Defining and Maintaining the Legal Health Record

Webinar

April 22, 2008

Practical Tools for Seminar Learning

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Faculty

Keith Olenik, MA, RHIA, CHP

Keith Olenik received his bachelor's degree in medical record administration from the University of Kansas and his master's degree in health services management with an emphasis in computer resources and information management from Webster University. Keith has over 20 years of experience in every healthcare setting and is currently operating The Olenik Consulting Group. He has worked in a variety of healthcare settings including long-term care, rehabilitation, and psychiatric facilities. Prior to starting his own business he was the Chief Privacy Officer and Corporate Director of Health Information Management for Saint Luke's Health System in Kansas City, Missouri. He is also a visiting professor for the University of Cincinnati Health Information Management Program and has contributed to two current health information management text books.

Keith is currently a director on the FORE Board, chair of the virtual lab advisory committee, and member of both the PHR and EHR practice councils. He was a director on the AHIMA board in 2004-2006. Keith has held various positions for the Missouri Health Information Management Association including President in 1998. He is also a member of the Health Information Management and Systems Society and serves on the following task forces; privacy and security, research, and EHR accreditation. In addition to these activities Keith has been a speaker at various conventions and educational seminars on HIPAA, project management, HIM functions, and electronic health records.

Victoria S. Barcena-Weaver, RHIA

Victoria Barcena-Weaver is Director of the Shared Services Division, HIM, at HCA, Hospital Corporation of America. In this role she works as the HIM Electronic Health Record Director. Her additional responsibilities include working as the corporate Health Information Management resource for the EHR Program. Currently, Victoria is participating in the EHR Coordinating Steering Committee, Print Minimization Pilot, EMPI, Legal EHR, and Portal Pilot; HIM Workflow Project; the HIM Shared Services Strategy projects; and other initiatives that support the transformation of health information management at HCA.

Prior to joining HCA, Victoria most recently worked for Initiate Systems, Inc. software vendor focusing on identity management (EMPI). Her project portfolio with Initiate included work on the Canadian EHR, identity management business process assessment redesign and MPI remediation consultation.

Victoria has also worked for the Joint Commission (JCAHO), worked as a project manager in the Division of Research. Her responsibilities primarily focused on the quality initiatives related to ORXY and Core Measures.

Victoria has a BS in Health Information Management from the University of Illinois at Chicago. She is an active member of AHIMA and HIMSS, and has recently served as a member of AHIMA's EHR Practice Council.

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Definitions

- **Legal Health Record**

  "generated at or for a healthcare organization as its business record and is the record that would be released upon request."

- **Custodian of the EHR**

  is the health information manager in collaboration with information technology.

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Definitions

- **Electronic Health Record**

  "a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface — including evidence-based decision support, quality management, and outcomes reporting."

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Definitions

- **Business Record**

  "is a record made or received in conjunction with a business purpose and preserved as evidence or because the information has value."

- **Designated Record Set**

  "a group of records maintained by or for a covered entity..." as defined by the HIPAA Privacy Rule section 164.501.

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Definitions

- **Hybrid Record** – a system with functional components that:
  - Include both paper and electronic documents
  - Use both manual and electronic processes

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Polling Question #1

Many electronic health records are hybrid, reflecting a combination of paper and electronic documents. What percentage of your medical record originates as paper based?

a) 0%

b) 1% – 20%

c) 21% – 40%

d) More than 41%

e) Not applicable

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Roles of a Legal Health Record

♦ **Support the decisions made in a patient's care**

♦ **Support the revenue sought from third-party payers**

♦ **Document the services provided as legal testimony regarding the patient's illness or injury, response to treatment, and caregiver decisions**

