THE LEGAL HEALTH RECORD IN AN ELECTRONIC AND MANUAL

Presented by: Rhonda L. Anderson, RHIA
President, Anderson Health Information Systems, Inc.
940 West. 17th Suite B
Santa Ana, California 92706
office:714-558-3887 or Rhonda@ahis.net

Objectives

- The Participants will identify:
- Key items in preparing for a legal health record
- Replication of the record that reflects the record was developed in the regular course of business "in a change from manual to electronic; electronic to changes in electronic systems and regulations
- Legal issues in the 'manual' and Electronic Health Record
  - **HEAR SOME POTENTIAL SOLUTIONS AND PARADIGM CHANGES'—FOR EVALUATION!!**

LEGAL HEALTH RECORD AND RELATED POLICIES/PROCEDURES AND ACTIVITIES

- The facility will Create and maintain health records that in addition to their primary intended purpose of clinical and resident care use will:
  - Serve the business and legal needs **that will not be compromised.**
  - Identify the medical record of the facility (both manual and electronic and the date of effective electronic health record E HR).
  - Include the identified manual transition to E HR in the individual health record – know the dates of transition of a document
  - Include if transitioned to more than one E.H.R system
  - Maintain both the manual and E HR if have not transitioned to total E HR

LEGAL HEALTH RECORD AND RELATED POLICIES/PROCEDURES AND ACTIVITIES-2

- IN SUMMARY THE LEGAL HEALTH RECORD –
  - Contains protected health information >in any Medium> collected and directly used for the purpose of documenting health care or health care status.
  - **Generated at or for a healthcare organization as its business record and is the record that would be released upon request".**

LEGAL HEALTH RECORD – PHYSICIAN – off-site E HR system

- Have any of the physicians indicated they have an **E HR** that will include their H & P and Progress Notes where you can go into their file and get the information with your own sign on?
- Questions to ask the physician:
  - Can anyone else see our information?
  - Who and how do you keep track of the Security of the information?
  - Is it set up for each facility to have their own 'domain for their facility'?

LEGAL HEALTH RECORD – PHYSICIAN – off site E HR system-2

- E-sign – Who actually does the e-sign?
  - Is it the physician?
  - PA/NP for their own, etc. or other processes?)
- Are there policies and procedures?
- ASK FOR COPY OF THEIR POLICIES AND PROCEDURES – MAY INCLUDE AS PART OF CREDENTIALING UPDATE
- In other words – what are the privacy and security rules around the system??

LEGAL HEALTH RECORD – WHO IS RESPONSIBLE??

- **WHO OVERSEES THE E HR**?
  - Should be the same as the Manual Record, except you have "Information Technology professionals" to assist.
  - **HIM Professional (RHIA or RHIT) will have access to or have the latest guidance on E HR to provide the facility. (USE THEIR EXPERTISE!!)**
  - Designated Clinical Staff and support staff within the organization oversee the operations functions related to collecting, protecting and archiving the legal health record
  - Information Technology staff manages the technical structure of the E HR

HIPAA

- The designated record set is defined by the organization
  - **>> manual or electronic via HIPAA**
- Did you update the designated record set identification as you added new documentation?
  - Maybe a new assessment
  - **pictures used and integrated into the E HR (utilizing only a facility camera)!**
  - Recordings from IDT Conferences with resident/representative – HOW DO YOU INCORPORATE INTO THE e hr? Are these available later as part of the designated record set? Intent of recorders?

COLLECTING, PROTECTING AND ARCHIVING THE LEGAL HEALTH RECORD

- **Manual Record** – locked doors vs. storerooms vs. lack of labeling for retention?? Have you ever seen this??
  - **VS**
- **E HR -** It is all in one place? Yes, Maybe or you may have a 'hybrid record'
  - Different dates of implementation of different documentation (as mentioned above)
  - Have you changed systems for electronic record keeping?
    - Do you have access to prior records?
    - How are they retrieved?
  - Is a Master Patient Index stated in a previous system still available to you?

E HR AND DERIVED DATA

- **Not considered part of the legal record but comes from the legal record**
  - Reports from the Minimum Data Set
  - 672, 802 – used for the last date Facility Assessment – required by the new CMS guidance – does it match your last report related to those dates?
  - KEY - are the reports generated from the latest information? Did you update or change the information after that report that is the "official report"

ADMINISTRATIVE DATA

- **Not considered part of the legal record**
  - Authorization Forms
  - Correspondence
  - Protocol and care guidelines
  - Resident identifiable information – reviewed for Quality Assessment and Assurance or Quality Assurance Performance Improvement – Performance Improvement Projects.

