Legal EHR Policy Template
Developed by Members of the EHR Practice Council
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How to Use This Tool

Health care providers must maintain a health record that documents care and services provided to an individual. In addition to their clinical purposes, health records must also be maintained for business and evidentiary purposes. Many electronic health record (EHR) systems have limitations that may affect their use for such purposes. Regardless of whether the media used to create and store health records is electronic, paper or other, AHIMA advocates that organizations define one set of health information that meets the legal, business and compliance needs of the organization.

Because 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, and legal standards. These standards may vary based on care setting, legal jurisdiction and locale. Therefore, 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.

This tool is intended as a guide only to assist health care organizations in creating an organizational policy that defines the legal health record for business and disclosure purposes. It provides considerations and questions that should be addressed as your policy is developed. If you are a specialty institution or maintain specialty records such as behavioral health, additional considerations may impact your legal health record policy that have not been addressed in this outline. The organization should consider the formation of a multi-disciplinary team comprised of HIM, Risk Management, Legal Services, Information Technology, clinicians, leadership and other organizational units to fully develop its policy.

This tool is not intended to be legal advice and should not replace the need or importance of consulting with your own legal counsel in developing your organization's policy. Additionally, there are a number of related policies and procedures that may be referenced in your policy, but are not likely to be included in your policy on the Legal Health Record for Business and Disclosure Purposes. Examples of additional policies that may need to be developed are listed below:

- 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

In this tool, information in bold italics in this document is used to indicate the considerations for the organization as the policy is being developed. Non-bolded italics are placeholders for the organization's name or other unique information.

This template was developed by:

Kathleen Addison
Barbara Demster
Terri Hall
Beth Liette
Keith Olenik
Mary Ellen Mahoney
Ann Tegan
Victoria Weaver
Lydia Washington
Lou Ann Wiedemann

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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PURPOSE: The purpose of this policy is to identify the health record of [*Organization Name's*] for business and legal purposes during and after the transition to electronic health records and to ensure that the integrity of health records is maintained during and after this period so that it can support business and legal needs.

SCOPE: This policy applies to all uses and disclosures of the health record for administrative, business or evidentiary purposes. It encompasses records that may be kept in a variety of media including, but not limited to, electronic, paper, digital images, video and audio. It excludes those health records not normally made and kept in the regular course of the business of *[Organization's name]* ***The determining factor in whether something is to be considered part of the LHR is not where the information resides, or the format of the information, but rather how the information is used and whether it is reasonable to expect the information to be routinely released when a request for a complete health record is received. The LHR excludes health records that are not official business records of a healthcare provider organization. It is highly advisable that organizations seek legal counsel when deciding what constitutes the organization's legal health record.]***

POLICY: It is the policy of [*Organization's Name*] to create and maintain health records that, in addition to their primary intended purpose of clinical and patient care use, will also serve the business and legal needs of [*Organization's Name*].

During its transition to electronic health records, [Organization] will document what information comprises the health record for business and legal purposes, the various sources and location of the information and the media in which the information is maintained. This document will be used to identify what information will be disclosed upon receipt of an authorized request for health records.

It is the policy of [Organization] to maintain health records such that their integrity will not be compromised and they will support the business and legal needs of *[organization's name]*.

PROCEDURE:

Accurate Patient Identification

Responsible:	Actions:
Health Information Management	It is the responsibility of *[the Health Records Manager or other designated position]*, to: o working in conjunction with Information Services, Legal Services and others [name other stakeholders], create and maintain a matrix or other document that tracks the source, location and media of each component of the health records *[Here, reference an addendum or other source where this* the health record *information is found]* o identify any informational content that may be used in decision-making and care of the patient that may be external to the organization (outside records and reports, PHR's, email, etc.) that is not included as part of the legal record because it was not made or kept in the regular course of business o develop, coordinate and administer a plan that manages all information content, regardless of location or form, that comprises the legal health record of *[Organization*] o develop, coordinate and administer the process of disclosure of health information. o devise and administer a health records retention schedule that complies with applicable regulatory and business needs. o *[List other responsibilities of health records manager, here.]*
Information Services and Technology:	It is the responsibility of Information Services *[or other appropriate department(s)]* to o ensure appropriate access to information systems containing components of the health record. o execute the archiving and retention schedule pursuant to the established retention schedule o *[List other responsibilities of Information Services , here.]*
Other:	*[List applicable responsibilities for other individuals or departments, here.]*

