The Legal Health Record and Records Management

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December 5, 2016

Agenda

- What is the Legal Health Record (LHR)
- Legal Hybrid Health Record
- Managing the Legal Electronic Health Record (EHR)
- Health Records Management Principles and Considerations

What is the Legal Health Record (LHR)?

- American Health Information Management Association (AHIMA) defines the legal health record as **“generated at or for a healthcare organization as its business record and is the record that would be released upon request”.**

What is the LHR?

- The LHR is the documentation of healthcare services provided to an individual in any type of healthcare organization (IHS Direct/Tribal/Urban [I/T/U]).
- It is consumer- or patient-centric.
- The LHR contains individually identifiable data, stored on any medium, and collected and directly used in documenting healthcare.

Who is the Custodian?

- Health Information Management (HIM) is responsible for the care, custody, and control of the health record whether stored in paper or electronic format.
- HIM professionals oversee the operational functions related to collecting, protecting, and archiving the LHR.
- The custodian should be authorized to certify records and supervise all inspections and copying of records.
- The custodian of the health record may be called to testify to the admissibility of the record (Federal Rules of Evidence (803(6).

Certification

- Certification verifies that “this is the true copy of the original.”
- A statement or affidavit and signature of the record custodian are sufficient; some states may require a witness or notary signature.

The LHR…

- Must meet accepted standards as defined by Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, federal regulations, applicable state laws and/or tribal code and accrediting agencies such as CMS and The Joint Commission, as well as organizational internal policies
- Is the record of care used by healthcare professionals while providing patient care service, used for administrative purposes such as cost reports, planning, or for payment purposes
- May exist in paper, electronic, or both (hybrid)

CMS Conditions of Participation

- Maintain a medical record for each patient
- Properly filed and retained to ensure prompt retrieval
- The medical record must be accessible
- The medical record system must ensure that medical record entries are not lost, stolen, destroyed, altered, or reproduced in an unauthorized manner
- Locations where medical records are stored or maintained must ensure the integrity, security, and protection of the records
- All entries in the medical record must be timed, dated, and authenticated, and a method established to identify the author

HIPAA and the LHR

- HIPAA Privacy Rule (Section 164.501) requires that organizations identify their **designated record set,** which is defined as “a group of records maintained by or for a covered entity.”
- Example: The designated record set for IHS is the Privacy Act System of Records “Health, Medical and Billing Records” Notice No. 09-17-0001

Legal Hybrid Health Record

- When the LHR consists of information created as paper documents and information created in electronic media, it is considered to be in a *hybrid* environment.
- Document the information that is considered the LHR and identify the source (paper or electronic) of that information. A matrix should be used for this purpose. See AHIMA's matrix at www.ahima.org

LHR Matrix Example

Report/ Document Types	LHR Media (P)aper (E)Lectronic *	Source System Application (nonpaper)	Electronic Storage Start Date	Stop Printing Start Date
H&P	P/E	RPMS-EHR Version 1.2	1/2/2005	1/2/2006
EKG	P			
Orders	E			
Consents*	E	RPMS EHR Version 1.2	1/2/2005	6/1/2005
* Includes Scanned Images		RPMS EHR Version 1.2	TBD	

Documents Not Included in the LHR

- Administrative Data and Documents are patient-identifiable data used for administrative, regulatory, healthcare operations, and payment (financial) purposes.
  - Authorization forms/valid written requests for Release of Information (ROI)
  - Financial and insurance forms
  - Incident or patient safety reports
  - Indices (disease, operation, death)
  - Institutional Review Board lists
  - Logs
  - Acknowledgment of Receipt of the Notice of Privacy Practices
  - Patient identifiable claims
  - Patient identifiable data reviewed for quality assurance (QA) or utilization review (UR)
  - Registries

Other Records

- Organizational policy should address how information from the Personal Health Record will or will not be incorporated into the patient's health record. (Example: direct messages)
- Copies of patient health information from other sources, such as, glucometer logs, blood pressure logs, records from other providers, monitoring devices, etc. that the patient provides needs to be evaluated for inclusion in the LHR.

Federal Rules of Civil Procedure

- Amendments were made to the Federal Rules of Civil Procedure (FRCP), which were effective December 1, 2006 (e-discovery)
- Almost half of the states have adopted the amendments (AZ adopted the new rule January 2008)
- The rule ensures that all sources of relevant electronic information is preserved in anticipation of litigation

Legal Hold (Preservation Order)

- A “legal hold” defines the processes by which information is identified, preserved, and maintained when it has been determined that a duty to preserve has arisen.

Spoliation

Intentional destruction, mutilation, alteration, or concealment of evidence.

- Records in any form must be reasonable protected
- Burden rests on organizations to show information lost was a result of a good faith operation – effort – of the system
- Policies and procedures are abided by

Do you have a process to recreate a destroyed, missing record?

- Begin reconstruction immediately – any duplicate copies
- Note Date/time of record reconstruction
- Any computer reports from ancillary department, (labs, X-rays, etc.)
- Contact Physician of record ASAP – use judgement to ask to recall details if time gap occur

Missing Record Trail Considerations

- Cover sheet for the record
- Date of loss discovery
- Dates of record reconstruction
- What was replicated and how, including names of reports and source of duplicate reports
- List of known missing record portions
- Status Statement: “This record is a replica of the original. The original has been reconstructed to the extent possible with the efforts noted here. For purposes of hospital business, it is considered to be an entire and complete record at this time. It will be replaced with the original upon recovery.”
- Instruction statement: “This form is considered part of the medical record until such time that he original medical record is recovered. It is filed above the face sheet and is to be released with any record release requests when missing portions, or those unable to be replicated, are requested.”
- Signature of HIM department director or designee
- Maintain a lost medical records list within HIM
- Create a policy with input from other disciplines, like nursing.

Source: **AHIMA Journal** "Resurrecting Lost or Missing Records." *In Confidence* 8:6 (Nov/Dec 2000)

Authentication

- Authentication is an attestation that something, such as a medical record, is genuine
- The purpose is to show authorship and assign responsibility for an act, event, condition, opinion, or diagnosis
- Every entry in the health record should be authenticated and traceable to the author of the entry (Provider File)
- e-signatures are acceptable if allowed by state, federal, and reimbursement regulations

