Complete Medical Record in a Hybrid EHR Environment. Part III: Authorship of and Printing the Health Record

This practice brief has been updated. See the latest version here. This version is made available for historical purposes only.

Background

The transition from a paper-based health record to an electronic health record (EHR) environment must be addressed and managed on many different and complex levels: administratively, financially, culturally, and institutionally. Most organizations will not transition from a paper-based environment to an electronic environment in one quick and easy step. In fact, some organizations may find that their progression to an EHR has been and continues to be an unplanned process, whereas other organizations will have the foresight to plan and determine their steps along the way. The EHR journey is one that will evolve over many years, requiring many change-management dynamics that will challenge each of those involved with the transition process.

Given the complexities involved with the transition to an EHR environment, implementation has been slow. Many healthcare providers today are maintaining a "hybrid" health record.

Definition of Hybrid Health Record

Organizations should define health record content and format at a high level in their organization-wide policies. The health record comprises individually identifiable data, in any medium, that are collected, processed, stored, displayed, and used by healthcare professionals. This information in the health record is collected and/ or directly used to document healthcare delivery or healthcare status.

A hybrid health record is a system with functional components that

- Include both paper and electronic documents
- Use both manual and electronic processes

For example, dictation, lab, and x-ray results might be available electronically, whereas progress notes, ancillary care, provider information, graphic sheets, and doctors' orders remain on paper. Other health information may be maintained on various other media types such as film, video, or an imaging system.

Managing health information in this hybrid environment is challenging, particularly given the transition-management requirements. Nevertheless, there is some risk to any organization that patient quality of care may be adversely affected if the transition from a paper-based environment to an electronic environment is not effectively managed.

This practice brief is intended to provide guidance and practical steps for managing the issues of authorship (who may "write in" or be an "author" in the record) and the specific points at which the EHR may be printed.

Legal and Accreditation Requirements

As organizations develop their vision and accompanying policies and procedures for the EHR, it is important that there be an understanding and address of the many federal, state, accreditation, and other regulatory requirements that affect health information.

Federal

The HIPAA privacy rule requires that covered entities adhere to certain standards when using protected health information (PHI). It provides broad guidance insofar as defining to whom and under what circumstances information may or may not be requested, used, or disclosed.[1]

The HIPAA security rule establishes the administrative, physical, and technical safeguards covered entities must implement in order to protect electronic PHI.[2]

The Confidentiality of Alcohol and Drug Abuse Patient Records Rule establishes requirements for the use and disclosure of information maintained in connection with the performance of a drug abuse prevention function assisted directly or indirectly by the federal government.[3]

The Privacy Act of 1974 grants people the right to find out what information has been collected about them, correct and amend that information, and exercise limited control over disclosure.[4] The provisions of the Privacy Act apply to healthcare organizations operated by the federal government and record systems operated pursuant to a contract with the federal government.

The Federal Rules of Evidence, Article VIII, outlines the criteria necessary for health records to be acceptable as evidence in federal court.[5]

State

Often states have laws or regulations that define the circumstances under which patient health information may be used, disclosed, and retained. Many states have special rules for access and disclosure of sexually transmitted disease, drug/ alcohol abuse, or mental health information.

State rules and regulations should be completely researched to determine what specific laws exist regarding health records in these areas:

- Electronic signature of entries in the health record
- Access and disclosure of PHI
- Retention and destruction of health records

When federal and state law exists, it is important that policies and procedures comply with both. When it is not possible for organizations to comply with both, they must comply with the more stringent law or regulation.

States may also have rules that relate to the use, disclosure, and retention of business records and/ or materials that may be admitted into evidence. Organizations should examine and consider such rules when designing electronic or hybrid health information systems, policies, and procedures.

Accreditation

Many accreditation organizations such as the Joint Commission, American Osteopathic Association, and the Accreditation Association for Ambulatory Healthcare establish standards aimed at ensuring access to needed health information by authorized users and safeguards preventing access by unauthorized individuals. Organizations that are or wish to be accredited must look to their own accreditation standards for guidance.

For example, the Joint Commission has posted pre-publication editions of standards for hospitals and long-term care facilities on its Web site that state:

- Only authorized individuals make entries in the medical record.
- Every medical record entry is dated, the author identified, and, when necessary according to law or regulation and organization policy, is authenticated.[6]

Guidelines for Authorship and Printing of the Health Record

(See the "The Complete Medical Record in a Hybrid EHR Environment: Managing Access and Disclosure" Practice Brief for more information.)