Record Integrity [*Each organization will need to consider the following issues for maintaining the integrity of the legal health record and address procedurally. These issues can be addressed as part of this policy or in separate policies*]

Process:	Actions:
Health Information Exchange; Electronic Sharing With Other Entities; Records and Information Received From Other Facilities:	***[Healthcare organizations should develop policies and procedures addressing acceptance and retention of documents, images, waveforms, and other information received from external facilities whether the information is received electronically or in paper. Generally a physician should determine the efficacy of the information received from an external facility. This decision-making should include both the content and the clarity of the information once transferred to the receiving organizations EHR. If acceptance is not possible, the policy should further address the retention/destruction of non-compatible medium.]***
Record Completion (lock down):	***[Organizations that have several source systems, systems that do not automatically record date and time of entries, and systems that allow editing documents without tracking changes, should consider locking down documents at some determined time after the patient encounter. This will assist with ensuring a health record that is accurate and can meet spoliation expectations.*** ***The same multidisciplinary group that was identified earlier should also be included in discussions to determine when electronic documentation will be considered complete. There are subtle differences between how we determine if documentation is complete in an electronic record versus a paper chart. First of all organizations need to determine when a user can no longer create or make changes to electronic documentation. In the paper world we picked up the chart and could control who would add or change anything.*** ***One of the benefits of electronic health records is the ability for users to access the information from anywhere that access is allowed. This means the application must control when an individual can perform documentation functions. The organization must determine how long the documentation function will be available. There may be limitations with how the EHR handles this function and the organization will need to factor this into their policy.]***
Amendments and Corrections:	***[Procedures should address how amendments and corrections should be made to the EHR. If possible, the system should clearly identify amendments including date, time, and author.***

	Corrections to the EHR should indicate the date and time and should be visible to anyone with access. Identification and tracking of corrections should not be limited to a background/back end program only visible to IT staff. Amendments and corrections should be in chronological order and be included in with the original document both on-line and in printed format. ***A special type of correction is the retraction. This occurs when it has been identified that the entire patient record or a significant portion thereof has been mis-identified or erroneously entered into another patient's health record and must be corrected. Clear procedures to retract, correct and track this type of correction must be established.]***
Authentication:	***[The person entering the data should authenticate individual health record entries. Electronic entry should automatically record the person documenting the care with their full name, credentials, date, and time. Consideration should also be given to situations where multiple individuals are responsible for creating the documentation. An admission assessment for example may contain sections requiring input from a variety of caregivers. The organization's policy should address how this is accomplished in coordination with the functionality within the electronic health record application. There may also be times when an individual forgets to enter some documentation at the time of care delivery and another individual will make the entries on their behalf. Policy must indicate when this is appropriate and how it will be handled based on functionality within the EHR. To ensure adherence to State Regulatory requirements an organization should also review state specific guidelines on authenticating orders.*** ***Documents prepared outside the EHR, e.g., transcribed documents and scanned images should have a process to assign an electronic signature that is automatically dated and timed. This type of authentication should clearly state 'electronically signed' to differentiate the source of the document. The authentication of each health record entry should be visible to anyone with access. Authentication, date, and time stamps should not be limited to a background/back end program only visible to IT staff. Authentications should be readable when EHR documents are printed.*** ***Co-signatures should also be defined both from a policy standpoint (what positions need co-signature) and a procedure standpoint. How and where co-signatures are accomplished should be***