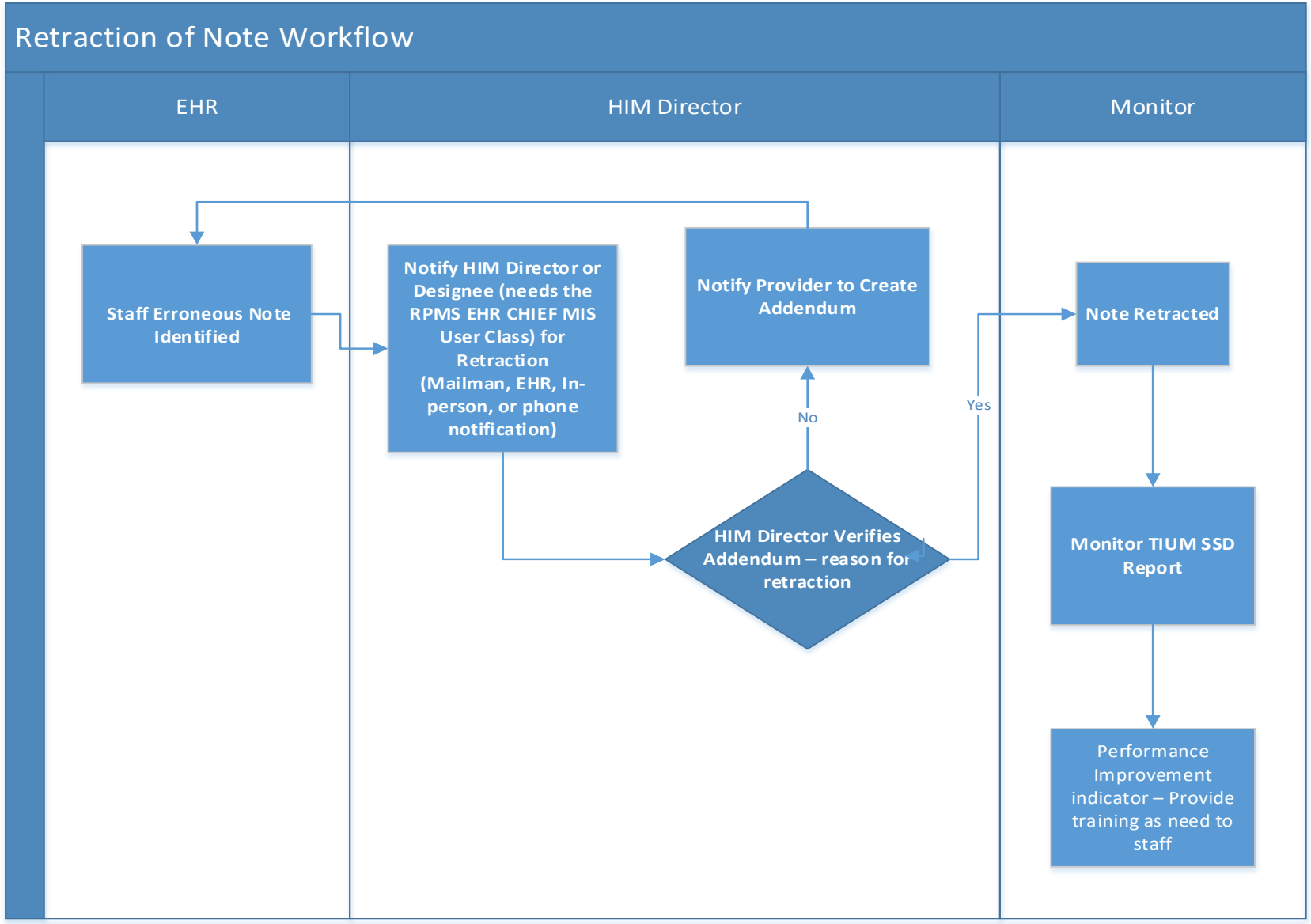
Managing the Legal EHR

Barbara Fairbanks, RHIA

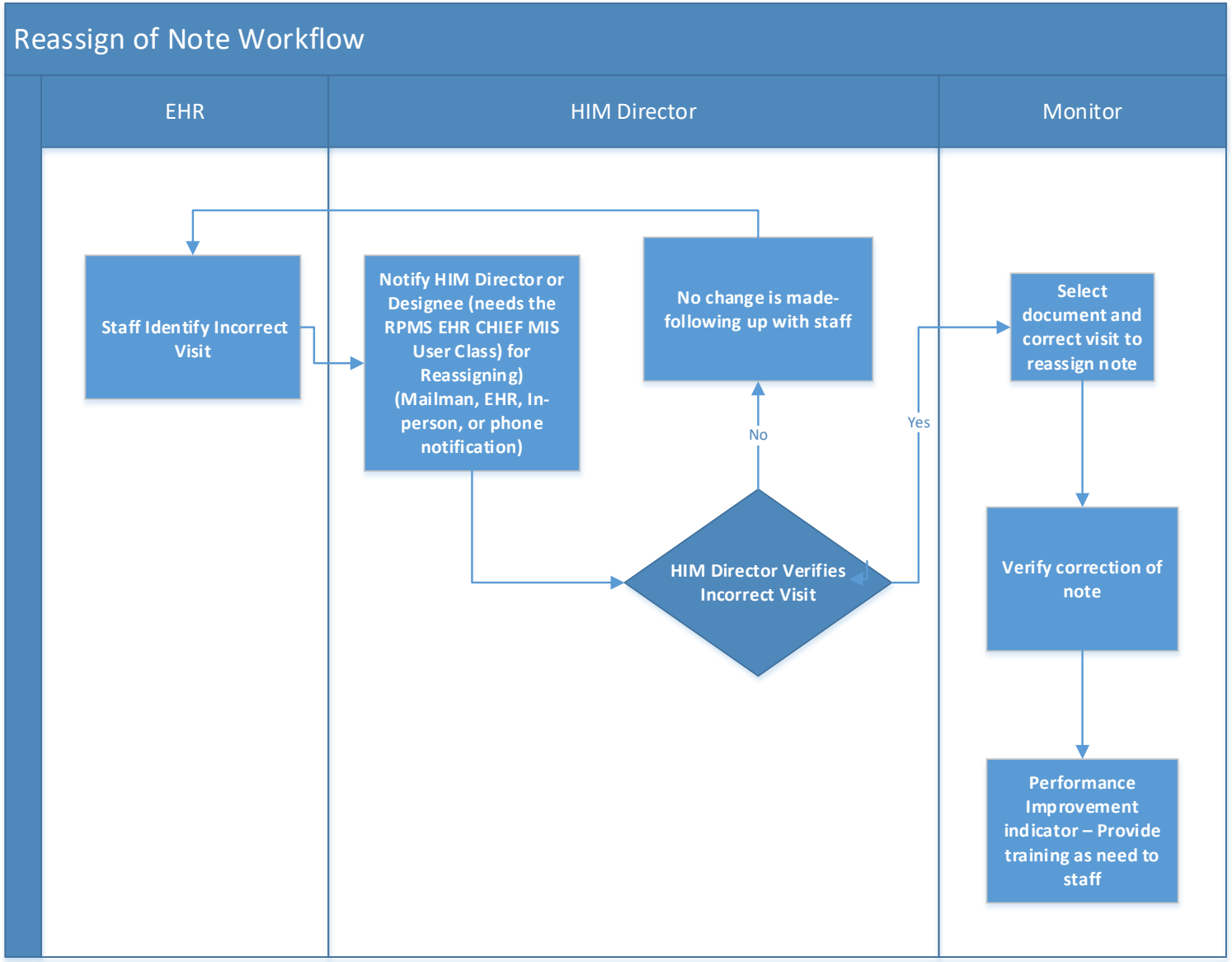
Acting Bemidji Area HIM Consultant

Director, HIM Department, Cass Lake Service Unit

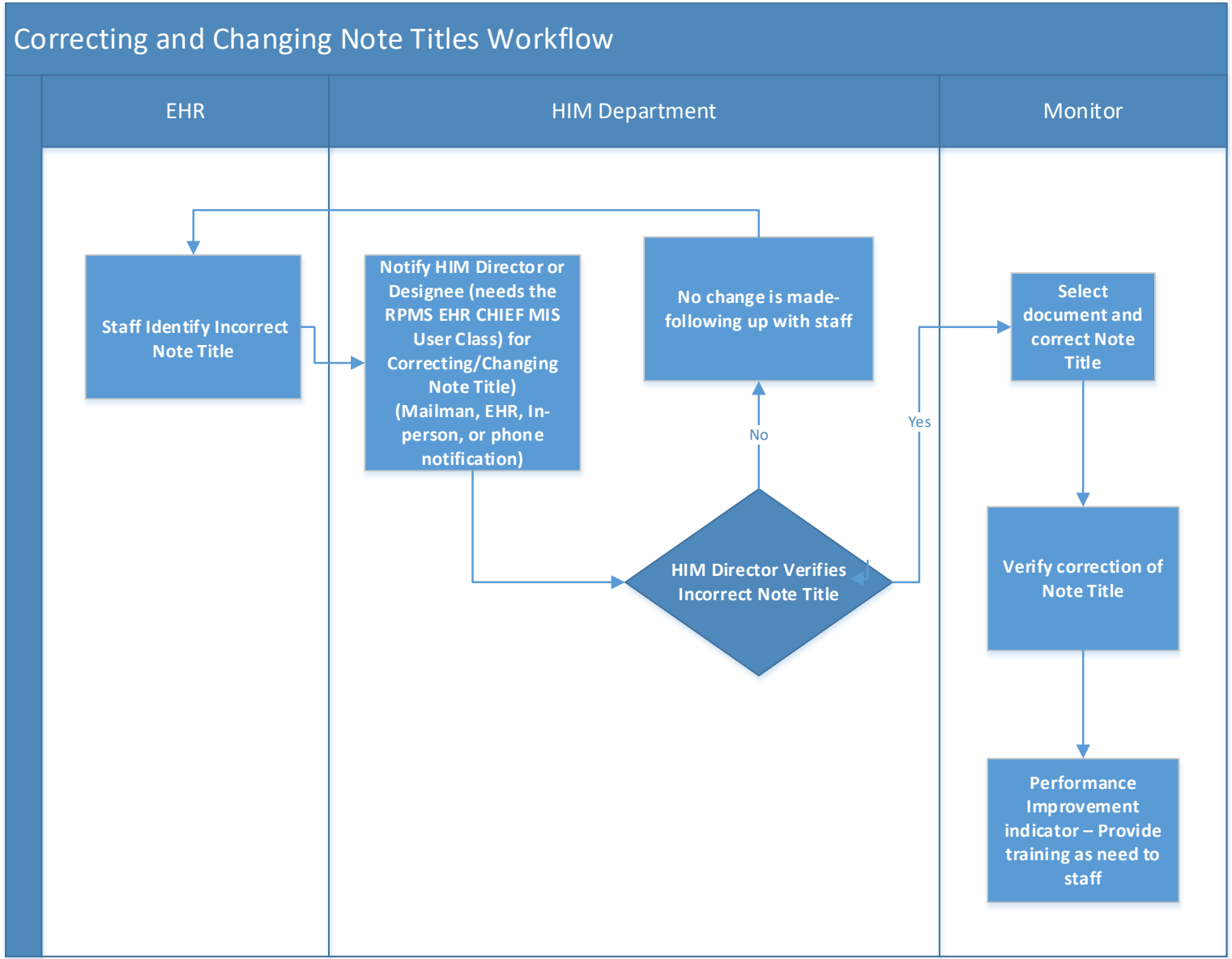
Retraction of Note Workflow



Reassign of Note Workflow



Correcting and Changing Note Titles Workflow

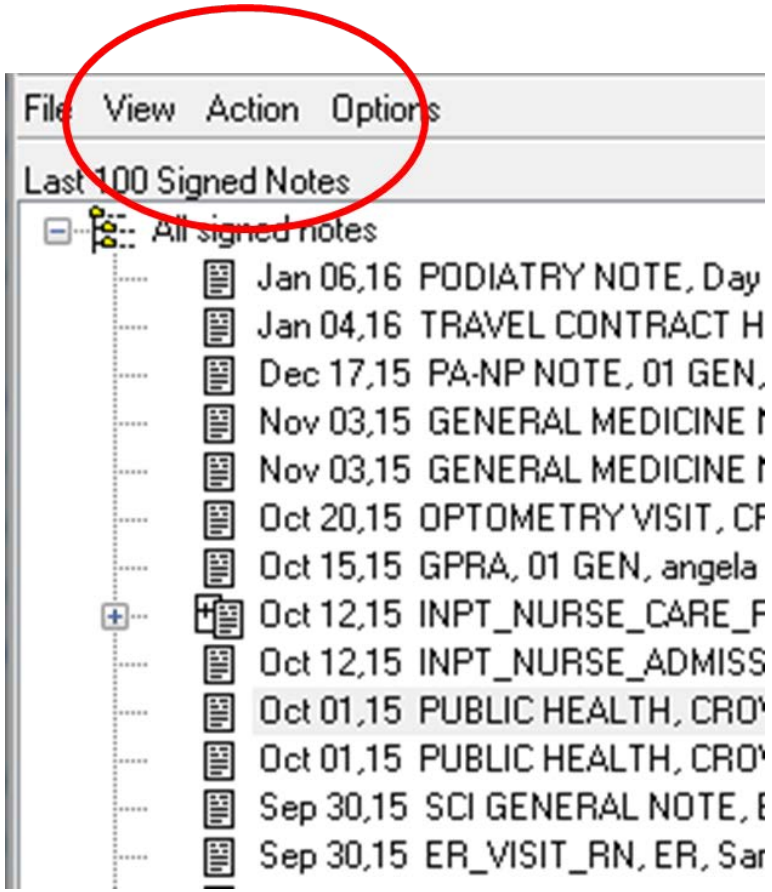


Best Practice: The author of the erroneous note must attach an Addendum stating the original note is an erroneous entry prior to retraction (deletion).

