by the LCSW.) No PHI required for Medical Records can be put in Psychotherapy Notes to keep it out of the Medical Record. Psychotherapy Notes must be kept in a separate file from the Medical Record.

Breaches of PHI

There are numerous references in HIPAA rules to "breaches," i.e., intentional or unintentional disclosure of PHI to non-covered entities. A thorough description of the various forms of breaches and their consequences is beyond the scope of this paper. All LCSWs should educate themselves about the way to handle breaches according to the number of clients affected and notification of clients or the public. The 2013 amendment to HIPAA rules included covered entity and business associates as equally responsible for breaches of PHI if a business associate causes a breach. Complaints about breaches of PHI are sent to the Federal Office of Civil Rights, but are prosecuted by a given state attorney general.

HIPAA Violations

There are many ways that HIPAA violations may result in a sanction to the LCSW or legal action. Complaints about an LCSW's violation of HIPAA rules are reported to the Office of Civil Rights, which may sanction the LCSW directly and/or send the violation to the state attorney general for prosecution. The prudent LCSW will become educated about violations that may result in a sanction or legal action. A complaint may also result in an audit of the LCSW's records (Department of Health and Human Services 2014).

State Clinical Social Work Privacy Laws

State clinical social work licensure laws and regulations have almost all included the right to "privilege" for communications between the LCSW and client (Alabama and Pennsylvania are the only states that use the lower standard of "confidentiality".) Privilege is a legal concept that means communications are considered private except for mandatory reporting on child or vulnerable adult abuse; criminal prosecutions; threats to national security; or other state legal requirements. The legal concept of privilege is more consistent with the HIPAA concept of privacy than the legal concept of confidentiality is, but both are relevant to protecting PHI (Groshong 2009).

Standards used to vary widely among states in the areas of patients' rights to read their record; to amend their record; marketing of patient information; patient authorization for disclosure of records; disclosure for treatment or payment purposes; disclosure of mental health information to government agencies; disclosure of mental health information to insurers; and several other areas. Since HIPAA rules went into effect, all the above rights are allowed. LCSWs still have to withhold Medical Records if the LCSW believes the information they contain may harm the client.

Emails and Clinical Social Work Practice

Before sending PHI or ePHI on an open server (e.g., Gmail, AOL, Comcast), the prudent therapist would ask for a BAA to be signed with the server that will transmit the data. The request would probably be denied, since open servers cannot guarantee the kind of confidentiality that an encrypted server can. This is one reason using open servers "just for scheduling" is a confidentiality risk, like sending a postcard in regular mail.

Responsible clinicians should do their best to understand and comply with HIPAA rules, even if they seem unnecessary, unlikely to result in sanction, or unreasonable. They are laws that apply to our practices as much as the ones that are in our licensure laws. The practice of encrypting emails is much more protective of client information than the use of open servers. While many LCSWs use open servers for

administrative tasks like scheduling, the likelihood that information about the client will be disclosed is much greater than on an encrypted email system.

Texting and Clinical Social Work Practice

Many LCSWs who work with adolescents have begun to use texting, short messages sent through smart phones, to communicate with these clients. What is often overlooked by this practice is that there is significant risk to client privacy, as most text services are not encrypted and do not have the protection necessary to keep these communications private. The importance of privacy in the treatment process is at odds with the way that many adolescents think about texting. The concept of privacy has changed drastically since the advent of smart phones and the almost constant communication that takes place through texting. Educating clients of all ages about the importance of privacy in psychotherapy is a consideration that used to be understood (Karacz et al. 2009; Turkle 2011), and is of increasing importance today.

Communication Policy for LCSWs

Kolmes (2010), Ph.D. developed the first "Communication Policy," a summary of how, when and through what means Dr. Kolmes would communicate with clients outside the treatment sessions. This policy is well worth considering for LCSWs. There is room for variation in the way that LSCWs decide to communicate with clients outside the treatment, but the risks of using electronic methods should be considered before engaging in texting, emails, videoconferencing or social media. Other communication should be evaluated as well, for example, communication during vacations, payment communication, or Googling of therapist or client once treatment commences.

The use of the Internet to provide us with ready information has become automatic. However, electronic communication needs to be considered in a different light, through the lens of the psychotherapeutic process, by LCSWs and they should make adjustments accordingly. An example of a Communication Policy for LCSWs can be found on the Clinical Social Work Association website, (www.clinicalsocialworkassociation.org).