	documented as well, e.g., should the co-signature occur in the designated EHR, in the source system, or in the scanning system? The method used to perform the co-signature in the EHR should be evaluated to determine whether or not the documentation will still be considered legal if two people need to authenticate the same documentation. If digital signatures are used in the EHR you will not be able to perform the co-signature function as the second signature will invalidate the first signature along with the documentation. The organization may need to consider implementing the process and function of allowing the first author to indicate that they have reviewed the documentation and the second person actually authenticates the information. If the EHR is not using digital signature for authentication the process of co-signing done on paper can be imitated in the EHR. ***Timing of co-signatures should be addressed in policy as well. Some states regulate the timing of co-signatures on verbal orders. The Physician At Teaching Hospitals (PATH) guidelines are clear about timing. "The teaching physician must review with each resident during or immediately after each visit the beneficiary's medical history, physical exam, diagnosis, and record of tests and therapies." (AMA & CMS: "Documentation Guidelines for Evaluation and Management Services"). From a legal perspective, co- signatures should not be done once per shift while supervising students as it appears that oversight might not be managed in a timely manner.]***
Versioning:	***[The organization must address management of document versions. This will relate primarily to transcribed reports that are made available for viewing prior to authentication or review by the author. Organizations must decide whether all versions of a document will be displayed or just the final; who has access to the various versions of a document; and how the availability of versions will be flagged in the electronic health record. Once again a multidisciplinary group of at least physicians, risk management, health information management, and information technology representatives should be included in this discussion.*** ***There are significant legal implications if information was either initially distributed or just made available in the EHR that is later changed or updated and now the original report or information is unavailable. It is acceptable for a draft of a dictated and transcribed note or report to be changed before authentication unless there is a reason to believe the changes are suspect and would not reflect actual events or actions. Organization policy should define the acceptable period of time allowed for a document to remain in draft form before the author reviews and***

	approves it (e.g., 24 to 72 hours). Once a document is no longer considered a draft or has been authenticated, any changes or alterations should be made following the procedures for a correction, late entry or amendment. The original document must be maintained along with the new revised document.]

Metadata:	***[Organizations need to be aware of the metadata being stored in their electronic health record systems. Metadata will not be routinely disclosed as a part of the legal health record, but this information could be requested for legal purposes as part of electronic discovery. The organization should be aware of this information and determine how long this information needs to be kept. Data retention policies should definitely include this type of information.]***
Clinical Decision Support:	***[There aren't any generally accepted rules yet about whether or not decision support, including system-generated notifications, prompts, and alerts should be part of the legal record. It will be up to the organization with input once again from physicians, legal counsel, risk management, and administration. At a minimum the electronic health record should include documentation of the clinician's actions in response to decision support. This documentation is evidence of the clinician's decision to follow or disregard decision support. The organization should define the extent of exception documentation required (e.g., what does no documentation mean).]***

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. Because this information created, received and maintained as evidence and information by an organization or person, in pursuance of legal obligation or in the transaction of business, it must consistently delivery a full and accurate record with no gaps or additions.[i]

Data – basic facts about people, processes, measurements, and conditions represented in dates, numerical statistics, images and symbols. An unprocessed collection or representation of raw facts, concepts, or instructions in a manner suitable for communication, interpretation or processing by humans or automatic means.[iii]

Data element – a combination of one or more data entities that forms a unit or piece of information, such as patient identifier, a diagnosis or treatment.[iii]

Electronic health record – medical information compiled in a data gathering format for retention and transferal of protected information via secured, encrypted communication line. The information can be readily stored onto an acceptable storage medium such as compact disk.[iii]

Evidence – information that a fact finder may use to decide an issue. Information that makes a fact or issue before court or other hearing more or less probable.[iii]

Legal Health Record:

- 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. It does not affect the discoverability of other information held by the organization. The custodian of the legal health record is the health information manager in collaboration with information technology personnel. HIM professionals oversee the operational functions related to collecting, protecting, and archiving the legal health record, while information technology staff manage the technical infrastructure of the electronic health record.[iii]
- The legal health record is a formally defined legal business record for a healthcare organization. It includes documentation of healthcare services provided to an individual in any aspect of healthcare delivery by a healthcare provider organization.[ii iii] The health record is individually identifiable data in any medium, collected and directly used in documenting healthcare or health status. The term also includes records of care in any health-related setting used by healthcare professionals while providing patient care services, reviewing patient data, or documenting observations, actions, or instructions.[iv]

Metadata - descriptive data that characterize other data to create a clearer understanding of their meaning and to achieve greater reliability and quality of information. Metadata consists of both indexing terms and attributes [v]

Original document – an authentic writing as opposed to a copy.[iii]

Personal health records – (PHR) is an electronic, universally available, lifelong resource of health information needed by individuals to make health decisions. Individuals own and manage the information in the PHR, which comes form healthcare providers and the individual. The PHR is maintained in a secure private environment, with the individual determining rights of access. The PHR is separate form and does not replace the legal health record of any provider.[vi]

Regular course of business – doing business in accordance with your normal practice and custom, as opposed to doing it differently because you may be or are being sued.[iii]

Source systems – where the data was originally created.