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Legal EHR subset of the EHR

Legal Health Record

Designated Record Set

EHR Content

EHR Systems
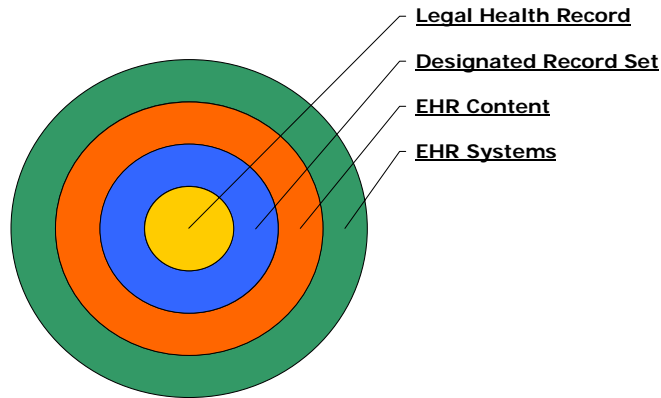
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Background on the Legal Health Record

- ◆ **The health record is a legal business record for the healthcare organization, it must be maintained in a manner that complies with**
  - • applicable regulations
  - • accreditation standards
  - • professional practice standards
  - • legal standards
- ◆ **Each organization must identify the content required for its own legal health record as well as the standards for maintaining the integrity of that content**

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Template Objectives

- **A guide only to assist health care organizations in creating an organizational policy that defines the legal health record for business and disclosure purposes**
- **Identifies considerations and questions that you should address as your policy is developed**
- **Specialty institution and the maintenance of specialty records such as behavioral health, may impact your legal health record policy**

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Getting Started

- **Review policy template**
- **Consider the formation of a multi-disciplinary team**
  - **Clinicians**
  - **HIM**
  - **Risk Management**
  - **Legal Services**
  - **Information Technology**
  - **Leadership**

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Legal Counsel

- Consult your facilities legal counsel
- Determine special considerations for your facility
- Local jurisdiction considerations

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Additional Policies To Consider

- Business continuity planning
- Down time procedures
- Electronic sharing of clinical information with other organizations
- Ownership of the electronic record
- Records/information from others facilities and providers
- Amendments to the electronic record

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AHIMA Legal EHR Policy Template Components

- ◆ **Purpose**
- ◆ **Scope**
  - • **How is the information used?**
  - • **Is reasonable to expect the information to be routinely released when a request for a complete health?**
- ◆ **Policy**

AHIMA Legal EHR Policy Template			
Subject/Title	The Health Record for Legal and Business Purposes		Page _ of _
		Revision History	
		Effective Date:	
Departments Affected:	Health Information Management, Information Systems, Legal Services, *[list any others who will be affected]*.	*Original Issue Date:*	
		Last Reviewed:	
		Last Revision:	

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Procedure: Documentation

Define Responsible Parties and Actions

- ◆ **Health Information Management**
  - • **create and maintain a matrix of each component of the health record**
    - • **source, location and media**
  - • **External Content**
  - • **Disclosure of Health Information**
  - • **Health Record Retention**

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Procedure: Documentation - Continued

- ◆ **Information Services and Technology**
  - • **Appropriate Access**
  - • **Execution of the archive and retention schedule**

- ◆ **Other**

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Procedure: Record Integrity

Define Process and Actions
- ◆ **Authenticity**
- ◆ **Accuracy**
- ◆ **Authorship**
- ◆ **Authentication**
- ◆ **Amendments**
- ◆ **Alterations**

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Procedure: Record Integrity

Define Process and Actions

- **Health Information Exchange**
- **Record Completion (Lock Down)**
- **Versioning**
- **Metadata**
- **Clinical Decision Support**
- **Audit Trails**

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Procedure: Authenticity

- **What record is the "original"?**
  - **Imaged documents vs. paper documents vs. electronic information.**
- **Assurance that electronic information has not been altered.**
- **Integrity of the information must be maintained through sound information management principles.**

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Procedure: Accuracy

- ◆ **Validation of record identity-each entry linked to a specific record identifier.**
- ◆ **Authentication of patient information from feeder systems (ADT/MPI).**
- ◆ **Chronology must be apparent in the EHR.**

