



Indian Health Service

The Federal Health Program for American Indians and Alaska Natives

LEGAL HEALTH RECORD: Definition and Standards

DEVELOPING YOUR STRATEGY & Tool Kit

Diane Premeau, MBA, MCIS, RHIA, RHIT, CHP, A.C.E.

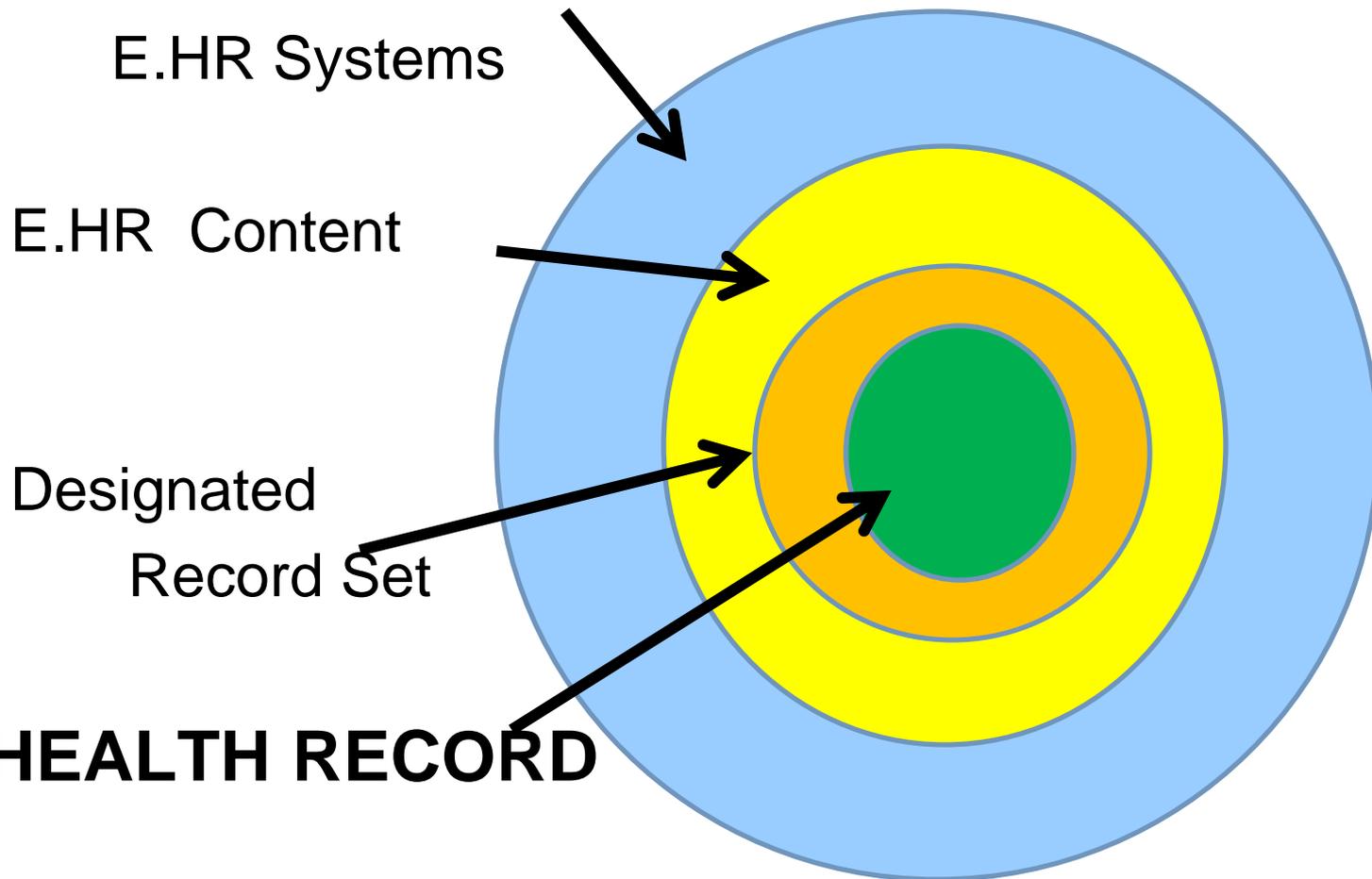
OBJECTIVES

- Define Legal Health Record
- Differentiate between Designated Record Set and Legal Health Record
- Identify Components of Legal Health Record Policy
- Understand importance to E-Discovery

What is a Legal Health Record?

- Information **created, received or maintained** by an organization that is the **business record** of **activities, operations**
- **Record** has value requiring adherence to **regulatory and retention rules.**
- **Generated for healthcare and would be released upon request.**

Where is the Legal Health Record?