Only **authorized** Health Information Management (HIM) staff assigned to retract notes that are members of the ***RPMS EHR*** TIU User Class “Chief, MIS” have the capability of retracting a signed EHR progress note**.**

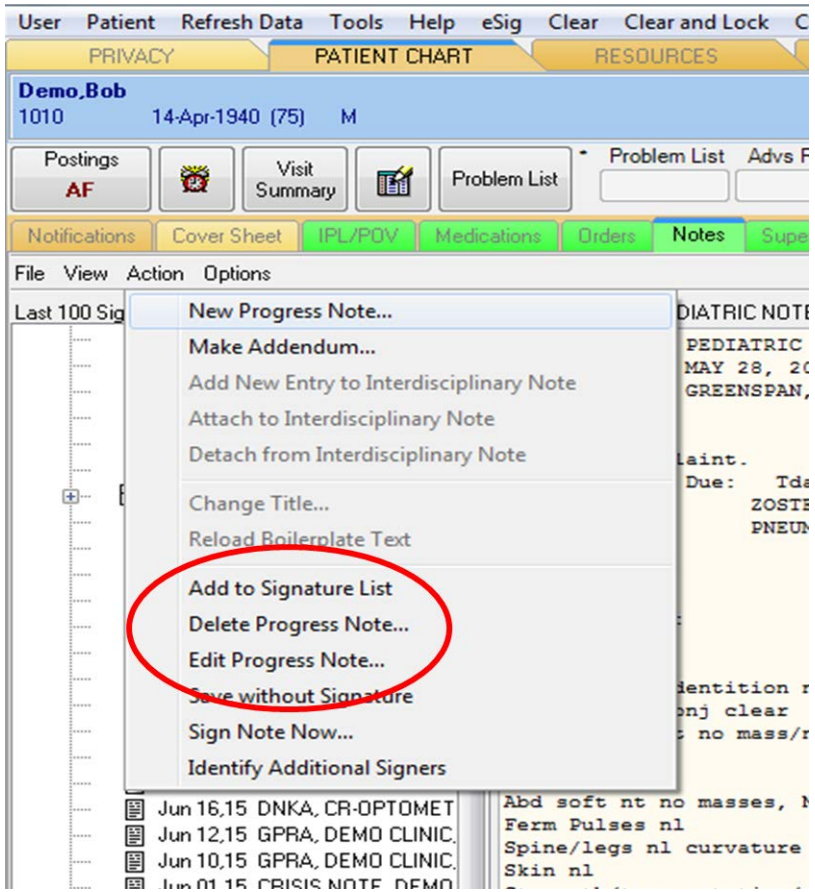
Retracting a Note (1)

Select the patient and select the entry that needs to be retracted. In the body of the note, right click to get the delete menu or select Action in the top left.



