Policies and Procedures for a Legal EHR

by Carol Ann Quinsey, RHIA, CHPS

As organizations move from paper to electronic health records (EHRs), one of the most critical steps is ensuring that there are policies that support the EHR as the legal health record.

Most managers know the importance of having up-to-date policies and procedures. Good policies reflect an organization's mission, values, and positions. Policies provide guidelines for HIM managers who write procedures.

Procedures provide staff with step-by-step instructions on how to carry out tasks that support policies. When an organization must produce health records for legal proceedings, policies and procedures ensure that its business records are reliable.

Key Elements for Good Documents

Policies that support a legal electronic health record most likely have roots in existing policies that support the legal paper health record. In hospitals some policies may be written at the facility level, but many items that should be included in policies are located in the medical staff bylaws, rules, and regulations.

Other care settings should have existing policies they can draw from that reflect relevant federal and state laws, accreditation standards, and community standards of practice. These typically address such things as:

- Content of a medical record and specific documents therein
- The timeline of when specific documents must be completed
- Who is authorized to document in the record
- When a record is considered complete
- How records are completed when staff no longer practice at the facility

Policies should be concise but sufficiently detailed to guide those responsible for carrying out the organization's position in department-level policies and procedures. Good policies typically state the policy's objective in a way that can be measured, cite who is responsible to carry out the policy, and describe how the policy may be enforced. If there are consequences for policy violations, these should be included in the policy as well.

Procedures provide detailed instructions that allow the organization's staff to carry out tasks. Procedures should reference the policy they support. Key elements of procedures generally include:

- The procedure's objective and how success will be measured
- Related policies and procedures
- Supplies, tools, or references needed to complete the task
- Specific job classes or personnel who are expected to carry out the task
- The event that initiates the task
- Detailed instructions to complete the task
- Decision points where different paths may be taken
- A description of when and how the task is determined to be complete
- How the product of the completed task is passed off or stored
- Effective and revision dates for the procedure
- Who approved the procedure

Procedures may be written in a variety of formats. Some organizations have an approved format for policies and procedures. There may be flexibility in formats at the department level, but there should be consistency in the formats used in a single

department. The most common procedure format is a list that enumerates each step in the process. Flowcharts with decision points often accompany procedures.

Special Considerations for the EHR

When drafting policies and procedures for the EHR, some areas need special attention if the electronic record is defined as the legal health record for a patient. EHRs offer many benefits, but the technology that enables them also brings challenges that must be considered from a policy perspective before systems are implemented.

The systems chosen may enable familiar tasks to be done in new ways, but some capabilities pose risks. Every organization must have clear policies that guide the use of its system's capabilities, balancing ease of use with the fact that at some future date the record may be used to defend the organization and potentially the physician in litigation. Some of the most common issues include the following.

Cutting, Copying, and Pasting. To save time, clinicians may decide to cut or copy and paste all or part of a previous note about the patient into the current record. The note may have been written by someone else, or the information may come from an e-mail from the patient or another clinician. Many scenarios could lead to the decision to cut or copy and paste.

While this strategy may be efficient for the clinician, there are risks associated with it. The note may go into the wrong patient's chart. If another person composed the original entry, the original author may object to having his or her written material used without knowledge or permission.

Before organizations create a policy on cutting, copying, and pasting, they should investigate limitations present in the technology. For example, if the clinician is copying a note from one system into another, do both systems use the same software or a different version of the software? Different versions of the same software can create format problems resulting in an unreadable note. This should be tested carefully before making a final decision so all notes are legible, accurate, and complete.

Photographs and Videotapes. Photography and videotaping are fairly common tools used in patient care. Organizations use them to evaluate modalities to determine if special consent is needed from the patient. An organization's policies should detail how such information is to be stored for safekeeping or disclosed. Photographs and videotapes raise questions in organizations using EHRs:

- Can such items be uploaded into the EHR?
- Are patient consents created in the EHR, or must they be scanned into the EHR?
- Will photographs and videotapes be referenced in the EHR and stored separately?
- Do procedures ensure that items stored outside the EHR are available for the life of the electronic record?
- If someone is required to produce or disclose the record, how will they know about and locate items stored separately?

Verbal and Telephone Order Authentication. Nearly all federal and state laws, accreditation requirements, and organizations require that verbal and telephone orders be authenticated by the ordering clinician within a specified time frame. With paper records this was hard to monitor, but an EHR will accurately date and time stamp the signature. How will clinicians be notified when orders need to be signed?

Evidence of Results Review. Physicians usually initial test results or document in progress notes when they have reviewed the results. Policies must reflect the system's capability for documenting such reviews since the information reflects the basis on which clinical decisions were made.

Patient Access and Amendment to Health Records. Several federal and many state laws give patients the legal right to view and amend their health records, without regard to the media in which they are kept. Policies must support these rights, and procedures define how it is accomplished. Will patients be granted special one-time access to the online record to view it? Can patients make entries directly into the record? Are patient addendums or amendments integrated into the record adjacent to relevant clinician entries?

Transferring and Receiving Patient Health Information. Federal and state laws, Medicare Conditions of Participation, and accreditation standards have long supported the transfer of relevant health information about patients among healthcare

providers. Some questions to consider include whether information received from outside sources will be integrated into the EHR. If so, would it be produced in legal proceedings? When transferring patients, what criteria determine whether health information is sent electronically or printed to paper and sent with the patient? Can the system document what is sent with transferred patients?

These represent a few areas that must be considered when writing policies and procedures that support the legal EHR. There are many more, some of which are unique to individual care settings. Each should be reviewed as your organization plans its move to an EHR.

Resources and References

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