HAWAII HEALTH SYSTEMS CORPORATION *"Quality Healthcare For All"* **POLICY**	**Department:** Corporate Legal	**Policy No.:** **ADM 0045A**
		Revision No.: N/A
	Issued by: General Counsel	**Effective Date:** August 25, 2016
Subject: ***LEGAL HEALTH RECORD***	**Approved by:** HHSC Board of Directors By: Antonette Torres Its: Secretary/Treasurer	**Supersedes Policy:** N/A
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Last Review: 8/25/16; Next Review: 7/27/19

I. **PURPOSE**: This policy defines and governs HHSC's Legal Health Record as of the Effective Date, establishes guidelines for the content of HHSC's Legal Health Record, identifies the components that constitute the Legal Health Record for HHSC facilities, and implements standards to ensure that the integrity of HHSC's Legal Health Record is maintained, thereby supporting HHSC's legal and business needs.

II. **DEFINITIONS**:

All capitalized terms used herein are defined in this Section II. Any other capitalized terms used in this policy and the terms "covered entity," "individual," and "protected health information" are defined by the HIPAA Rules.

"Administrative and Financial Data" – patient specific administrative or financial data. Such data belong in the Designated Record Set but not in the Legal Health Record. Examples of administrative and financial data include, but are not limited to: super bills or encounter forms, coding summaries, and remittance advice.

"Medical Record" – records created and used for the clinical care of an individual. The medical record is part of both the Legal Health Record and Designated Record Set. Examples of medical records include, but are not limited to: history and physical, orders and results, progress notes, lab reports, vital signs, assessments, consults, clinical reports, case management records, and authorization and consent forms.

"Committee Reports of Patient-Specific Care Decisions" – hospital committee reports reflecting decisions of the Committee affecting patient care. Such reports shall not be maintained as part of an individual's Legal Health Record and Designated Record Set. When a Committee report exists, providers and other health care staff shall document the care implications contained in the report and may reference the fact that a Committee report was considered in determining the course of patient care.

"Designated Record Set" – as defined by the HIPAA Rules, is a group of records maintained by or for a covered entity that is: (1) the medical and billing records about individuals maintained by or for a health care provider, (2) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (3) used, in whole or in part, by or for a HIPAA covered health care provider to make health care and treatment decisions about individuals. For purposes of a Designated Record Set, "record" means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for a covered entity.

"External Records and Reports" – available records and reports generated outside of HHSC facilities. Such records and reports may or may not belong in the Designated Record Set or Legal Health Record. Examples of external records and reports include, but are not limited to: external records referenced for patient care such as other providers' records and records provided upon transfer from an outside facility to an HHSC facility, patient-generated records, and Personal Health Records.

"HIPAA Rules" – the Privacy, Security, Breach Notification, and Enforcement Rules in 45 CFR Parts 160 and 164.

"Legal Health Record" – data created, collected and directly used in documenting a patient's health status or the health care services provided to a patient, or both, in HHSC's regular course of business. It is a subset of HHSC's Designated Record Set. The Legal Health Record is the record that shall be released upon receipt of an appropriate legal request. It includes records 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 HHSC's business.

"Personal Health Record" – an electronic, universally available, lifelong resource of health information needed by an individual to make health decisions. An individual owns and manages the information in his/her Personal Health Record, which comes from health care providers and the individual. The Personal Health Record is maintained in a secure private environment, with the individual determining access rights. The Personal Health Record is separate from and does not replace the Legal Health Record of any provider.

"Source Medical Data" – data created and used in the development of the Medical Record. Such data are part of both the Legal Health Record and Designated Record Set. Examples include, but are not limited to: x-rays, images, fetal strips, videos and pathology reports.

III. POLICY:

A. Declaration of HHSC's Legal Health Record

HHSC's Legal Health Record is comprised of data created, collected, and directly used in documenting a patient's health status or the health care services provided to a patient, or both. HHSC's Legal Health Record shall not be released except upon receipt of an appropriate legal request or valid authorization form. In no circumstance shall HHSC's original medical records be released unless a HHSC facility is required to do so under applicable laws and regulations. The following categories of records are considered part of HHSC's Legal Health Record (refer to Appendix 1 to determine whether specific types of records are considered part of HHSC's Legal Health Record): Medical Records, Source Medical Data and certain External Records and Reports used to make decisions about and provide health care services to a patient. Committee reports and administrative and financial data about patients are not considered part of HHSC's Legal Health Record.