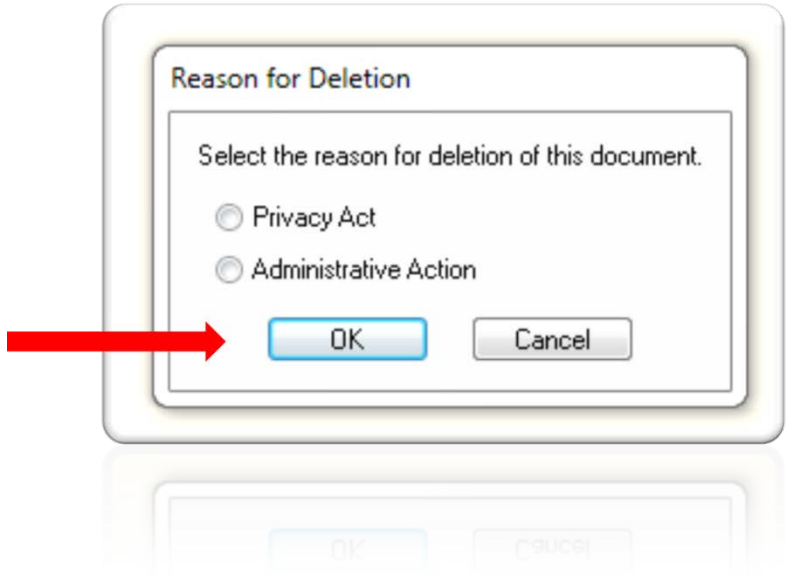
Reacting a Note (2)

Select Delete Progress Note and you will be prompted to supply a reason for the Deletion



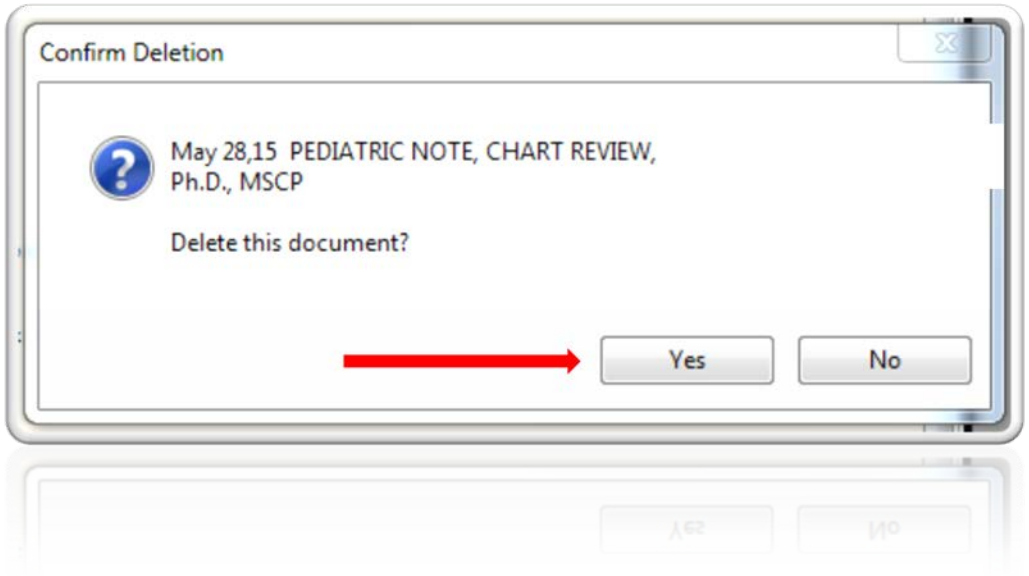
Retracting a Note (3)

Make the selection based on the reason for the retraction.



Retracting a Note (4)

Verify the date and the Note title prior to confirming.



Retracting a Note (5)

```
 LOCAL TITLE: PEDIATRIC NOTE
DATE OF NOTE: MAY 28, 2015@08:23     ENTRY DATE: MAY 28, 2015@08:23:48
      AUTHOR:                      EXP COSIGNER:
     URGENCY:                           STATUS: RETRACTED
```

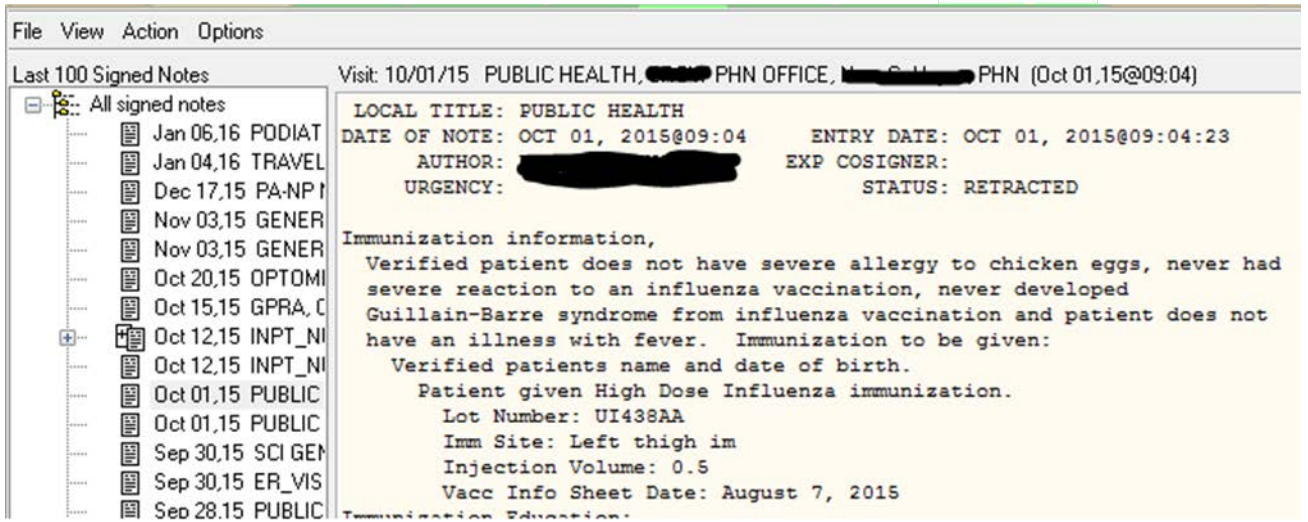
The status of the entry will now state RETRACTED as opposed to COMPLETED

```
  ENTRY DATE: DEC 17, 2015@12:52:53
EXP COSIGNER:
      STATUS: COMPLETED
```

Retracting a Note (6)

Note 1: If an addendum was created and attached to the original note it will be retracted along with the note.

Note 2: This note is still part of the record but ***cannot*** be viewed by average users of EHR. It can only be viewed by members of the Chief MIS TIU User Class.



* Don't be confused by the note appearing in the list of signed notes on the left, remember you have the access to view ***retracted*** notes.

Retracting Report Menu

- TIU Menu for Medical Records [BTIU MENU2]
- SSD Search for Selected Documents
  - Select Status: UNVERIFIED// “Retracted”
  - Select CLINICAL DOCUMENTS Type(s): “ALL”
  - Select SEARCH CATEGORIES: AUTHOR// “ALL”
  - Start Reference Date [Time]: T-7//
  - Ending Reference Date [Time]: NOW//

Retracted Document Report

RETRACTED Documents Jan 22, 2016 16:54:44 Page: 1 of 3

by ALL CATEGORIES from 07/26/15 to 01/22/16 40 documents

	Patient		Document	Ref Date	Status
1	DEMO,G	#88888	PA-NP NOTE	12/18/15	retracted
2	DEMO,G	#88888	OPTOMETRY HEAD START	11/30/15	retracted
3	DEMO,G T	#666665	NURSE MEDS	11/10/15	retracted
4	DEMO,J	#949494	PA-NP NOTE	11/05/15	retracted
5	DEMO,B	#1010	GENERAL MEDICINE NOTE	11/03/15	retracted
6	DEMO,B	#1010	GENERAL MEDICINE NOTE	11/03/15	retracted
7	DEMO,J	#949494	GENERAL MEDICINE NOTE	11/03/15	retracted
8	DEMO,J	#949494	MEDICATION RECONCILIATION	11/03/15	retracted

