Developing and Defining a Legal Health Record Policy

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Yale New Haven Health (YNHH) began implementing the electronic health record (EHR) across four delivery networks in 2012. As the system moved to the electronic world, it became evident that YNHH needed to address the issue of defining the organization's legal health record (LHR), a subset of the designated record set (DRS).

YNHH began this initiative by creating a work group that included members from information technology, Yale Medicine, and corporate health information management (HIM). At YNHH, the new EHR vendor included both the university medical record and the system medical record as one component. Yale Medicine is a separate entity from the YNHH, although Yale University physicians (Yale Medicine) admit their patients to Yale New Haven Hospital. Yale Medicine physicians are credentialed by the medical staff office. Their clinic medical records are a component of the YNHH EHR. The residents and fellows further their training at Yale New Haven Hospital.

Clearly, with the EHR on the horizon, Yale New Haven Health needed to define the LHR with YNHH and Yale Medicine stakeholders.

At YNHH, an EHR is maintained for each patient who is evaluated or treated as an inpatient, outpatient, or emergency patient at the delivery network and clinics, care centers, and physician offices both for the Northeast Medical Group, the physician entity, and Yale Medicine.

At the first work group meeting, the work group established steps to defining the LHR. The group:

1. Determined what legal entities enforce regulations, guidelines, standards, or laws within healthcare referencing the LHR definition and the LHR and/or designated record set (DRS).
2. Determined whether the records are created or referenced in the course of business at YNHH.
3. Addressed retention requirements.
4. Created a matrix that defines each document in the LHR and/or DRS.
5. Established if the document is released to third parties in response to legally permissible requests.

Designated Record Set

The DRS is defined by HIPPA. The DRS consists of the patient medical records, billing records, patient enrollment, payment information, claims, adjudication and cases, and medical management record systems maintained by or for a health plan; or information used in whole or in part to make care-related decisions.

YNHH determined it was important to define and differentiate explicitly the LHR from the DRS, which includes clinical data stored on any medium and collected and directly used in documenting healthcare or health status. The DRS is broader than the LHR and includes all protected health information and billing information.

Definitions

YNHH's policy defines the LHR and DRS as follows:

- The LHR is the collection of information created and maintained to document healthcare services provided to a patient by YNHH in the course of the covered entity's business. The LHR is a subset of the DRS and

is the record that is released for legal proceedings or in response to requests for release of patient medical records.
- The DRS is the group of records that include protected health information along with business information that is maintained, collected, used, or disseminated by or for a covered entity for each individual that receives care.

The primary reason for the development of the LHR policy was to identify those documents that YNHH and Yale Medicine would release for formal business and legal purposes and to ensure that the integrity of the health record is maintained so that it can support business and legal needs.

In reviewing Connecticut state law, the LHR was not addressed from a state law perspective. The work group's primary references were the AHIMA practice brief and the HIPAA regulations referencing the DRS.

Defining the components of the LHR required the work group to inventory the documents maintained in the EHR that included scanned documents. The work group reviewed each document and determined if that document was referenced and used to document healthcare services provided to the patient.

The work group wanted to keep the matrix simple to include as an attachment to the policy for all to reference. The LHR could be generated by departments other than HIM, including:

- The regulatory department when the Department of Public Health and the Joint Commission perform site visits.
- IT when depositions occurred.
- The privacy officer when working with patient complaints.

The work group limited the matrix to include the document name and a column defining the document as the DRS and/or LHR. There are a total of three columns in the final matrix that are posted on the system intranet. All the documents included in the matrix are components of the EHR documents.

Overall, the policy applies to all uses and disclosures of the health record for administrative, business, or evidentiary purposes. It encompasses reviewing documents that were recorded on a variety of media including, but not limited to, electronic, paper, digital images, video, and audio.

It was the intent of the work group not to compromise the LHR and to include all documents that are created and authenticated in the ordinary course of the hospital's business during the patient's encounter.

The matrix also addressed external content used in decision-making and care of the patient, such as record forms and reports from other healthcare providers.

YNHH has a policy that requires physicians to identify which external documents they referenced in the care of the patient. Those are the documents that are scanned into the EHR.

Numerous documents required review and consensus. The following documents were discussed and it was then determined if they were part of the LRH and/or DRS:

LHR components:

- EKG and EEG tracings
- Clinical photographs
- Diagnostic images
- Fetal monitor strips

LHR and DRS components:

- Personal health records (PHR) at the time the PHR was accepted by the provider
- Patient portal messaging was accepted both in the LHR and DRS
- Physician queries were also part of the LHR

Documents that were not included in LHR nor DRS:

- Administrative data
- Employee health records
- Video/audio

The LHR is printed when the button to print is selected in the EHR. This was programmed by IT. It is not uncommon for the regulators to ask for the LHR policy and matrix when they are onsite and reference it throughout their visit.

IT ensures appropriate access to the LHR and DRS occurs in compliance with the delivery networks' archiving and retention schedule.

An ongoing quality control program is in place to monitor timeliness and accuracy of scanning and indexing. Where decentralized scanning is deployed, HIM remains accountable for all aspects of the quality control and verifies the completeness of the medical record in accordance with established guidelines.

All medical records are completed within 21 days following discharge, with a less than one percent suspension rate across all YNHH networks. Audit trails of user access, action, and date of action to the EHR are monitored by the IT security area.

The LHR and DRS policy is reviewed on an annual basis and updated as needed.

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