Self-Disclosure and Clinical Social Work Practice

Most LCSWs regard bringing personal information into the treatment process as a mindful decision, one which is not made lightly (Goldstein 1997). Yet much personal information may be available to past, current, or future clients through the Internet if an LCSW does not carefully consider what s/he is willing to have potentially available to anyone. For example, hashtags of pictures that are posted by others may reveal information about an LCSW to a client that may not be helpful to the treatment. Any information that is on the Internet should be considered an intentional disclosure, and policies about how to handle the feelings that emerge if a client comes across such information should be in place at the beginning of treatment. The best use of the Internet for LCSWs is a website that describes the professional work of the LCSW. Use of blogs, social media, and other potentially public disclosures of personal information should be considered carefully. Most LCSWs do not have personal pictures of family and friends in their offices; putting such pictures or information on the Internet has a similar meaning and should be limited for the same reasons. Some LSCWs have decided that being a psychotherapist is not consistent with the personal privacy that is generally considered the standard of practice, and have not opened social media accounts for this reason (see Social Media below).

Videoconferencing and Clinical Social Work Practice

There are a few state social work boards that allow a certain number of videoconferenced sessions a year, via Internet or otherwise, by LCSWs who are not licensed in the state (usually within 30–90 days). There are also some social work boards that require licensure in the client's state. The majority of states currently have no regulations about videoconferencing to conduct psychotherapy within the state in which the LCSW is licensed. Almost all social work boards are reviewing the issue. The military does allow videoconferencing in any state if an LCSW is licensed in one state. This may be the wave of the future.

The use of videoconferencing to provide psychotherapy has its pros and cons. One positive feature is the ability to connect with people who are not in proximity to an LCSW and provide them with psychotherapy services. On the other hand, the current state of videoconferencing technology does not convey a full body picture of the client or the LCSW, the location from which they are communicating, and whether anyone else may be in the location. These considerations need to be balanced, along with backup if the client is at risk of self-harm or harm to others. Finally, the risk to client privacy is one that is just starting to be considered.

LCSWs who use videoconferencing to conduct psychotherapy are at risk of privacy violations that can lead to sanctions or malpractice litigation (not generally covered by malpractice insurance). Prudent LCSWs should consult

with their malpractice provider. These are all more problematic grey areas, from a legal perspective, than what sort of videoconferencing platform is used. The best protection for those who decide to use videoconferencing is a server willing to sign a BAA (NASW General Counsel 2011).

This area of clinical social work practice is in flux. The diligent clinical social worker will find a platform that is willing to sign a BAA and protect the privacy of communication that takes place through the videoconferencing site. Many LCSWs are thinking through the risk to client privacy that they are willing to take. As with social media, if the line between the professional and personal cannot be maintained, it is more responsible to avoid practices that may blur it.

Social Media and Clinical Social Work Practice

The use of social media by LCSWs is an area that is evolving. Many examples of privacy violations now exist in which the user thought the privacy setting would prevent the release of information. When LCSWs disclose personal information on social media, they are engaging in unintentional self-disclosure. Most LCSWs are careful to decide if and when self-disclosure occurs in the treatment; putting personal information on the Internet should involve a mindful approach as well. Here is an example of an LCSW who decided to take down her Facebook account when personal information was revealed to clients:

> "As a 30-something MSW student, I find that Facebook, LinkedIn, and Twitter have become some of my primary methods of communication with former and current colleagues, family, and friends…I, for one, can't imagine giving up social media. It is integral to my life… [Nonetheless, to become an ethical therapist] I locked down my Twitter account and hid my Facebook profile. I find myself doing more self-censoring of information I post, not because it would violate confidentiality or be overtly inappropriate, but because I am now more mindful that the joke I was making may be misconstrued or cause misunderstandings that might reflect poorly on the social work profession. I deleted my personal blog. However, these actions were not without personal loss."

(Lisa Kays, "Must I Un-friend Facebook: Exploring the Ethics of Social Media," *The New Social Worker*, http://www.socialworker.com/home/Feature_Articles/Ethics/Must_I_Un-Friend_Facebook?_Exploring_the_Ethics_of_Social_Media/).

As Luepker (2012) has pointed out, clients can be disturbed about finding out information about their LCSW.

> "The same clinical and ethical standards that guide our practice during face-to-face psychotherapy need to guide our practice during online therapy and when electronic media interrupts our otherwise face-to-face practices….We must develop thoughtful policies and procedures related to the use of technology in our practices and discuss these with our [clients.] (p.133)

Considerations for Electronic Communication in Clinical Social Work Practice

The three main areas in which electronic communication is likely to occur in clinical social work practice include disclosure of client records for treatment, payment, or operations; conducting psychotherapy or counseling through videoconferencing, email or texting; and communication for purposes of scheduling through email or texting. The ethical implications of these forms of communication depend on the degree of encryption and computer password protection that are used to maintain confidentiality of client communication and client records. The fact that over 41 million clients have had their records disclosed without permission (Melamed 2014) (http://www.melamedia.com/HIPAA.Stats.home.html), since complaints about HIPAA violations began in 2003, should give LCSWs pause. There is a "Catch-22"in the HIPAA rules; all information must be backed up on a thumb drive or externally in a cloud or hard drive. But this requirement increases the chances that information will be disclosed without client or LCSW permission. The more that LCSWs can do to minimize potential HIPAA violations, the better.

