Definition of the Health Record for Legal Purposes

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Historically, the definition of a legal medical or health record seemed straightforward. The contents of the paper chart formed the provider of care's legal business record. Patients had limited interest in or access to the information contained in their record. With the advent of various electronic media, the Internet, and the consumer's enhanced role in compiling health records, the definition of the legal health record became more complex. The need remains to ensure information is accessible for its ultimate purposes regardless of the technologies employed or users involved. The definition of the legal health record (LHR) must therefore be reassessed in light of such new technologies, users, and uses.

As the national organization of health information management (HIM) professionals, the American Health Information Management Association (AHIMA) consistently takes a leadership role in implementing systems and standards that ensure quality health information. Recognizing that new systems, standards, and users result in a health record with virtual properties, AHIMA formed a special task force of members from provider settings and law practices, information technology vendors, and information systems consultants to develop guidelines that assist organizations in defining their health records for legal applications.

Introduction

A patient's health record plays many important roles:

1. It provides a view of the patient's health history. In other words, it provides a record of the patient's health status (sickness and wellness) including observations, measurements, and history and prognosis, and serves as the legal document describing the healthcare services provided to the patient.
2. It provides a method for clinical communication and care planning among the individual healthcare practitioners serving the patient.
3. It provides supporting documentation for the reimbursement of services provided to the patient.
4. It documents and substantiates the patient's clinical care and serves as a key source of data for outcomes research and public health purposes.
5. It serves as a major resource for healthcare practitioner education.
6. It serves to document evidence of the quality of patient care.
7. It serves as the legal business record for a healthcare organization and is used in support of business decision making.

There is no one-size-fits-all definition of the legal record because laws and regulations governing the content vary by practice setting and by state. However, there are common principles to be followed in creating a definition. The table below, "Guidelines for Defining the Health Record for Legal Purposes," breaks down the health record into four categories to provide guidelines for assisting healthcare organizations in defining the content of their legal record.

Guidelines for Defining the Health Record for Legal Purposes

Legal Health Record *The legal business record generated at or for a healthcare organization. This record would be released upon request.*	The LHR is the documentation of the healthcare services provided to an individual in any aspect of healthcare delivery by a healthcare provider organization. The LHR is individually identifiable data, in any medium, collected and directly used in and/or documenting healthcare or health status. The term includes records of care in any health-related setting used by healthcare professionals while providing patient care services, for reviewing patient data, or documenting observations, actions, or instructions. Some types of documentation that comprise the legal health record may physically exist in separate and multiple paper-based or electronic/computer-based databases (see examples listed below). The LHR *excludes* health records that are *not* official business records of a healthcare provider organization (even though copies of the documentation of the healthcare services provided to an individual by a healthcare provider organization are provided to and shared with the individual). Thus, records such as personal health records (PHRs) that are patient controlled, managed, and populated would not be part of the LHR. Copies of PHRs that are patient owned, managed, and populated by the individual but are provided to a healthcare provider organization(s) may be considered part of the LHR, if such records are used by healthcare provider organizations to provide patient care services, review patient data, or document observations, actions, or instructions. This includes patient owned, managed, and populated "tracking" records, such as medication tracking records and glucose/insulin tracking records. Examples of documentation found in the LHR: • advance directives • anesthesia records • care plan • consent for treatment forms • consultation reports • discharge instructions • discharge summary • e-mail containing patient-provider or provider-provider communication • emergency department record • functional status assessment • graphic records • immunization record • intake/output records • medication orders • medication profile • minimum data sets (MDS, OASIS, etc.) • multidisciplinary progress notes/documentation • nursing assessment

	• operative and procedure reports • orders for diagnostic tests and diagnostic study results (e.g., laboratory, radiology, etc.) • patient-submitted documentation • pathology reports • practice guidelines or protocols/clinical pathways that imbed patient data • problem list • records of history and physical examination • respiratory therapy, physical therapy, speech therapy, and occupational therapy records • selected waveforms for special documentation purposes • telephone consultations • telephone orders
Patient-Identifiable Source Data *An adjunct component of the legal business record as defined by the organization. Often maintained in a separate location or database, these records are provided the same level of confidentiality as the legal business record. The information is usually retrievable upon request. In the absence of documentation (e.g.,interpretations, summarization, etc.), the source data should be considered part of the LHR.*	Patient-identifiable source data are data from which interpretations, summaries, notes, etc., are derived. Source data should be accorded the same level of confidentiality as the LHR. These data are increasingly captured in multimedia form. For example, in a telehealth encounter, the videotape recording of the encounter would not represent the LHR but rather would be considered source data. **Examples of patient-identifiable source data:** • analog and digital patient photographs for identification purposes only • audio of dictation • audio of patient telephone call • diagnostic films and other diagnostic images from which interpretations are derived • electrocardiogram tracings from which interpretations are derived • fetal monitoring strips from which interpretations are derived • videos of office visits • videos of procedure • videos of telemedicine consultations
Administrative Data *While it should be provided the same level of confidentiality as the LHR, administrative data are not considered part of the LHR (such as in response to a subpoena for the "medical record.")*	Administrative data are patient-identifiable data used for administrative, regulatory, healthcare operations, and payment (financial) purposes. **Examples of administrative data:** • authorization forms for release of information • birth and death certificates • correspondence concerning requests for records • event history/audit trails • patient-identifiable claim • patient-identifiable data reviewed for quality assurance or utilization management