- ***Primary Source System*** *– an information system that is part of the overall clinical information system in which documentation is most commonly first entered or generated.*
- ***Source of Legal Health Record*** *- the permanent storage system where the documentation for the legal health record is held.*

[Define other key terms included in the policy]

References and Resources:

Relevant State & Federal Laws & Regulations References

- Applied Discovery
  http://www.lexisnexis.com/applieddiscovery/lawLibrary/default.asp

- California Civil Discovery Law.
  http://californiadiscovery.find law.com/index.htm.

- Discovery Resources
  http://www.discoveryresources.org/

- Federal Judiciary. "Summary of the Report of the Judicial Conference Committee on Rules of Practice and Procedure."
  www.uscourts.gov/rules/ Reports/ST09-2005.pdf#page=177.

- Federal Rules of Civil Procedure addressing discovery of electronically stored information. Effective Dec. 1, 2006.
  http://judiciary.house.gov/media/pdfs/printers/109th/31308.pdf

- Findlaw
  http://findlaw.com

- National Conference of State Legislatures
  http://www.ncsl.org

- "Thomas"—federal bill tracking
  http://thomas.loc.gov

- US Courts
  www.uscourts.gov/rules

Accreditation Standards

- The Joint Commission
  http://www.jointcommission.org/Standards/

Practice Standards

a. AHIMA Resolution on the Legal Health Record

Submitted by AHIMA's Electronic Health Record Practice Council & passed by the AHIMA House of Delegates in 2006.
http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_032187.hcsp

b. AHIMA Practice Briefs

AHIMA e-HIM Work Group on the Legal Health Record. "Update: Guidelines for Defining the Legal Health Record for Disclosure Purposes." *Journal of AHIMA* 76, no. 8 (September 2005): 64A–G.
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_027921.hcsp

c. Other Article Citations

AHIMA e-HIM Work Group on the Legal Health Record. "Update: Maintaining a Legally Sound Health Record—Paper and Electronic." *Journal of AHIMA* 76, no. 10 (November–December 2005): 64A–L.

AHIMA e-HIM Work Group on the Legal Health Record. "The Legal Process and Electronic Health Records." *Journal of AHIMA* 76, no. 9 (October 2005): 96A–C.

AHIMA Work Group on Electronic Health Records Management. "The Strategic Importance of Electronic Health Records Management. Appendix A: Issues in Electronic Health Records Management." 2004. Available online in the FORE Library: HIM Body of Knowledge, www.ahima.org.

Amatayakul, Margret, et al. "Definition of the Health Record for Legal Purposes." Journal of AHIMA 72, no. 9, (2001): 88A-H.

Black's Law Dictionary (8th ed. 2004). See Hannah v. Heeter, 213 W.Va. 704, 584 S.E.2d 560 (W.Va. 2003).

Cottrell, Carlton. "Legal Health Record: a Component of Overall EHR Strategy." *Journal* of AHIMA 78, no.3 (March 2007): 56-57, 66.
http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_033673.hcsp

Kohn, Deborah. "When the Writ Hits the Fan." Journal of AHIMA 75, no. 8 (2004): 40–44.

McWay, Dana C. *Legal Aspects of Health Information Management*. Albany, New York: Delmar Publishers, 1997.

Patzakis, John. “How the New Federal Rules Will Likely Change eDiscovery Practice.” The Metropolitan Corporate Counsel. June 2006.

Quinsey, Carol Ann. "Is 'Legal EHR' a Redundancy?." *Journal of AHIMA* 78, no.2 (February 2007): 56-57.

The Sedona Conference Working Group Series. “Best Practices for the Selection of E-Discovery Vendors.” July 2005.

The Sedona Conference Working Group Series. “The Sedona Conference Glossary for E-Discovery of Digital Information Management.” May 2005.