Practical HIPAA

Here are some simple ways to accomplish protection of client information according to HIPAA rules:

1. *Client Records*—Any client records that are stored on a computer should be stored with an encrypted password on an electronic health record that is encrypted in transmission and at rest, and change passwords for computers regularly.
2. *Communication with Clients Electronically*—Electronic communication with clients, whether through texting, email, or videoconferencing, creates the risk of confidentiality violations, "breaches" in HIPAA terms. The decision to communicate with clients electronically is one that must be made by each LCSW and client. The LCSW is responsible for making clients aware of their electronic communication policies and receiving informed consent about them (Gabbard et al. 2011).
3. *TPO Exceptions*—HIPAA allows client information to be transmitted electronically for treatment, payment and

operations purposes. This does not mean that such communication is required, though some insurers require electronic communication for reimbursement. The number of breaches that have occurred, even with electronic protections, may give LCSWs pause when sending client information electronically. A risk assessment is the prudent way to make a decision about whether to use electronic communication of client information.

4. *Social Media*—Avoid communication with clients on social media. The blurring of the personal and the professional on social media not only provides more chances for breaches, it also may reveal information about the LCSW to the client that will interfere with the treatment process (Zgoda 2011). Some LCSWs are avoiding social media accounts (see Kays, above) to maintain the boundary between the treatment relationship and personal information.

Summary

The legal, ethical and practice issues raised by electronic communication require careful reconsideration of how LCSWs communicate with clients in order to maintain the privacy of the client, the treatment and the LCSW. Limiting personal information on the Internet may cause some frustration for those who are accustomed to communicating electronically. But the advantages to clinical social work practice of maintaining privacy are clear, and the use of the Internet or other technologies should be seriously deliberated. Understanding the HIPAA rules, including the NPP, the BAA, the Medical Record, and Psychotherapy Notes, is an important part of good clinical social work practice. No doubt, many more issues will arise concerning electronic communication, but the more that LSCWs consider how best to protect the privacy of client information, the more the treatment will maintain the high standards called for in our codes of ethics.

HIPAA Glossary

Authorization for Release of PHI (ROI)	A form that allows a CE to release protected health information to a non-CE with the client's permission
Business Associate (BA)	A person or company that performs a service on behalf of a Covered Entity in which the BA has access to PHI
Business Associate Agreement (BAA)	The form which is signed by a BA to confirm that the BA will abide by the CE's confidentiality policies and procedures
Covered Entity (CE)	A health care provider that has access to PHI who develops policies and procedures to protect the confidentiality of that information
Department of Health and Human Services (DHHS)	The federal agency that oversees HIPAA policy
Electronic Medical Record (EMR)/Electronic Health Record (EHR)	A computer-based record containing PHI
HIPAA Gap Analysis	HIPAA Gap Analysis is a process that enables a CE to review their policies and practices to see if there are any 'gaps' in the implementation of HIPAA Security Rules
HIPAA Risk Assessment	HIPAA Risk Assessment is a process that enables a CE to review their policies and practices to make sure that they are in compliance with HIPAA Privacy Rules
Minimum Necessary	"Minimum Necessary" defines the amount of PHI that should be disclosed by CEs for TPO purposes
Office of Civil Rights (OCR)	The federal agency that DHHS has delegated as the body to oversee the enforcement of HIPAA rules and issue sanctions for HIPAA violations
Policies and Procedures	The basis for a CE's NPP and BAA is the confidentiality policies and procedures that they create for themselves according to HIPAA Rules
Protected Health Information (PHI)	Protected Health Information is data can in written, electronic or verbal form which the client has given the CE
Privacy Officer	Covered entities are required to have a designated Privacy Officer whose responsibilities include the development and implementation of policies defined in the HIPAA Privacy Rule for sole practitioners they are their own privacy officer

Privacy Rule	The provision within HIPAA that specifies that CEs are responsible for developing policies and procedures about PHI, while defining what level of access everyone who is not covered by the TPO exemption, or client directly, has to PHI. The Privacy Rule also requires the creation of an NPP and BAA
Security Rule	The section of HIPAA that defines the specific safeguards and security procedures that CEs must adopt when dealing with electronically-stored and transmitted PHI
Treatment Payment, and Health Operations (TPO)	Treatment, Payment or Health Care Operations are the reasons that a CE may disclose PHI without authorization according to HIPAA Rules

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