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Procedure: Authorship

- ◆ **Who may document in the EHR?**
  - • **Defined by organizational policy**
  - • **Must follow standards and policies for level of documentation based on licensure, certification and professional practice standards**
  - • **Emerging Issue with EHR-Cut and Paste or Copy Forward**

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Procedure: Cut and Paste Functionality

- ◆ **Risks**
  - • **Copying to wrong patient or wrong encounter**
  - • **Inadequate identification of original author and date**
  - • **May be illegal or unethical in some circumstances, e.g. clinical trials, pay for performance, quality assurance data**

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Procedure: Copy Forward Functionality

- ◆ **May be acceptable if:**
  - • **Appropriate attribution and source made in new entry**
  - • **Organizational policy states when it can and cannot be used**
  - • **Methods exist to cross check accuracy of entry in correct patient record/encounter**

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Q&A Session...

To ask a question:

• **Click the "Q&A" button near the upper-left**
• **Click "NEW"**
• **Type your question in the white box**
• **Click "SEND"**

(For LIVE seminar only)

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Procedure: Authentication

♦ **Indicates authorship and completion by the individual who is legally responsible for the entry**

♦ **Must comply with applicable statutes and regulations, which may vary substantially**

♦ **Should be addressed in organizational policy-meaning, responsibility, timeliness,form and format**

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Procedure: Authentication

- ◆ **CMS Interpretive Guidelines for Hospitals 482.24(c)(1)** *all entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.*

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Procedure: Authentication Issues

- ◆ **Auto-authentication**
- ◆ **Entries completed by multiple individuals**
- ◆ **Authenticating care provided by colleagues**

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Procedure: Amendments

- ◆ **Follow basic tenet of never obliterating or altering an original entry**
- ◆ **Includes: corrections, clarifications, addendums, late entries, patient amendments**
- ◆ **Policies and procedures should address each type of action and when it is appropriate**

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Procedure: Amendments

- ◆ **Amendments – additional documentation added after original documentation has already been authenticated**
- ◆ **Corrections – changes to original documentation that does not delete the original, but does replace what was originally documented**

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Procedure: Amendments

- **Late entries – information entered after the fact indicating current date and time, but reference to previous date and/or time**

- **Patient amendments – ability to add information from the patient if a request for an amendment is approved**

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Procedure: Amendments-Version Management

- **Critical if information will be used to support clinical decisions**

- **Clear indication of versions and linkage among versions when reviewing any entry**

- **Need policy and procedure for "continuous documents"**

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Procedure: Alterations

- ◆ **"Amendments" which intentionally change the content or character of health information in the EHR for less than honorable purposes**
- ◆ **Tampering**

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Process: Health Information Exchange

- ◆ **Development of appropriate policies and procedures**
- ◆ **Acceptance and Retention (regardless of the media)**
  - • **Documents**
  - • **Images**
- ◆ **Determine efficacy of information**
  - • **Content**
  - • **Information Clarity**
- ◆ **Retention and Destruction of Information of Non-Compatible Medium**

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Process: Record Completion

- ◆ **Need to ensure compliance with spoliation**
- ◆ **Date and time of entries**
- ◆ **Determine when record is complete**
  - • **Limit user ability to create and/or modify documentation**
- ◆ **Account for user ability to access information**
  - • **Application controls for documentation functions**

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Process: Versioning

- ◆ **Need to determine various aspects of version history**
  - • **Display all history**
  - • **Final version**
  - • **Draft versions**
- ◆ **Date and time of entries**
- ◆ **Account for user ability to access information**
  - • **User interface**
  - • **Back end reports**

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Process: Metadata

- **What is metadata?**
  - **Descriptive data that characterize other data to create a clearer understanding of their meaning and to achieve greater reliability and quality of information**
- **Inventory what data is collected**
- **Typically information is not disclosed as part of the legal health record**
- **Electronic Discovery Rules**
- **Retention Policies**

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Process: Clinical Decision Support

What information should be included in the legal health record?