Consistent with HHSC's HIPAA Privacy and Security Policy and Practices Requirements – Policy Number CMP-020A, the same privacy and security requirements established under the HIPAA Rules that apply to the protected health information contained within HHSC's Designated Record Set shall apply to HHSC's Legal Health Records.

B. Documentation Requirements

HHSC's Legal Health Record shall consist of legible, finalized and verified documents, including any addenda and amendments. Only authorized HHSC clinical staff members, including employed and contracted clinical personnel, may document in a patient's Legal Health Record. Documents that are unverified shall not be part of HHSC's Legal Health Record. For purposes of this Section III.B., "authorized HHSC clinical staff member" means providers who have been granted clinical privileges to practice at a HHSC facility or are members of HHSC facilities' medical staff, employed and agency nursing staff, other health care professionals involved in patient care, including but not limited to: physical therapists, occupational therapists, respiratory therapists, speech therapists, pharmacists, social workers and case managers.

For purposes of this Section III.B., verification may be achieved by hospital information management ("HIM") record analysis. The verification process shall include the visual inspection of all scanned document images. Each scanned document image shall be compared to the original paper document to ensure the scanned document image is an exact copy of the original paper document in accordance with CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Section 30.30.

C. Authentication

All entries in HHSC's Legal Health Record shall be dated, timed, and signed, in written or electronic form, by the HHSC authorized staff member responsible for providing or evaluating the services furnished to patients. The time and date of each entry shall be accurately documented. For paper records, HHSC authorized staff shall separately date and time his/her signature authenticating an entry even when there may already be a date and time on the document. For electronic medical records, if the date and time are automatically recorded with each entry, the authentication requirements shall be met. Each author of an entry must verify that: (1) the entry being authenticated is his/her entry, (2) he/she is responsible for the entry, and (3) the entry is accurate.

D. External Records and Reports

External Records and Reports that are used to make decisions about the health care of a patient in order to provide the patient with health care services shall become part of HHSC's Legal Health Record. Records created pursuant to a contract and generated by other providers that are used to make decisions about the health care of a patient shall be included in HHSC's Legal Health Record.

A Personal Health Record that is created, owned and managed by a patient and is provided to HHSC shall be considered part of and incorporated into HHSC's Legal Health Record only if the Personal Health Record is used 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 intake records and blood sugar and insulin tracking records.

IV. Applicability: All HHSC facilities including corporate office.

V. Authority:

- 45 C.F.R. § 164.502; 42 C.F.R. § 482.24(c);
- Hawaii Revised Statutes Chapter 622, Part V;
- Federal Rules of Evidence Rule 803(6);
- Hawaii Rules of Evidence Rule 803(b)(6); CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Section 30.30, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c07.pdf;
- CMP 0020A – HIPAA Privacy and Security Policy and Practices Requirements.

VI. Attachments: Appendix 1

Appendix 1
Inventory of Documents and Data that Comprise HHSC's Legal Health Record

Document Group	Type of Document	Media Type (P) Paper, (E) Electronic, (S) Scanned or (T) Transcribed	Part of (LHR) Legal Health Record, (DRS) Designated Record Set or (B) Both
Activities	Activity assessments and notes		B
	Activity records		B
	Resident care records		B
Admitting	Advance directives		DRS (LHR if used to make decisions regarding health care services)
	Admission information		B
	Conditions of admission forms		B
	Conditions of registration forms		B
	Outpatient records		DRS (LHR if used to make decisions regarding health care services)
	Registration forms		B
Cardiology	Rhythm strips		B
	Consultation records		B
	Pre-procedural assessments		B
	Diagnostic test results		B
	Cardiology reports and notes		B
	EKG results and notes		B
	Cardiology flowsheets		B
Case management	Case management notes		B
	Case management assessments		B
	Discharge planning		B
	Correspondence		B
	Social service histories		B
	Plans of care		B
	Screenings		B
	Social service histories and assessments		B
	Social service progress notes		B
	Social work assessments		B
Consents	Consent forms		B
	Treatment refusal forms		B