Definitions: Business Record

- A recording/record made or received in conjunction with a business purpose and preserved as evidence or because the information has value. Information is created, received and maintained about a person.
- Must be maintained to comply with applicable regulations, accreditation standards, professional practice standards & legal standards.

Legal Health Record (LHR)

- Record generated at or for a healthcare organization as its **business record** and is the record that would be **released upon request**.
- Supports decisions made in patient care.
- Supports claims for revenue.
- Serves as legal testimony regarding illness, injury, response to treatment, and caregiver decisions.
- Each entity **MUST define the content & standards**

Designated Record Set (DRS)

(HIPAA 164.501)

A group of records maintained by or for a covered entity that is the:

- medical and billing records about individuals;
- enrollment,
- payments,
- claims records,
- medical management record systems maintained by or for a health plan (case management);
- information used in whole or in part by entity to make decisions about individuals.

Hybrid Record

- Information that is maintained in a variety of media, including paper and electronic.
- Comprised of both paper and electronic processes to collect, store, retrieve and utilize the information.
- *Hybrid record is more difficult to define and manage as legal record.*

Electronic Health Record (E.HR)

Medical information compiled in a data gathering format (point of care) for retention and transfer of Protected Health Information (PHI) via secured, and/or **encrypted** communication options.

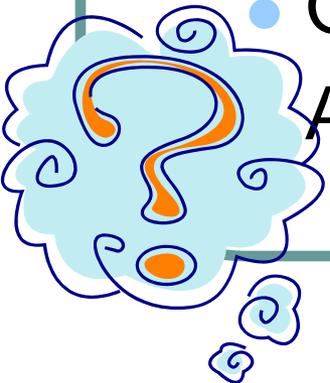
- Can generate a health record of a clinical encounter
- May provide clinical decision support, alerts, outcomes reporting, quality monitoring.
- Components that can be released can be variable.

Personal Health Record (PHR)

- An **Individuals own record**, maintained by the individual, created by the individual and health care providers.
- PHR is separate from and does not replace the legal health record. Can be incorporated into Legal Health Record.
- Individual owns and determines access rights.

WHO IS THE CUSTODIAN

- **Past:** Director of HIM
 - **Present:** Hybrid, E.HR - Several custodians...
 - Direct Custodian (typically HIM)
 - Data Owner or Steward
 - Business Associate/ Third Parties
 - Office Record and Systems Custodian
- And.....



Where is your Legal Health Record

Define the location of your record from creation to storage

- Past: Chart order



- **Present: Variety of Sources**

Best Practice - Development a matrix

(attachment)

Track source system, location, retention, media,
designated record set

Identify content external to organization

Where do you Start??

Do you know how your record is created?

FIND ALL Systems – All media

- Conduct a source system review
- Where, Who, What – output?
- Do you have SPECIAL considerations?
 - Mental Health, Custody, Children or ??

Hybrid Record Matrix

IP Document (list all your documents)	VIEWING LOCATION	Source System	SCANNED	Location for Legal Record (P, E)	Part of Designated Record Set	Created by	Interface 1
1. ADMITTING INFO							
Inpatient Admission Registration sheet	Paper/ EDM	Core System		E	Y	Admitting	System A
Conditions of Admission							
Code Status Orders							
Medication Consents							
Legal Status documents:							
Organ Donation Form							
2 ADMINISTRATIVE DOCUMENTS							
Advance Directive Alert Form							
Advance Directives Acknowledgement							
Interfacility transfer sheet							
Health Facility Minor Release Report							
Discharge Summary	Paper/ EDM	Chart Script	No	E	Y	Transcription	System A
Physician/Treatment Coordinator Discharge Summary							
Death Notice							
Death Certificate Worksheet							
Autopsy							

Hybrid Matrix (con't)

IP Document (list all your documents)	Able to Print	Version Management	Back-up	Location where stored	Meta data	Audit Trail	Location of Training for Access	Special Category (mental health, administrative)
1. ADMITTING INFO								
Inpatient Admission Registration sheet	Yes	Yes	Yes	IT	Yes	Yes	Admitting	administrative
Conditions of Admission								
Code Status Orders								
Medication Consents								
Legal Status documents:								
Organ Donation Form								

Designated or Legal Health Record?

STEP 1: Identify Record Content

Understand DRS from LRS

Designated Record Set	Legal Health Record
<p>Includes LHR <u>PLUS</u> medical and billing records; enrollment, payment, claims, health plan, decision making documents</p>	<p>Individually identifiable data in any medium collected and used in <u>documenting healthcare services or health status.</u></p> <p>Excludes administrative, derived or aggregate data</p>

STEP 2: Components of the Legal Health Record Policy?