- **System generated notifications**
- **Prompts**
- **Alerts**
- **Exception documentation**

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Process: Audit Trails

- **User Audit Trail**
  - **All commands directly initiated**
  - **All identification and authentication attempts**
  - **Files and resources accessed**
- **Necessary to support:**
  - **Evidence of timeliness**
  - **Chronology of events**
  - **Information integrity**

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Additional Resources

- **Definitions**
- **Relevant State & Federal Laws and Regulations**
- **Accreditation Standards**
- **Practice Standards**
- **Article Citations**

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Polling Question #2

Does your EHR have an automated records management module?

a) **Yes**

b) **No**

c) **Planned or in development**

d) **Not applicable**

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Matrix Tables: Elements to Consider

- **Alerts/Reminders/Pop-Ups**
- **Continuing Care Records**
- **Administrative Data/Documents**
- **Derived Data/Documents**
- **Data/Documents**
- **Data from Source Systems –**
- **New Technologies**
- **Personal Health Records (PHRs)**

- **Research Records**
- **Discrete Structured Data**
- **Diagnostic Image Data**
- **Signal Tracing Data**
- **Audio Data**
- **Video Data**
- **Text Data**
- **Original Analog Document**

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Legal Health Record Matrix

Type of Document	LHR Media Type Paper (P) or Electronic (E) *	Primary Source System Application (non-paper)	Source of the Legal Health Record	Electronic Storage Start Date	Stop Printing Start Date	Fully Electronic Record (drill down composition)
H&P	P/E	Transcription System	EHR	1/2/2007	3/2/2007	12/17/2007
Physician Orders	E	CPOE System	EHR	1/2/2007	3/2/2007	12/17/2007
EKG	P					

*Includes Scanned Images

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Maintaining the Legal EHR

				Document Principles			
Report/Document Type	Audit	Authentication	Authorship	Copy/Paste	Amend	Correct	Clarify
Encounter History	O*	O	O	X*	O	O	O
Encounter Physical	O	O	O	X	O	O	O
Medical History	O	O	O	X	O	O	O

*O –   Allowed & Monitored - based on reported and randomized audits to determine
adherence to P&P for accurate, timely, and complete documentation principles.

*X –   Prohibited & Monitored - based on reported and randomized audits to determine
prohibited use of copy and past, pull forward, etc.

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EHR Management (EHRM)

- ◆ **"The process by which electronic (e.g., digital) health records are created or received and preserved for evidentiary (e.g., legal or business) purposes."***

- ◆ **The requirements remain the same (indeed, with some new wrinkles) but the processes change.**

*e- HIM® Workgroup

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EHRM – Strategic Importance

- ◆ *From a strategic standpoint, it is important to go beyond the record creation phase and develop a plan that results in an EHR and EHR system that maintain a high level of integrity for business and legal purposes.*

- ◆ *The management of the EHR and the EHR system is and will continue to be a mission-critical function in the provision of care across the healthcare continuum.*

AHIMA Practice Brief: The Strategic Importance of EHR Management 10/2004

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EHRM Strategic Importance

♦ *However, given today's urgency to begin deploying EHRs, healthcare entities, vendors, and others sometimes neglect to build in the processes and system capabilities needed to enable optimal EHRM functions and ensure the electronic rather than the paper version can stand as the* *legal business record*.

AHIMA Practice Brief: The Strategic Importance of EHR Management 10/2004

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EHRM: Requirements

♦ **Creating and maintaining** EHR retention and disposition schedules based on administrative, legal, fiscal, and historical needs.

♦ **Establishing documented procedures** for the scheduled destruction of obsolete EHRs and retaining proof of such destruction.

♦ **Developing, implementing, and maintaining** efficient EHR filing systems.