	• patient identifiers (e.g., medical record number, biometrics) • protocols/clinical pathways, practice guidelines, and other knowledge sources that do not imbed patient data
Derived Data *While it should be provided the same level of confidentiality as the LHR, derived data are not considered part of the LHR (such as in response to a subpoena for the "medical record.")*	Derived data consists of information aggregated or summarized from patient records so that there are no means to identify patients. **Examples of derived data:** • accreditation reports • anonymous patient data for research purposes • best practice guidelines created from aggregate patient data • MDS report • OASIS report • ORYX report • public health records • statistical reports

Assessment Guidelines for Defining the Health Record for Legal Purposes

The following assessment guide was developed to provide a practical professional tool for HIM professionals as they begin to define the health record for legal purposes. There are no right or wrong responses to the assessment guide. Innovation and creativity in developing responses throughout this assessment will be key in ensuring the best outcome for a healthcare organization. The assessment process/guide uses a three-tiered approach: organizational preparation, global definitional assessment, and specific definitional assessment.

Legal Health Record Assessment Guide

Assessment Guidelines	Discussion Points
1. Organizational Preparation	*This step establishes a framework for the definition process. This level ensures a solid foundation for the remaining definition processes.*
Background Research Investigate state laws, regulatory definitions, and accreditation requirements for your practicesetting pertaining to record content/documentation, discoverability, authentication, and retention.	*Appropriate research should be conducted at the beginning of the definition process. The background research will help establish the initial foundation for the new LHR definition. The research is a prerequisite in establishing fundamental ground rules.*

Review your organization's policies, if any, on the LHR. Research authoritative references regarding the LHR.	*If policies exist, they should be reviewed and updated in consideration of the current electronic medical record (EMR) environment.* *Identify authoritative references and professional peers who may be working through similar issues. The more information shared, the better the overall outcome.*
Executive-Level Support Identify the executive authorities (e.g., administration, medical staff) who will review and approve all LHR recommendations and authorize necessary resources.	*Support at this level is critical for the initial definition process as well as ongoing support as the electronic environment evolves.*
Organizational Structure Identify a specific organizational structure, such as a special task force, to define and document the LHR for the organization.	*Integration of all interested parties is a critical component to ensure ongoing success of the definition process. A multidisciplinary approach is highly recommended.*
Task Force Mandates Incorporate the EMR vision for your organization into the LHR definition. Realign roles and responsibilities for existing organizational bodies related to the ongoing evolution of the LHR definition (e.g., forms committee). Identify operation work flows and processes related to the changing definition of the LHR and evolving technology that should be assessed using an interdisciplinary approach. Revise organizational policies in response to operational issues identified with the new definition of the LHR.	*This is critical to ensure consistency and uniformity as the enterprise EMR vision continues to expand into the future.* *Example of realigning roles and responsibilities: if optical imaging is one of the media sources for the legal medical record, then incorporation of "image-friendly" requirements into existing forms standards would be a new role for the forms committee.* *This is a complex step in the evaluation process. Using an interdisciplinary approach will help to identify those operational areas that could "own" a component of the LHR based on the new definition. Proper coordination is needed to ensure the LHR can be accessed in an efficient and effective manner.* *Synchronizing organization policy changes with the new definition is imperative for ongoing success and identification of changes.*
Organizational Impact Analysis Complete an organizational impact analysis to examine the immediate and long-term costs or	*As the LHR definition cuts across multiple media sources, the costs for managing this information to ensure appropriate access and distribution for all business purposes should be assessed. It is important to attain a balance*

