

The Legal Health Record

**Virginia Association of Government
Archives and Records Administrators**

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Presentation Goals

- Basis for Defining the Legal Health Record (LHR)
 - Paper vs Electronic Health Record (EHR)


- Role of the Personal Health Records (PHR)
 - Your Rights and Options
 - Making an Informed Decision



Legal Caveats

- This presentation is not legal advice
- Its purpose is to share with you how health information management (HIM) professionals define and maintain documents and data elements that serve as the LHR for the provider and are used to respond to routine requests for information

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Patient Information is Exploding

- Moving from paper to electronic information expands boundaries
- More information available, databases merged, expanded capabilities
- Requires providers to clearly define their legal health record

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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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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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Definition of Legal Health Record

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



LHR Definition - General


- Important to any healthcare organization
- Applies to all types of patients and patient services
- Includes protected health information (PHI) stored in any medium that is collected and used in delivering healthcare or assessing health status
- **REMEMBER:** There is no “one size fits all” standard for all providers



Legal Basis of LHR Content

- Federal Rules of Evidence (FRE)
 - (aka Business Record Rule)
 - Article VIII, Rule 803(6) – exception to hearsay rule
 - Article VIII, Rule 902(11) – requires business record to be accompanied by an affidavit by Custodian certifying the record meets the requirements of Rule 803(6)


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Legal Basis of LHR Content

- Federal Rules of Civil Procedure (FRCP)
 - Relates to the production of electronic data
- State Rules of Evidence
 - Uniform Rule of Evidence Act
 - State licensing regulations
 - Other licensing bodies (JCAHO)
- Medicare Conditions of Participation (COP)
- Medicare Billing Guidelines


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Source of LHR Content- Issues

- Consider issues
 - Current practice
 - State laws/regulations
 - Advice of legal counsel
- Document decisions
- Revisit as laws and practices change


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Source of LHR Content - Issues

- Originating Systems – Lab, Radiology, Pharmacy, Cardiology, CPOE, Transcription, Fetal Monitoring
- Secondary Systems – Results reporting, EHR, Clinical Data Repository
- Data may be duplicated – which system will be used for LHR?

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LHR – Issues

- Assess how information is used

- Determine if it is pertinent to documentation of patient care

- Are there other sources for data (e.g. dictated reports, diagnostic study data)?

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LHR Content Definition – Grid

Document/ Data Element	Source	Medium	Date in EHR	Citations References
H & P	Tx Sys	Electronic Interface	06/05/05	Mcare COP; JC; st. law
Lab findings	LIS	Electronic Interface	07/01/05	Mcare COP; JC; st. law
Op Consent	Paper	Separate folder	In Pt Access	JC; St law
Progress Note	Paper	Scanned	10/15/06	Mcare COP; JC; st. law

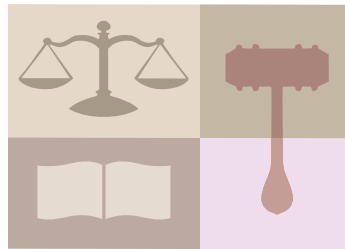
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Additional Policies to Consider

- **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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Maintaining The LHR

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"7 Absolutes" for Record Integrity

- Access
- Authenticity
- Accuracy
- Authorship
- Authentication
- Amendments
- Alterations



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Access

- Determine the right of access to patient information based on individual's need to know. Role based access.
- Also determine
 - Who can print or fax patient information
 - Who can download information
 - Who can change or delete information

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Access Cont.

- Establish types of information to be released to certain types of requestors
 - Researchers
 - Payers
 - Students
 - Physician office staff


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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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Accuracy

- Documentation should reflect care given
- Author of entry responsible for accuracy
 - Authentication of information from “feeder systems”
- A policy/procedure must be in place to govern documentation requirements

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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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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 in regards to responsibility, timeliness, form and format

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Authentication Cont.

- 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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Authentication Issues...

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

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Authentication Methods



- Hand-written signatures
- Rubber stamps
- Computer keys
- Electronic/digital signature

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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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Amendments Cont.

- 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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Amendments Cont.

- 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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Patient Requested Amendments

- Process required by HIPAA 45 C.F.R 164.526(a)
 - Amendment should refer back to original information
 - Include correct information with date and time
 - Do not remove or change original information

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Correction: Retraction

- Retraction = removing a document from one record and placing it into another record
 - Need to keep documentation on situation and date of retraction
 - May need to notify users of both records



Correction: Reassignment

- Involves moving a document from one episode of care to another
- Need explanatory note in patient's file



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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Alterations

- “Amendments” which intentionally change the content or character of health information in the (electronic) health record for less than honorable purposes

- Tampering

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Retention and Destruction


- Those documents/data elements included in the LHR content definition must be preserved for the length of time specified by the provider's retention schedule (based on legal requirements)
- If the same date is in multiple systems, only need to preserve the date in that system designated as the source for the LHR




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.




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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Role of the HIM Professional

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The HIM Professional.....

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

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SO.....What about

Personal Health Records?


..... **My Rights?**

How can an HIM professional help?

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First Things First



- Legal Caveat:
 - The American Health Information Management Association (AHIMA) does not sell or endorse any of the PHR products listed in this presentation. It is important to be aware that PHRs that are NOT part of a Provider's electronic health record are NOT considered to be legal records, and therefore, are not HIPAA covered entities.


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Informed Decisions

- Become an educated consumer
- Know your rights
- Self advocacy

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Personal Health Records

What?

Why?

How?

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What is a PHR ?

- A tool for collecting and maintaining and **sharing** important information about your health or the health of a loved one.

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Why Keep a PHR?

- Your health information is scattered among many providers. By keeping your own up-to-date health information, you have the knowledge to play an active role in managing your health.

- You wouldn't write checks or use the debit card with out keeping an up to date transaction register, would you???.....

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How to Create a PHR

- Gather pertinent information
 - DEMOGRAPHICS
 - LIST OF MEDICATIONS
 - ALLERGIES
 - DIAGNOSIS / PROBLEM LIST
 - HISTORY OF TESTS AND PROCEDURES
 - RECORD OF IMMUNIZATIONS
 - PERTINENT FAMILY MEDICAL HISTORY

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How to Request Records

1. Complete an "authorization for the release of information"
a sample form is available at:
www.myphr.com/rights/disclosure_authorization_frm.pdf
2. Have proof of identification available
3. Most facilities charge fees for records
4. Allow up to 60 days to receive records

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Tools You Need

- USB drive
- Word Doc software
- Scanner
- Label
- www.myPHR.com
- www.AHIMA.org

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Your Rights: Under HIPAA

You have the right to.....

access, inspect and copy health information

request correction or amend health information

request an accounting of disclosures of health information (who has received it)

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Rights Under HIPAA Cont.


You have the right to.....

revoke a previous authorization with written notification


..... BUT BE AWARE!!!



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CAUTION




PHR's that are not part of a provider's electronic health record are not considered to be legal records, and therefore are **not HIPAA covered** entities!

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Questions



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THANK YOU

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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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