Reassign a Note

- Best Practice
  - Do Not Reassign Notes
  - Why?
- Discussion welcome

NEVER Reassign to Another Patient

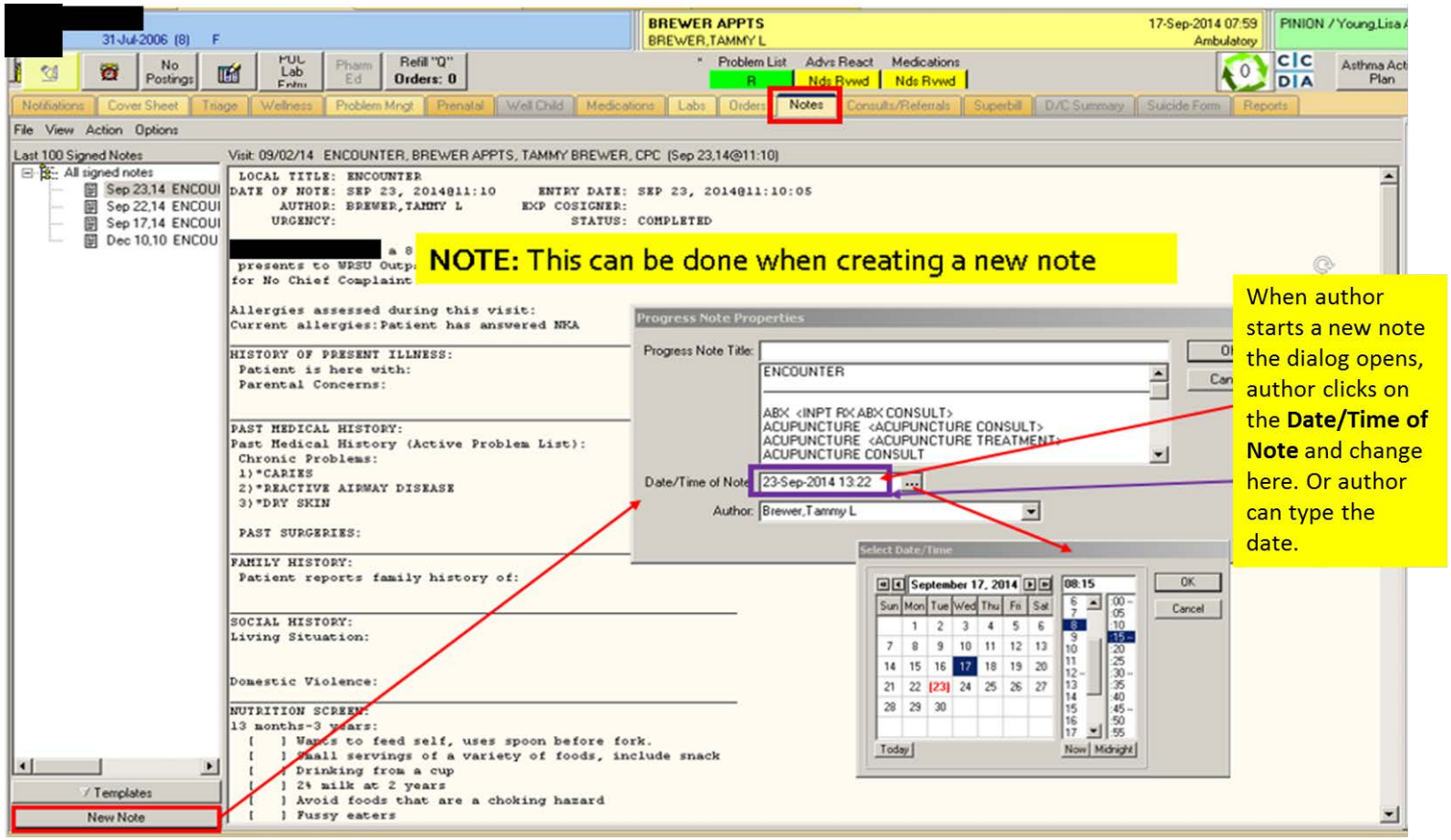
- Do ***Not*** copy and paste
- Some information belonging to the wrong patient follows the note crossover
  - Data object
    - Vitals
    - Personal History
    - Lab Results

Train the Providers

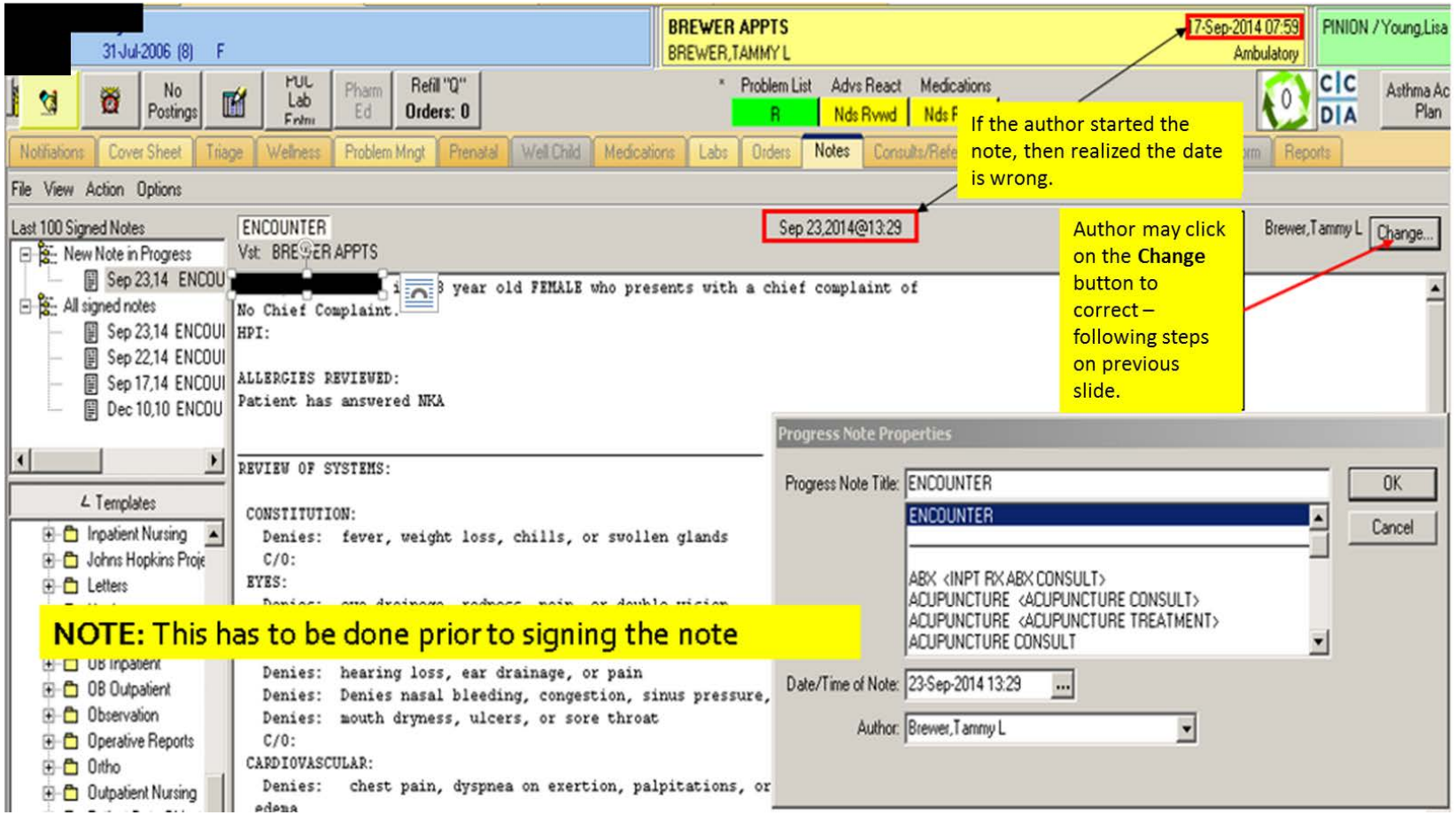
Emphasis to:

- Select the correct visit date
- Change the date prior to signing their note
- Begin all late notes with a comment of “Late entry…”
- Keep the notes reference date in chronological order