- The organization must have a multidisciplinary steering committee to develop and express the vision, strategic plan, and policies and procedures for the hybrid environment.

  (See "The Complete Medical Record in a Hybrid EHR Environment: Managing the Transition.")

- With regard to policy issues about authorship, the hybrid steering committee should

  - Designate which individuals are authorized to make entries (author) in the hybrid record across all pre-designated legal media
  - Identify those documents and authors that require co-signatures across all media such as medical students, residents, physician assistants, and nurse practitioners
  - Identify who is authorized to make changes when someone has discovered a nonclinical error such as wrong title of template, wrong patient, or wrong attending assigned
  - Determine the methodology to capture patient-originated data, as approved
  - Identify and help the organization procure and implement software that supports the organization's authorship guidelines

- The hybrid steering committee should address policy issues regarding printing:

  - Designation of those electronic components of the legal health record where printing will occur and requiring authorized users to access clinical information in the EHR rather than keeping paper copies. (Refer to AHIMA's practice brief on defining the health record for legal purposes.[7]) Organizational policy must address and regulate the keeping of and referring to "shadow records." (See "Legal Source Legend," Appendix.)
  - Identification of the date when an electronic report will no longer be routinely printed and available only through the EHR (see "Legal Source Legend," Appendix). For example:

    - Transcribed reports (discharge summaries, operative notes)
    - Diagnostic reports (lab, radiology, cardiology, pathology)

  - Identification of the date(s) on which the following will be or is eliminated:

    - Routine printing of reports by ancillary departments
    - Concurrent filing of in-house reports into facility patients' records
    - Discharge report filing

  - Availability or nonavailability of online transcribed reports prior to verification and authentication (please refer to AHIMA's practice brief on electronic signature[8])
  - Determination of the methodology to be used to indicate any online changes to a signed EHR document to ensure clear visibility of any changes for users
  - Determination of a formal process for review and approval of all new requests for access and printing
  - Designation of where copies of an EHR may be printed in the organization and methods to be used for copy disposal
  - Labeling of reports printed by authorized users to include a prominent watermark or label with the following information:

    - "Confidential medical information"
    - Instructions for use such as:

      --"Do not file in patients' medical record"
      --"Do not remove report from facility"
      --"Discard report in designated disposal area"
    - For all unauthenticated reports, indication that the report has not been reviewed for accuracy or authenticated

  - When information is no longer printed, users are notified by one of the following methods:

- Medical record folder or tabs in paper-based record to alert users that additional medical information is in the EHR with similar cross-references in the EHR where feasible
- The EHR has an online reference listing (see " Legal Source Legend") of all available reports and dates of availability

- Auditing of Printing
  - The development of audit trails and associated processes to identify and monitor users who have printed reports or screen-printed patient information

- Disclosure of Information/ Subpoenas and Audits
  - Requests for disclosure of information, subpoenas, and audits requiring printing from all designated sources of the LHR that may be in a hybrid environment, in addition to photocopying the paper medical record or downloading onto disks or CD-ROMs
  - On-site audits and regulatory reviews requiring printing reports or allowing auditors to have online access to EHRs. Development of viewing stations for on-site requesters and staff training to support them is needed.

Notes

1. "Standards for Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR, subtitle A, subchapter C, parts 160 and 162. *Federal Register* 67, no. 157 (August 14, 2002). Available at http:// aspe. hhs. gov/ admnsimp.

2. "Health Insurance Reform: Security Standards, Final Rule." 45 CFR, subtitle A, subchapter C, parts 160 and 164. *Federal Register* 68, no. 34 (February 20, 2003). Available at http:// aspe. hhs. gov/ admnsimp.

3. Public Health Service, Department of Health and Human Services. "Confidentiality of Alcohol and Drug Abuse Patient Records." *Code of Federal Regulations,* 2000. 42 CFR, chapter 1, part 2.

4. Section 5 U. S. C. 552a. Available at http:// www. usdoj. gov/ 04foia/ privstat. htm.

5. Federal Rules of Evidence, article VIII, rule 803. Available at http:// expertpages. com/ federal/ a8. htm.

6. Joint Commission on Accreditation of Healthcare Organizations, 2003. Standard IM 6.10, 2004 pre-publication edition. Available at www. jcaho. org/ accredited+ organizations/ hospitals/ standards/ new+ standards/ 2004+ standards. htm.

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

8. Rhodes, Harry. "Implementing Electronic Signatures (Updated)." Available in the FORE Library: HIM Body of Knowledge at www. ahima. org.

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