The Sedona Conference Working Group Series. “The Sedona Guidelines for Managing Information and Records in the Electronic Age.” September 2005.

The Sedona Conference Working Group Series. “The Sedona Principles Addressing Electronic Document Production.” July 2005.

Tomes, Jonathan P. “Spoliation of Medical Evidence.” Journal of AHIMA 76, no. 9 (2005): 68–72.

University of Sydney. “Records Management Services.” Available online at www.usyd.edu.au/arms/rms/body.htm.

Withers, Kenneth, J. Esquire Federal Judicial Center and Sedona Conference Observer, MER Conference, Chicago, IL May 24, 2006.

ATTACHMENTS: Appendix A--Matrix

APPROVALS:

Legal Department Approval:		Date:	
HIM Department Approval:		Date:	
IT Department Approval:		Date:	
Specify Other Department		Date:	

[i] AHIMA e-HIM Work Group on e-Discovery. “New Electronic Discovery Civil Rule”. Journal of AHIMA 77, no. 8 (September 2006): 68A_H

[ii] Amatayakul, Margaret, et al. “Definition of the Health Record For Legal Purposes.” Journal of AHIMA 72, no. 9 (2001): 88A-H

[iii] AHIMA e-HIM Work Group on the Legal Health Record. "Update: Guidelines for Defining the Legal Health Record for Disclosure Purposes." Journal of AHIMA 76, no. 8 (2005): 64A-G

[iv] Ibid

[v] AHIMA Data Standards, Data Quality, and Interoperability (AHIMA Practice Brief)

[vi] AHIMA e-HIM Personal Health Record Work Group. "The Role of the Personal Health Record in the EHR." Journal of AHIMA 76, no. 7 (July-August 2005) 64A_D

Appendix A

[The Matrix tables below are an example of a tool that can help an organization identify and track the paper and electronic portions of the legal health record during and up to the full implementation of a paperless environment. Items for special consideration as to whether to include on the matrix may include those listed below. It is up to each individual organization to determine what health information is considered a part of their legal health record.]

- **Alerts/Reminders/PopUps.**
- **Continuing Care Records** (unless they are used in the provision of patient care).
- **Administrative Data/Documents**: (Patient-identifiable data used for administrative, regulatory, healthcare operations and payment (financial) purposes.
- **Derived Data/Documents** (information aggregated or summarized from patient records so that there are no means to identify patients).
- **Data/Documents** – documentation of patient care that took place in the ordinary course of business by all healthcare providers.
- **Data from Source Systems** – Written results of tests. Data from which interpretations, summaries, notes, flowcharts, etc., are derived.
- **New Technologies** – audio files of dictation, audio files of patient telephone calls, nursing shift to shift reports handwritten, telephone consultation audio files, videos of office visits, videos of procedures and videos of telemedicine consultation.
- **Personal Health Records** (PHRs) – Copies of PHRs that are created, owned, and managed by the patient and are provided to a healthcare provider organization (s) might be considered part of the LHR if so defined by the organization.
- Research Records: Organizational policy should differentiate whether research records are part of the legal health record and how these records are kept.
- **Discrete Structured Data** is Laboratory Orders/Refills, Orders/Medication orders/MARs, Online Charting and Documentation and any detailed charges.
- **Diagnostic Image Data** is CT, MRI, Ultrasound, Nuclear Medicine, etc.
- **Signal Tracing Data** is EKG, EEG, Fetal Monitoring Signal Tracings, etc.
- **Audio Data** is Heart Sounds; Voice Dictations and Annotations, etc.
- **Video Data** is Ultrasound and Cardiac Catheterization Examinations, etc.
- **Text Data** is Radiology Reports, Transcribed Reports, UBS and Itemized Bills, etc.
- **Original Analog Document – Document Image Data** is Signed Patient Consent Forms, Handwritten Notes and Drawings, etc.

Name of Organization

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

Name of Organization
Maintaining the Legal EHR: Verification Legend

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.

This template was developed by:

Kathleen Addison
Barbara Demster
Terri Hall
Beth Liette
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Mary Ellen Mahoney
Ann Tegan
Victoria Weaver
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Lou Ann Wiedemann