	Against medical advice forms		B
Correspondence	Correspondence and notes of other communication with patient or resident		B
Dietary	Nutrition assessments		B
	Nutrition progress notes		B
	Nutrition records		B
Discharge	Discharge plans		B
	Discharge and transfer summaries		B
	Discharge packets		B
	Discharge plans of care		B
	Discharge teaching		B
	Clarification notes		B
Emergency department	ED flowsheets		B
	ED Physician records		B
	ED Procedure notes		B
	ED assessments and notes		B
	ED Physician orders		B
	ED Screening exam notes		B
	Trauma resuscitation records		B
	ED nursing records and notes		B
External records	Received documents		DRS (LHR if used to make decisions regarding health care services)
	Records from other facilities		DRS (LHR if used to make decisions regarding health care services)
HP/Consults	Admission history and physical		B
	Physical examination results/reports/notes		B
	Consultation notes and reports		B
	Health histories		B
	Asthma control test results and notes		B
	Dental record examinations		B
	Diabetes notes		B
	Foot care examination notes		B
	History and physical records		B

	Physician records		B
	Evaluations		B
	Questionnaires		B
IDT	Discharge letter		B
	Interdisciplinary reports		B
Imaging	Radiology reports		B
	Nuclear medicine progress notes		B
	Images, films, screens		B
	Ultrasound prints		B
Labs	Autopsy reports		B
	Blood transfusion records		B
	Blood treatment records		B
	Cytology reports		B
	Pathology reports		B
	Laboratory reports		B
	Transfusion reaction reports		B
MDS	Resident Assessment and Care Screening		B
Medications	Medication lists		B
	Medication administration records		B
	Medication flowsheets		B
	Patient medication history		B
	Pharmacy orders		B
	Medication counseling records		B
Neurology	EEG results and reports		B
	Neurology diagnostic reports and notes		B
	Neurology flowsheets		B
Nursing	Alcohol use screenings		B
	Allergy list		B
	Nursing assessments and notes		B
	Nursing interventions		B
	Clinical notes		B
	Plans of care		B
	Teaching records		B
	Nursing flowsheets		B
	Nursing notes		B
	Nursing evaluations		B
	Vital signs		B
	Intake/output records		B
	Surgical unit follow up records		B

	Treatment records		B
	Resident care records		B
	Postpartum records		B
	Vital sign records		B
	Graphic records		B
Obstetrics	Labor and delivery reports		B
	Fetal strips		B
	Maternal admission summaries		B
	Maternal progress notes		B
	Newborn discharge records		B
OR/Procedures	Preoperative records		B
	Postoperative records		B
	Surgery records		B
	Anesthesia records		B
	Operative reports		B
	Flowsheets		B
	Treatment records		B
	Operative nursing notes		B
	Labor and delivery summaries		B
	IV Medication reports		B
	Medical reconciliation reports		B
	Nursing records		B
	OR procedure photos		B
	Perfusion records		B
	Monitoring records		B
	Vital signs records		B
	Follow up records		B
	Questionnaires		B
Orders	Physician orders		B
Other	Family history		B
	Clinical photos		B
Progress notes	Charted interventions		B
	Clinical notes		B
	Follow up records		B
	Physician notes		B
	Physician progress notes		B
	Progress notes		B
Radiation/Oncology	Oncology plans of care		B
	Oncology teaching records		B
	Oncology admission records		B
	Oncology reports		B
	Oncology flowsheets		B
	Radiation therapy reports and notes		B

	Oncology treatment records		B
	Oncology triage records		B
Rehab/Therapy	Assessments		B
	Flowsheets		B
	Screening results and reports		B
	Examination reports and notes		B
	Treatment plans		B
	OT/PT/Speech evaluations		B
	OT/PT/Speech discharge summaries		B
	OT/PT/Speech reports		B
	OT/PT/Speech assessments and notes		B
	Progress notes		B
	Consultation reports		B
	Care plans		B
	Treatment plans		B
	Sleep study reports		B
Respiratory	Arterial blood gas results		B
	Flowsheets		B
	Education records		B
	Monitoring notes		B
	Assessments		B
	Oximetry and oxygen use records		B
	Respiratory reports and notes		B
	Respiratory therapy notes		B
	Evaluation reports		B
	Pulmonary function cardiac test results		B