AMENDMENTS, ADDENDUMS, CORRECTIONS

- DOCUMENTATION made in the E HR will be in chronological order or systematically referenced and included with the original document both online and in printed format?
- What does this mean when the record is copied for others?
- What about the metadata??? The data behind the E HR scene is still data and can be accessed in certain situations.
- What happens with Amendments to the "format" of a document, amendments to the documentation by the clinical staff, late entries

AMENDMENTS, ADDENDUMS, CORRECTIONS – 2

- **AMENDMENT due to regulatory change**.
- Where and how will you identify
  - User defined assessments or other terminology or system changes / updates
- Needs to be clear in the E HR process….manual and or electronic made part of the medical record
- Is a single record MANUAL and E HR (Hybrid) or MANUAL with ONE OR TWO DOCUMENTS E HR or entirely E HR
  - Is it important?
  - Why

ADDENDUMS, AMENDMENTS, CORRECTIONS – 3

- **AMENDMENT Recommendations**
  - Modified Nursing Assessment i.e., Chemical and Physical Restraint items – Alarms, etc. added to forms , or fall and skin risk added to Nursing Assessment and discontinued as a separate assessment
    - Add the date to the title or another method to the new form i.e. "INITIAL NURSING ASSESSMENT – version 9-21-17 or Version #3 with revised date in the footer or???
    - Must identify there is a change within the same record telling the "STORY ABOUT THE RESIDENT";
    - Regulatory documentation requirements may change and HOW WILL WE KNOW? How will the resident/representative know? HOW WILL REVIEW AGENCIES KNOW?
- ***>>SOME SYSTEMS MAY IDENTIFY THE DATES OF CHANGE OTHERS MAY NOT…DO YOU KNOW HOW YOUR SYSTEM ASSISTS YOU IN THE defined "legal health record" staying current?***

ADDENDUMS, AMENDMENTS, CORRECTIONS – 3

- CORRECTIONS OR LATE ENTRY: What happens when medication and treatments are not signed off ("red text" or other mechanism – will identify "documentation due or late")
- Addendum Automatically locks and registers the entry date, time and the electronic signature of the user; it does not modify the original entry;
- WHAT ABOUT THE **METADATA? Did you know all the changes are there??? Is there a pattern of late entries? Do the med sheets show that "pour, pass and chart" is the rule?**

A "PARADIGM SHIFT" - "AUDIT" or STAFF MANAGEMENT?

- How are you managing your records and data with…
- What we know as "old audit process"?
- What we know as QAPI Monitoring and "systems review"?
- How do you view this in your environment with the "Legal Health Record" with increased emphasis on "resident/representative access"

HAVE YOU MONITORED AND TRENDED THE ISSUES WITH THE 'E HR"?????

- Have you identified the issues?
- Have you looked at the legal issues?
- Have you shared with the Staff?
- Staff making entries will have their signature/sign on attached to the entry?
- Late entries are evident in the record and in the metadata; still require the same late entry requirement; and if system does not allow 'late entry' for certain areas…then another method has to be determined….how will your system accommodate?

DAILY MANAGEMENT SYSTEM FOR MONITORING THE E HR

- Tomorrow monitoring is "too late"???
- Do staff know the 'consequences'??
- Does staff know the 'legalities'??
- The METADATA??? What if requested in a legal case…???

DOCUMENTATION BY REGISTRY STAFF

- What system is in place to
  - Grant Access to Registry Staff
  - Is it unique to each user or do you have one sign-on used by all registry
  - Can you identify in the record the individual registry nurse who signed the record?
  - How will you do that for a record from several years ago?
  - Are you maintaining permanent logs of registry staff
  - How is that tied to your E HR
- ALL are important Medico-Legal documentation issues

E HR and QAPI!!

- Do you have a QAPI established to monitor the accuracy of the medical record and your E HR?
- Have you revisited the E HR requirements?
- Do staff understand the "meta data" and the risks of late documentation…and how that is more easily tracked in an E HR?? License risks??

ADDENDUMS, AMENDMENTS, CORRECTIONS – Lets digress a little to Manual Record

- How are Addendums, Amendments, Corrections completed and identified in the Manual Record
- Do you identify "late entry" for all the documentation that is updated when correcting audit deficiencies?
  - What about AUDITS?
    - What systems manually do you have in place to protect you from corrections that are not identifiable as to who, when, date, time, correction, omission, etc?
    - Are you just auditing and correcting the documentation?
    - Have you considered the legal risks?

STAFF MANAGEMENT PROCESS

- What staff management process do you have in place with the MANUAL RECORD…
  - To avoid audit deficiencies
  - Is your legal health record compromised now?
  - Have you considered what will happen with the E HR?

SOME SCENARIOS TO CONSIDER…

- The medical record is **available to the resident**; they ask for a copy and later asks for another copy
  - Will the two copies sent ever be different? Manual or E HR?
- The medical record is available to Attorneys? Department of Public Health, L & C.
- Any possibility of E HR or manual copies not matching prior copies???

Are you ready to sail?