In Lieu of Reassigning a Note

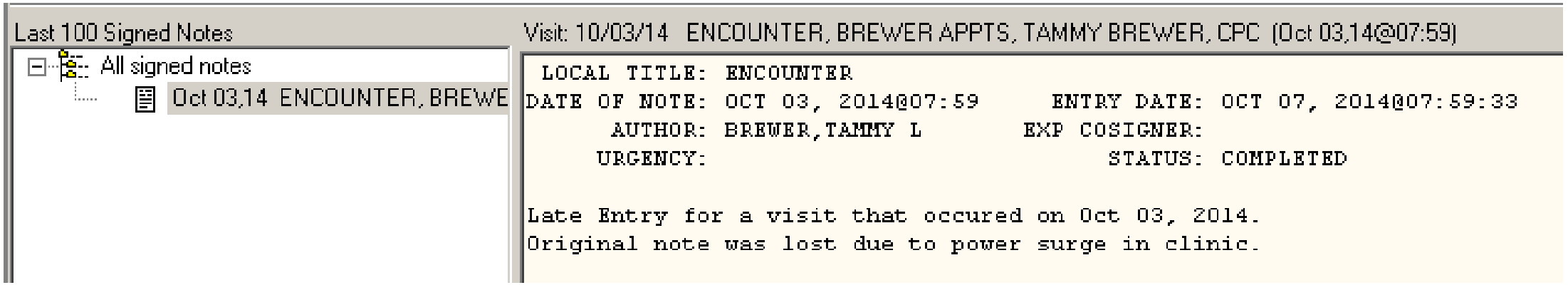


In Lieu of Reassigning a Note (cont.)



Late Entries

- According to local policies
- Should be done at the start of the note
- Noted with the actual date of the event
- Note the reason for the delayed entry



Correcting Note Titles/Changing the Note Title

Using the SSD option

- Select the status of the note title to change
- Select the type of document to change
- Search category will be the Note Title
- Enter the date range

Select the status

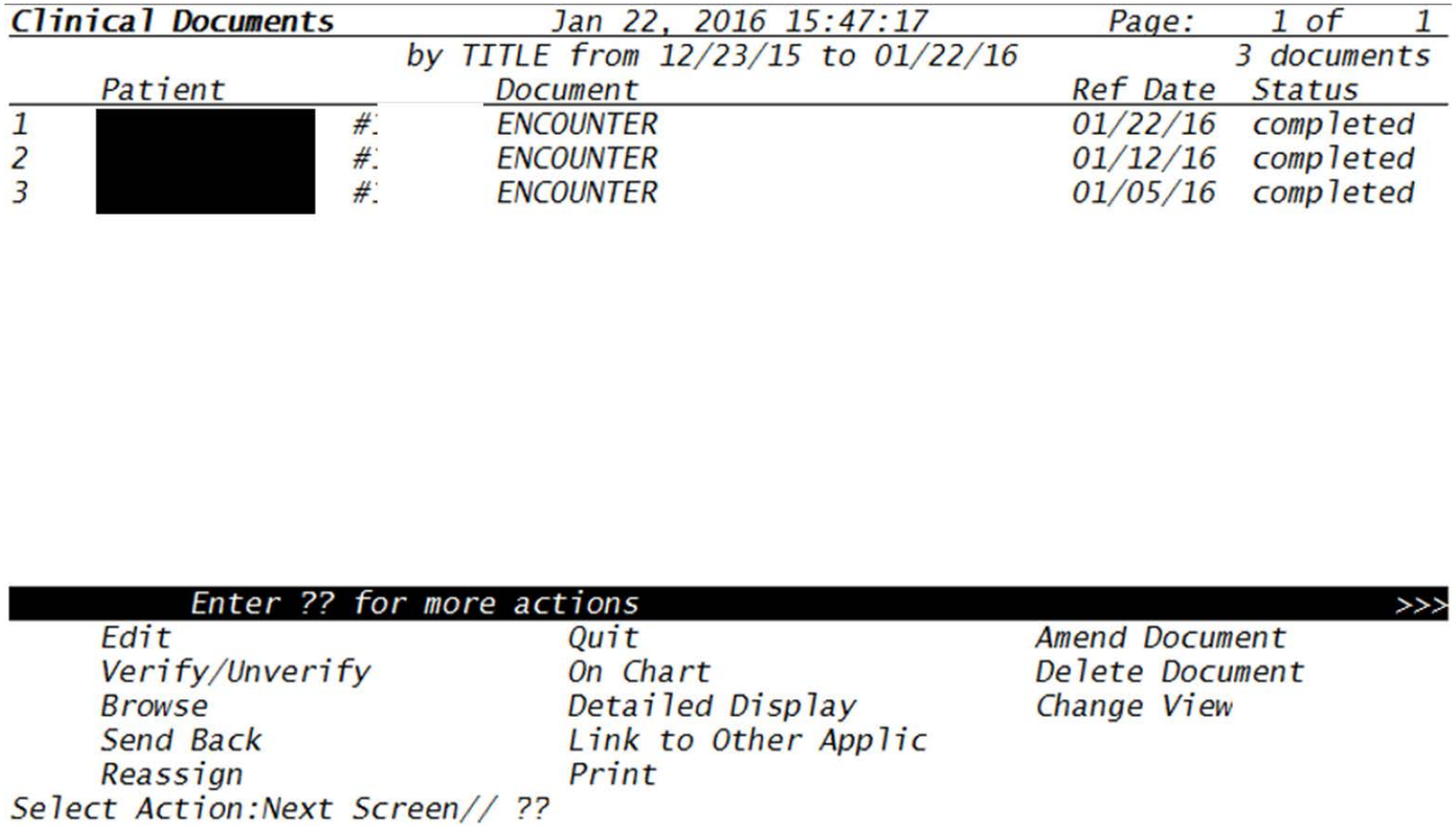
Status Options

```
Display items? Yes//        (Yes)

1  undictated                  5   unsigned            9      purged
2  untranscribed               6   uncosigned          10     deleted
3  unreleased                  7   completed           11     retracted
4  Unverified                  8   amended

Select Status: UNVERIFIED??
```

Note Titles


Clinical Documents
Jan 22, 2016 15:47:17
Page: 1 of 1
by TITLE from 12/23/15 to 01/22/16
3 documents
Patient
Document
Ref Date
Status
1 [redacted] #: ENCOUNTER 01/22/16 completed
2 [redacted] #: ENCOUNTER 01/12/16 completed
3 [redacted] #: ENCOUNTER 01/05/16 completed
Enter ?? for more actions >>>
Edit
Quit
Amend Document
Verify/Unverify
On Chart
Delete Document
Browse
Detailed Display
Change View
Send Back
Link to Other Applic
Reassign
Print
Select Action:Next Screen// ??

Document Status Options to Select

Amended: The document has been completed, and a privacy act issue has required its amendment.

Completed: The document has acquired all necessary signatures, and is legally authenticated.

Deleted: This status applies to documents which have been deleted per the Privacy Act, leaving the audit trail information intact, while deleting the body of the document, and its addenda.

Document Status Options to Select (cont.)

Purged: The grace period for purge has expired, and the report text has been removed from the on line record to recover disk space. ***NOTE: only completed documents may be purged.*** It is assumed that the chart copy of the document has been retained for archival purposes.

Retracted: The document has been signed, but may have been entered for the wrong patient. Reassignment to the correct patient has left the original document retracted in error.

Uncosigned: The document is complete, with the exception of cosignature (i.e., by the supervisor).

Undictated: The document is required, and a record has been created in anticipation of dictation and transcription, but the system has not yet been informed of its dictation.

Document Status Options to Select (more)

Unreleased: The document is in the process of being entered into the system, but has not yet been released by the originator (i.e., the person entering the text directly on line).

Unsigned: The document is on line, in a draft state, but the first-line (author's) signature has not yet been obtained.

Untranscribed: The document is required, and the system has been informed of its dictation, but the transcription has not yet been entered, or received by upload.

Unverified: The document has been released or uploaded, but an intervening verification step must be completed before the document may be displayed.