savings associated with the implementing the new definition of the LHR including: • management and staffing • patient care • patient information access and retrieval • patient information collection • patient information release • patient information security • patient information storage	*that allows for ease of access for business, legal, and patient care purposes while also ensuring that both the direct and indirect costs associated with managing this information across various media sources is reasonable.*
Final Approvals Obtain final approval for your organization's LHR definition from key sponsors.	*In addition to obtaining administrative approval, it is just as critical to obtain the approval of others who serve as advocates for the implementation efforts of the new definition.*
Strategic and Tactical Plan Approvals Draft organization-wide implementation plans for the LHR definition. Include a communication plan to manage organizational expectations.	*The strategic plans should handle many of the high-level organizational issues (e.g., political positioning). Tactical plans will ensure that the "how-tos" are carefully thought through.* *Without an effective communication plan, implementation efforts could be hampered or damaged. Managing expectations is key to success in the new definition rollout.*
2. Global Definitional Assessment	*This second tier allows the organization to establish general ground rules and parameters for the LHR definition. The boundaries are necessary to ensure that the evaluation process effectively meets the needs of the EMR movement for your organization. This tier also establishes the mandates for the taskforce established to define the LHR.*
Uses and Users Define both the internal and external uses for the LHR including legal, financial, clinical, and others as identified for your organization. Define the internal and external users of the LHR.	*It is important that any and all media sources defined as part of the LHR effectively accommodate all existing business requirements across each area (legal, financial, clinical, and other).* *The users may differ depending on the media type defined as part of the LHR. Multiple sets of users by media type may need to be established.*

Components Define the specific data, documents, images, and other potential components of the LHR.	*In a multimedia environment, each component should be clearly delineated and included in the overall definition of the LHR.*
Standards Delineate the standards for the new LHR definition including structure, format, and organization.	*Each of the standard sets for structure, format, and organization may vary depending on the media type. Each should be within the overall definition process of the LHR.*
Access Define access rights to the LHR.	*As the LHR is defined across more media sources, consideration of additional security measures for each health information component included in the LHR will be needed. This is particularly critical given that the EMR will provide much broader access capabilities. The "need to know" must be carefully balanced with protection of patient confidentiality.*
3. Specific Definitional Assessment	*This third tier is a more detailed set of evaluation criteria and issues. They are posed at a level that will assist the organization's drive through the critical issues that need to be addressed as part of the overall definition process.*
Current Situational Assessment Compare paper-based documents with comparable electronic versions where applicable. Determine which media type should be deemed part of the LHR. Determine how the different record types will be handled by the organization (LHR, patient-identifiable source data, administrative data, and derived data). If shadow records are maintained, determine if there is any unique content that should be included as part of the LHR.	*Having a clear understanding of where health information exists in duplicate across various multimedia materials is a critical first step in the detailed assessment process. Decisions on which media type for a given set of health information will serve as the LHR component need to be made.* *Handling standards for the different levels of records need to be established for medico-legal purposes. Some health information across each level may be retrieved as part of the LHR on an ongoing basis, some may be retrieved on an "as requested" basis, and some will never be retrieved as part of the LHR. These decisions need to be made for all health information contained within the four record levels.* *"Shadow" records typically contain copies of specific components of the legal medical record. A separate assessment should be*

	conducted to ensure that these records do not contain health information that is not already included within the LHR. Appropriate measures should be taken to correct such a situation.
"New" Health Information Considerations Determine how to handle the different types of records outlined in "Guidelines for Defining the Health Record for Legal Purposes." Consider: • clinical protocols/critical pathways • dynamic data (e.g., IV flow measurements) • e-mail • expert system rules • MD alerts/reminders • research protocols • user-specific screen views (e.g., MD-specific)	*In assessing the EMR information that could potentially be included as part of the LHR, nontraditional patient information should now be considered in the definition process.* *Consider other patient information such as patient inquiry forms (pre-procedure forms) or patient intake questionnaires. As this information becomes increasingly automated, it would be prudent to include it in the overall definition assessment.*
EMR Data Set Considerations Review each electronic medical record (EMR) data set and consider the following: • Can the EMR patient information be captured as a representative interpretation (that is, a snapshot) of a given patient's episode of care for medico-legal and other business needs? • If it has the potential to change over time, can it legitimately be included in the LHR? (e.g., preliminary versus final results such as lab, transcription, EKGs, etc.) • Can the LHR patient information be efficiently and legibly accessed and retrieved? • How is EMR information corrected	*The patient information included in the LHR should be able to accurately depict the events that took place during the episode of care.* *The response to the question on efficiently accessing and retrieving patient information is critical to the overall evaluation process. Any response that is not affirmative will make it difficult and impractical to consider the information for inclusion in the LHR.* *The dynamic nature of some health information will need to be carefully evaluated when considering it for inclusion in the LHR.*
Specific Legal Medical Record Event Capture Once the various components of the LHR are defined, determine how and where these defined events will be: • documented (current or late) • collected • stored • updated (current or late) • transferred	*Information about the events needs to be evaluated across each of the health information components (data, documents, images, or others, defined by the organization) that will be included in the LHR definition. This will ensure ongoing integrity of the health information.*

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