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EHRM: Requirements

- Quickly **locating and organizing** EHRs.
- **Training** personnel in the use and function of EHR management processes.
- **Ensuring** the confidentiality, security, and integrity of the information contained in the EHRs.
- **Monitoring / auditing** the completeness and accuracy of the EHR content.

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EHRM: Processes

- The **EHRM processes** require thoughtful decision making throughout the electronic health record life cycle
  - ✓ Creating / Receiving
  - ✓ Indexing
  - ✓ Searching
  - ✓ Retrieving
  - ✓ Processing
  - ✓ Routing / Distributing
  - ✓ Storing
  - ✓ Maintaining
  - ✓ Securing
  - ✓ Purging / Archiving / Destroying

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Polling Question #3

Can you produce your legal health record from one source system or do you have to go into multiple systems?

a) Yes, single system

b) No, multiple systems

c) Not applicable

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Retention

- Identify and document the method, location, and native file format of information created within the organization.

- Provide education on the retention schedule.

- Establish internal audits or controls to measure compliance with the organization's storage, retention, and destruction policies.

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Destruction

- ◆ **Does every piece of information or data need to be kept forever?**
- ◆ **Destruction Plan**
  - • **Instructions and guidelines for destruction.**
  - • **Instructions when destruction should be delayed or stopped.**
  - • **Include all types of information.**
  - • **Review of all laws and guidelines.**
  - • **Provide education.**
  - • **Safeguards for inappropriate destruction.**

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Managing electronic health records requires us to:

- ◆ **Preserve electronic data and documents that can reasonably anticipated to be relevant in litigation**
- ◆ **Ensure that data can be retrieved and produced in as cost effective and non-burdensome manner as possible**
- ◆ **Ensure that data and information is stored in a manner that facilitates future retrieval**

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Managing electronic health records requires us to:

- Ensure that mechanisms are in place to allow efficient searching and integration of subject records and information from various systems and applications
- Understand how systems handle deleted, shadow, fragmented, versions and temporary documents and data
- Understand what metadata systems generate

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Resource/Reference List

- AHIMA EHR Practice Council. "Developing a Legal Health Record Policy." *Journal of AHIMA* 78, no.9 (October 2007): 93-97
- AHIMA e-HIM® Work Group: Guidelines for EHR Documentation to Prevent Fraud AHIMA Practice Brief, *Journal of AHIMA*, AHIMA E-HIM Task Force Report, 1/2/07
- "Data Content for EHR Documentation." *Journal of AHIMA* 78, no.7 (July 2007): 73-76.

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Resource/Reference List

- **Dougherty, Michele. "How Legal Is Your EHR?"** *Journal of AHIMA* **79, no. 2 (February 2008): 24-30.**
- **HL7 EHR-S Records Management and Evidentiary Support Functional Profile. Released for ballot December 5, 2007. Available online at www.hl7.org**
- **"Data Elements for EHR Documentation."** *Journal of AHIMA* **78, no.7 (July-August 2007): web extra.**

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- **The 2008 Legal EHR conference will provide new information and industry expert's perspectives on issues impacting the legal EHR, evidentiary support, and records management. This conference addresses key issues in the management of EHRs in order to support the legal and business needs of healthcare organizations, and understand how EHRs will impact the legal process and emerging issues, including risks and liabilities.**

- **For information and registration, visit www.ahima.org/meetings/legalehrcon.asp**

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Appendix

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AHIMA EHR Practice Council. "Developing a Legal Health Record Policy." *Journal of AHIMA* 78, no.9 (October 2007): 93-97
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_035543.hcsp?dDocName=bok1_035543

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http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp?dDocName=bok1_033097

"Data Content for EHR Documentation." *Journal of AHIMA* 78, no.7 (July 2007): 73-76.
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_034459.hcsp?dDocName=bok1_034459

Dougherty, Michele. "How Legal Is Your EHR?" *Journal of AHIMA* 79, no. 2 (February 2008):
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