Hidden Menu Options

```
     Edit                          Quit                          Amend Document
     Verify/Unverify               On Chart                      Delete Document
     Browse                        Detailed Display              Change View
     Send Back                     Link to Other Applic
     Reassign                      Print

Enter selection by typing the name, or abbreviation.
Enter '??' or '???' for additional details.

The following actions are also available:
+    Next screen          >    Shift View to Right  CT   Change Title
-    Previous Screen      GO   Go to Page           CWAD CWAD Display

Press RETURN to continue or '^' to exit:

FS   First Screen         RD   Re Display Screen    EC   Edit Cosigner
LS   Last Screen          PL   Print List           EE   Expand/Collapse Entry
UP   Up a Line            QQ   Quick Quit           EX   Expand/Collapse Entry
DN   Down a Line          ADPL Auto Display(On/Off) F    Find
<    Shift View to Left   CP   Copy
```

Notes Status List

```
Clinical Documents          Jan 22, 2016 16:19:23          Page:    1 of    1
                        by TITLE from 12/23/15 to 01/22/16          3 documents
     Patient                          Document                Ref Date  Status
1    [redacted]          #.          ENCOUNTER               01/22/16  completed
2                        #.          ENCOUNTER               01/12/16  completed
3                        #.          ENCOUNTER               01/05/16  completed
```

```
          Enter ?? for more actions                                      >>>
     Edit                      Quit                      Amend Document
     Verify/Unverify           On Chart                  Delete Document
     Browse                    Detailed Display          Change View
     Send Back                 Link to Other Applic
     Reassign                  Print
Select Action:Next Screen// CT
```

Change Document Title

```
Change Document Title          Jan 22, 2016 16:22:45          Page:    1 of    6
                                    ENCOUNTER
[redacted]        #.                FEMALE  DOB: FEB 12, 2004 (11 YRS)

STANDARD TITLE: PRIMARY CARE NOTE
DATE OF NOTE: JAN 22, 2016@12:41     ENTRY DATE: JAN 22, 2016@12:42:06
      AUTHOR: BREWER,TAMMY L       EXP COSIGNER:

     URGENCY:                              STATUS: COMPLETED

 Visit: Jan 22, 2016@12:34  AMBULATORY-GEN     Dx: Headache |
------------------------------------------------------------------------------
This template was revised on 4/2/13 TLB

[redacted] is a 11 year old FEMALE who presents today for:

Chief Complaint: 1.) Patient complains of Moderate Head Ache for 2 Days. Has
taken motrin to relieve pain did not work. Took the last one an hour ago this
+         + Next Screen  - Prev Screen  ?? More actions
     Find                          Change Title
     Print                         Quit
Select Action: Next Screen// CT   CT
TITLE: ENCOUNTER// PUT THE NEW TITLE HERE
```

Records Management Principles

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Office of Information Technology, IHS

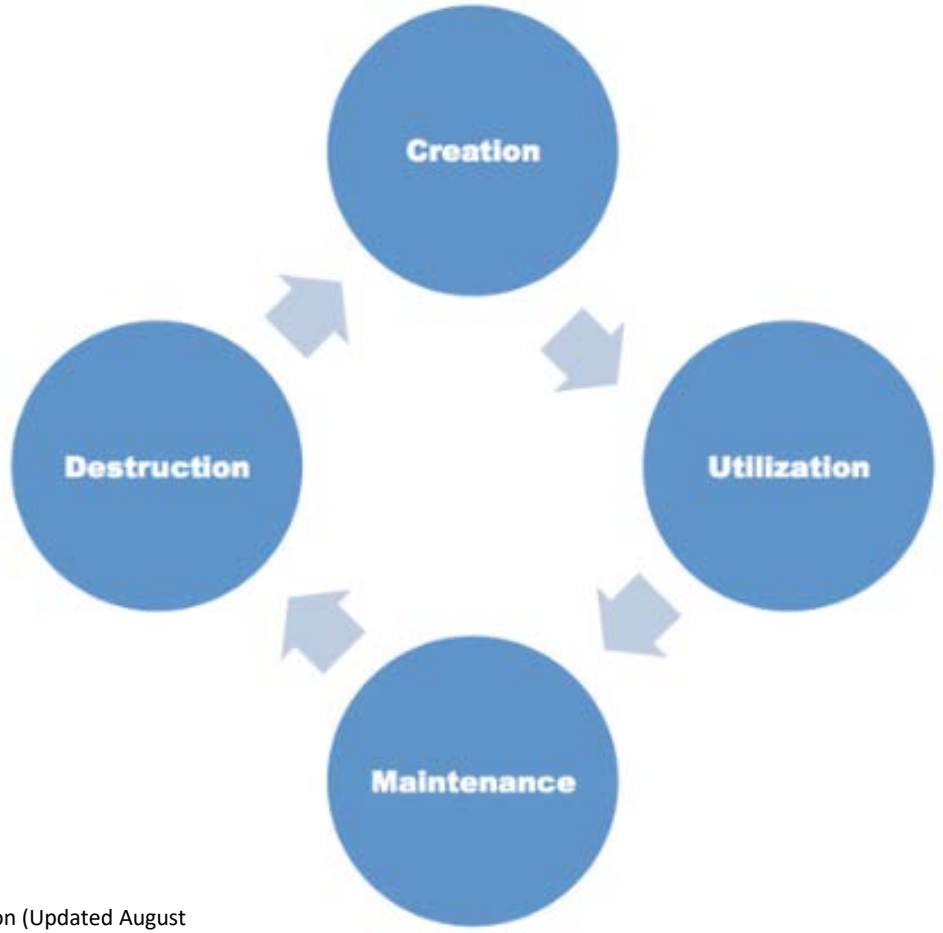
Retention and Destruction

- Organizations must know where all of their information is housed.
- HIM must work with Information Technology (IT) and other departments to identify where relevant information is stored such as back-up tapes *and MetaData*.

Purpose of Retention

- To ensure the availability of timely, relevant data and information for patient care purposes
- To meet federal, state, tribal and local legal requirements
- Organizations must establish appropriate retention and destruction schedules.

Life Cycle of Records Management



Source: AHIMA. "Retention and Destruction of Health Information (Updated August 2011).

Retrieval of Health Records

- Health Information resides in multiple storage media and locations and need to have a defined record retention plan.
- Lack of file space and volumes of information create labor-intensive maintenance processes for retrieval of health records.
- Historical health record maintenance processes include various methods such as scanning, use of microfilm or microfiche, and off-site storage of records.
- Many organizations do not have the capacity to go backward and scan records to free up storage space.

Record Retention Schedules must:

- Ensure information is available to meet the needs of continued patient care, legal requirements, research, education, and other legitimate uses of the organization
- Include guidelines that specify what information is kept, the time period for which it is kept, and the storage medium on which it will be maintained (e.g., paper, microfilm, optical disk, magnetic tape)
- Include clear destruction policies and procedures that include appropriate methods of destruction for each medium on which information is maintained

Creating a Compliant Retention Program

- Federal record retention requirements found within the *Federal Register*, and numerous acts such as the Higher Education Act of 1965 disclosure requirements (20 USC §1232g).
- States have specific retention requirements that should be used to establish the organization's retention policy.
- In the absence of state requirements, health information should be keep for at least the period specified by the state's statute of limitations or for a sufficient length of time for compliance with laws and regulations.

State Record Retention Requirements

- Patient that are minors, should retain health information until the patient reaches the age of majority (as defined by state law) plus the period of the statute of limitations.
- In addition, under the False Claims Act (31 USC 3729), claims may be brought up to seven years after the incident; however, on occasion, the time has been extended to 10 years.
- Organizations and providers should compare state retention requirements and statute of limitations with legal counsel when developing a record retention schedule.

Accrediting Agency
Record Retention Requirements

- Agencies such as the Accreditation Association of Ambulatory Health Care, Commission on Accreditation of Rehabilitation Facilities, Medicare Conditions of Participation, and the Joint Commission have incorporated record retention schedules into their accreditation survey processes.