Identify content of the LHR

- Health records
- Business & legal record

Administrative	Clinical	External
Bills, Encounter forms Case Management Records Remittance advice (Designated Record Set Only)	H&P; Orders; Progress Notes; Lab Reports/Diagnostics Nursing Documentation Therapies Authorizations/Consents Clinical Reports	External patient care records PHR

Step3: Develop YOUR Standards

LHR policy is NOT just a list of documents
LHR policy defines how to manage the record.

Part I: Define your Legal Record

- How created
- Who can create the record
- Formats
- Purpose
- Contents: Internal and External document

LHR Definition

(Sample Legal Record Definition and Standards)

- The Legal Medical Record (LMR) is the documentation of services provided to an individual during any aspect of healthcare delivery and is patient-centric.
- The legal health record contains individually identifiable data, **stored on any medium**, collected and directly used in documenting healthcare or health status.
- The legal health record is the **business record** and is the record that will be disclosed upon request.

LHR: How Created & Format

(Sample Legal Record Definition and Standards)

- The Legal Medical Record may be a hybrid record utilizing both paper-based and electronic documents, which are captured manually and via electronic processes.
- Only individuals authorized to do so by Hospital and/or Medical Staff Policies and Procedures make entries into the Legal Health Record.

LHR: Purpose

(Sample Legal Record Definition and Standards)

PURPOSE

- The Legal Health Record definition and standards set forth in this Policy provide a **framework for the integrity of paper and electronic clinical documentation systems** that compile and maintain Legal Health Records to meet patient care and regulatory requirements.
- The Legal Health Record contains sufficient information to identify the patient, support the diagnosis, justify the treatment and services, document the course and results of care, and promote the continuity of care among health providers. (CMS Language)

LHR:

Source Data; External documents

- The Legal Health Record may include ***source data*** in the absence of documentation or interpretations. (e.g., Fetal monitor strips, etc)
- The Legal Health Record may include records from ***other health care providers*** as the result of tests and exams when necessary for the evaluation of the patient and subsequent treatment.

PART II: Standards for LHR:

Identify Standards for Managing your LHR

- **Maintenance:** How generated & maintained
- **Confidentiality:** Data access, Data release
- **Content:** Matrix plus rules of “creation”
 - Drafts; System requirements for identification
- **Authentication & Completion**
- **Security and Retention:**
 - Downtime, Back-up, Disaster Recovery

Maintenance:

How generated & maintained

Maintenance of the Legal Health Record

- Your LHR may be considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the LHR may physically exist in separate and multiple locations in both paper-based and electronic formats. (See Grid to identify type and location of documents).
- The Legal Health Record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images, electronic messages (e.g. emails) and fetal monitor strips.
- The electronic components of the Legal Health Record consist of patient information from multiple electronic health record source systems.

Confidentiality

Personnel who access the electronic Health Record are required to have a unique user ID/ password, access to information is limited according to the **minimum necessary rule** and managed by role, as approved by designated management personnel.

LHR CONTENT

Legal Health Record content shall meet all State and Federal legal, regulatory and accreditation requirements

All documentation and entries in the record, both paper and electronic, must be identified with a minimum of two identifiers, preferably the patient's full name and a unique number.

All record entries should be made as **soon as possible after the care is provided, after an event occurs, or after an observation is made**. An entry for the **actual patient treatment or procedure will never be made in the Medical Record in advance** of the service provided to the patient.

Only forms/reports approved can be used to document or capture data in the Legal Health Record.

CONTENT

Preliminary reports/documents are available for patient care until they are authenticated. Once a document/report has been authenticated by the author (Final version) only that version is electronically displayed or filed in the paper chart.

Only approved abbreviations will be used in the Legal Health Record.

Completion

All inpatient records must be completed within 14 days from the date of discharge.

All ambulatory records will be completed immediately following the encounter.

All operative and procedure reports will be completed immediately after surgery.

All record entries are to be dated, the time entered, and signed.

Certain electronic methods of authenticating the record, including methods such as passwords, access codes, or key cards may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with **electronic signature policy**.

Do you have an electronic signature policy?

Define Standards for LHR (Advanced)

- **Downtime** (what are the options???)
- **Corrections & Amendments:**
 - Paper; Scanned Documents
 - Transcription
 - Point of Care Systems
- **Copy and Paste Guidelines:** YES OR NO??

Maintenance

All Health Records, regardless of form or format, must be maintained in their entirety, and **no document or entry may be deleted** from the record, **except in accordance with the destruction policy.**

Corrections and Amendments

If records requiring correction are from an outside provider, the patient should be instructed to contact the originator for an amendment.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision.

Correcting Electronic Version:

Do you know the options??

Documents that are created electronically must be corrected by one of the following mechanisms:

1. Adding an addendum to the electronic document to indicate the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.
2. Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered prior to signing (i.e., wrong work type, wrong date, wrong attending assigned).
3. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated above. Examples of documentation errors that are corrected by addendum include: wrong date, wrong location, duplicate documents, or incomplete documents. The amended version must be reviewed and signed by the provider.

Corrections - Scanning

Errors in Scanning Documents (if applicable)

What are your options????

Corrections: Point of Care

Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation, and mechanisms may vary from one system to another.

1. In general, correcting an error in an electronic/computerized health record should follow the same basic principles as corrections to the paper record.
2. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.
3. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time must be entered, and the person making the change must be identified.

COPY & PASTE

Organization specific....

G. Copy and Paste Guidelines

The “copy and paste” functionality available for electronic Medical Records eliminates duplication of effort and saves time, but it must be used carefully to ensure accurate documentation and must be kept to a minimum.

Copying test results/data: If a clinician copies and pastes test results into an encounter note, the clinical-provider is responsible for ensuring the copied data is relevant and accurate.

E-Signatures

Electronic signatures must meet standards for:

Data integrity to protect data from accidental or unauthorized change (for example “locking” of the entry so that once signed no further untracked changes can be made to the entry);

Authentication to validate the correctness of the information and confirm the identity of the signer (for example requiring signer to authenticate with password or other mechanism);

Non-repudiation to prevent the signer from questioning that they signed the document (for example, public/private key architecture). At a minimum, the electronic signature must include the full name and either the credentials of the author or a unique identifier, and the date and time signed.

What is NOT the LHR?

Secondary Patient Information

- Source data used to create summaries
- Administrative Data
- Derived Data
- Drafts, Work in Progress
- Audit Trails

Not Part of LHR

Patient-identifiable source data

- A. Patient-identifiable source** Examples include, but not limited to
1. Photographs for identification purposes
 2. Audio recordings of dictation notes or patient phone calls.
 3. Video recordings of an office visit, if taken for other than patient care purposes
 4. Video recordings/pictures of a procedure, if taken for other than patient care purposes
 5. Video recordings of a telemedicine consultation
 6. Communication tools
 7. Protocols/clinical pathways, best practice alerts, other knowledge sources.
 8. A patient's personal health record provided by the patient to his or her care provider.
 9. Medication reconciliation from an outside source (pharmacy, other providers)
 - 10. Alerts, reminders, pop-ups and similar tools used as aids in the clinical decision making process.**

Administrative Data

Administrative data are patient identifiable data used for administrative, regulatory, and healthcare operations and for financial purposes.

Examples include, but are not limited to:

1. Authorization forms for release of information
2. Correspondence concerning requests for records.
3. Birth and death certificates.
4. Event history/audit trails.
5. Patient-identifiable abstracts in coding system.
6. Patient identifiable data reviewed for quality assurance or utilization management.
7. Administrative reports.

Not Part of LHR

Derived Data

Derived data consist of de-identified information aggregated or summarized from patient records for statistical reporting, licensing and accreditation. Examples include, but are not limited to:

1. Accreditation reports
2. Best practice guidelines created from aggregate patient data.
3. External required reporting, public health records and statistical reports.

Not Part of LHR

Draft Documents

Draft Documents / Work in Progress.

- Electronic processes and workflow management require methods to manage work in progress.
- Draft/Interrupted documents are not considered a part of the official Medical Record until they are finalized and signed by an authorized signer.

Audit Trails

An audit trail is part of the metadata created around a document. It is composed of all transactions and activities, including access, associated with the health record.

Elements of an audit trail may include date, time, nature of transaction or activity, and the individual or automated system linked to the transaction or activity.

Legal Health Record & E-Discovery

Other considerations for E.HR's

- Clinical Decision Support Functions
 - Prompts
 - Alerts
 - System Notifications

Next Steps.....

- Evaluate **E-Discovery Process** against systems and record management.
- Understand how systems handle deleted, shadow, versions, temporary documents, data.
- Identify **Who** can provide system information, reports?

Resources/Reference List

- AHIMA. "Fundamentals of the Legal Health Record and Designated Record Set." *Journal of AHIMA* 82, no.2 (February 2011): expanded online version.
- Dougherty, Michelle, and Lydia Washington. "Defining and Disclosing the Designated Record Set and the Legal Health Record." *Journal of AHIMA* 79, no. 4 (Apr. 2008): 65–68. Available online in the AHIMA Body of Knowledge at www.ahima.org.
- Servais, Cheryl E. *The Legal Health Record*. Chicago, IL: AHIMA, 2008.
- [Deleting Errors in the EHR \(AHIMA September 2010, Working Smart\)](#)
- AHIMA e-Discovery Task Force. "Litigation Response Planning and Policies for E-Discovery." *Journal of AHIMA* 79, no.2 (February 2008): 69-75
- Legal Electronic Health Record Policy Template. www.AHIMA.org Body Of Knowledge

Audience Questions