Accreditation Agencies' Retention Standards

Accreditation Agency	Retention Standard	Reference
Accreditation Association for Ambulatory Health Care (AAAHC)	Requires organizations to have policies that address retention of active clinical records, the retirement of inactive clinical records, and the retention of diagnostic images.	*2010 Accreditation Handbook for Ambulatory Care*
CARF...the Rehabilitation Accreditation Commission	Requires organizations to have policies that address record retention. Retention periods are not specified for behavioral health. However, policy must comply with applicable state, federal, or provincial laws. Retention periods are not specified for employment and community services. Requires organizations to have policies that address retention of records and electronic records. Requires organizations to have policies that address retention of records and electronic records.	*2010 Adult Day Services Standards Manual* *2010 Behavioral Health Standards Manual* *2010 Assisted Living Standards Manual* *2010 Medical Rehabilitation Standards Manual*
National Committee For Quality Assurance (NCQA)	Retention periods are not specified.	

Other Agency Retention Guidelines

- Source: AHIMA Briefing

Community Health Accreditation Program (CHAP)	C25C - Elements 1 & 2: Records of adult patients must be retained for at least five years from the date of service and patient records for minors must be retained for seven years beyond the age of majority. C27C - Element 5: The records of occupationally exposed patients must be kept for 30 years.	*CHAP Core Standards of Excellence*
The Joint Commission	RC.01.05.01- The hospital retains its medical records. The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation.	*2010 Comprehensive Accreditation Manual for Ambulatory Care*
	- RC.01.05.01- The hospital retains its medical records. The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation.	*2010 Comprehensive Accreditation Manual for Behavioral Care*
	Data and information are retained for sufficient periods to comply with law and regulations and support member care, network management, legal documentation, research, and education.	*2010 Comprehensive Accreditation Manual for Health Care Networks*
	RC.01.01.01 The organization maintains complete and accurate medical records for each individual patient-	*2010 Comprehensive Accreditation Manual For Home Care*
	RC.01.05.01- The hospital retains its medical records. The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. -	*2010 Comprehensive Accreditation Manual For Hospitals*
	- RC.01.05.01- The organization retains its medical records. The retention time of medical record information is determined by law and regulation and by its use for resident care, legal, research or educational purposes. Intent of RC.01.05.01 Medical records are retained for the period of time required by state law, or five years from the discharge date when there is no requirement in state law. For a minor, the medical record is retained for the time period defined by state law or at least three years after a resident reaches legal age as defined by state law.	*2010 Comprehensive Accreditation Manual for Long Term Care*

Additional Considerations

- Special patient populations may have further regulations to consider in developing a records retention schedule:
  - Minors
  - Behavioral health
  - Research patients may be governed by other regulations.
- Paper, Hybrid, and/or electronic records

Indian Health Service (IHS)
Record Retention Requirements

- IHS retains the patient health record for 75 years after last episode of care
- Media Neutral – inclusive of electronic and paper record
- Ship to the Federal Records Center after 3 years of activity

Record Retention Considerations

Requirements	IHS	Tribal Organization	Urban Organization
Federal 42 CFR (Alcohol/Substance Abuse), Behavioral Health, HIPAA, etc.)	**X**	**X**	**X**
State Laws/Requirements *	X	X	X
CMS/Payer Requirements (if billing Medicare, Medicaid, other)	**X**	**X**	**X**
Accreditation Requirements (if accredited)	**X**	**X**	**X**
Indian Health Service	**X**	**638 Contract or Compact**	**Contract or Agreement**
Organizational Needs (legal holds, population health, etc.)	**X**	**X**	**X**

Determining More Restrictive Requirement

Federal Requirement	State Requirement	Accreditation Requirement	AHIMA Recommendation
Hospitals: five years. Conditions of Participation 42 CFR 482.24 (b)(1)	Healthcare facilities must retain medical records for a minimum of five years beyond the date the patient was last seen or a minimum of three years beyond the date of the patient's death. Oklahoma Dept. of Health Reg. Ch. 13, Section 13.13A	Joint Commission RC.01.05.01: The hospital retains its medical records. The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation.	Patient health and medical records (adults): 10 years after the most recent encounter.

Source: AHIMA Briefing

Active and Inactive Records

- After the retention schedule is developed, organizations need to identify active and inactive records:
  - "Active" means that the records are consulted or used on a routine basis. Routine functions may include activities such as release of information requests, revenue integrity audits, or quality reviews.
  - "Inactive" means that the records are used rarely but must be retained for reference or to meet the full retention requirement. Inactive records typically are based on the when the patient last sought treatment..
- Often active vs. inactive is depend on file space

Retention Guidelines

- Each organization should determine a cutoff point (often a discharge date) that signals the time at which a record becomes inactive. In determining the appropriate cutoff, consider the following:
- How often are the records accessed (e.g., daily, weekly, monthly)?
- What is the total retention requirement?
- What is the size of the record (a large long-stay record or a short emergency record)?
- What are the physical constraints (e.g., lack of file space, lack of off-site storage)?
- What activities or functions require routine access to the record (e.g., quality reviews, release of information)?
- Identifying and maintaining active and inactive records is an important step in the successful maintenance of a filing system. Once the organization defines active and inactive records, the purge process can begin

Purging Records

- Purging is the process of separating active from inactive records in a filing system or database according to the retention schedule.
- Identify the records to be purged, update patient registration to inactivate the record.
- Systematically file inactive records in storage box with appropriate labels for easy retrieval (based on off-site storage requirements)
- Transfer records to off-site storage

Record Destruction

- Patient health information destruction is done in accordance with applicable federal and state law.
- An approved retention schedule and destruction policy approved by appropriate organizational parties.
- Records involved in any open investigation, audit, or litigation must not be destroyed until the litigation case has been closed.
- In the absence of any applicable state law, organizations must ensure paper and electronic records are destroyed with a method that provides for no possibility of reconstruction of information.

Examples of Destruction Methods

- Paper record methods of destruction include burning, shredding, pulping, and pulverizing.
- Microfilm or microfiche methods of destruction include recycling and pulverizing.
- Laser discs used in write once-read many document-imaging applications are destroyed by pulverizing.
- Computerized data are destroyed by magnetic degaussing.
- DVDs are destroyed by shredding or cutting.
- Magnetic tapes are destroyed by demagnetizing.

Documenting Destruction of Records

- Organizations must maintain documentation of the destruction of health records permanently and include the following Date of destruction
- Method of destruction
- Description of the disposed records
- Inclusive dates
- A statement that the records were destroyed in the normal course of business
- The signatures of the individuals supervising and witnessing the destruction

Use of Outside Destruction Services

- Under the HIPAA privacy rule (45 CFR, Parts 160 and 164), when destruction services are outsourced to a business associate the contract must provide that the business associate will establish the permitted and required uses and disclosures and include the following elements:

  - The method of destruction or disposal
  - The time that will elapse between acquisition and destruction or disposal
  - Safeguards against breaches
  - Indemnification for the organization or provide for loss due to unauthorized disclosure

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Questions

- Thank you

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Resources

- AHIMA e-HIM practice brief “The Legal Process and Electronic Health Records.” Journal of AHIMA, 76, no. 9 (2005)
- AHIMA e-HIM practice brief “Update: Maintaining a Legally Sound Health Record-Paper and Electronic.” Journal of AHIMA 76, no. 10 (2005).
- AHIMA HIM Body of Knowledge, “The New Electronic Discovery Civil Rule.”
- IHS Records Disposition Schedule http://www.ihs.gov/FacilitiesServices/AreaOffices/Albuquerque/ResourceManagement/rmintro.cfm
- The Sedona Conference http://www.thesedonaconference.org/
- The National Archives http://www.archives.gov/records-mgmt/

Source of most information on Record Management within PowerPoint

“Retention and Destruction of Health Information”

AHIMA Practice Brief, Revised August 2011

The practice brief provides guidance on record retention standards and destruction of health information for all healthcare settings.

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