TITLE: HEALTH INFORMATION MANAGEMENT

PURPOSE: To establish requirements for University Health staff to ensure that each Patients care is appropriately documented in a health record to meet Regulatory requirements. This policy applies to all University Health facilities regardless of location unless otherwise specified. This is a revised policy and supersedes policy dated December 9, 2019. [Key Words: Abbreviations, Health Records (Medical Records), Physicians, Record Completion, Signature, and Supervision]

POLICY STATEMENT:

University Health will maintain Health records that are accurate, timely, readily accessible, and permit the prompt retrieval of information.

POLICY ELABORATION:

I. DEFINITIONS

A. Allied Health Professional (AHP) - Those duly licensed individuals who have been licensed or certified by their respective licensing or certifying agency or entity to render direct patient care under the supervision of the appropriate member of the staff. Allied Health Professional includes Advanced Practice Nurses, Physician Assistants, Clinical Associates, and Research Associates.

B. Attending Physician- the active staff physician who has primary responsibility for a patient's treatment and care.

C. Authorized Users- all employees, contractors and other persons or third parties authorized to access or use University Health protected health information.

D. House Staff- A physician, dentist or podiatrist participate in an accredited graduate-training program, whose practice requires supervision.

E. **Chaplain-** a person, who provides spiritual support to people of all faith traditions, explores spiritual questions and concerns that may arise during hospitalization.

F. **Corrections in the Health Record-** a change in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete.

G. **Electronic Health Record-** a record of a patient's long-term and aggregate health information generated by one or more encounters in any care delivery setting and created from interoperability of multiple providers. The electronic health record connects the various clinical systems and providers.

H. **Forms of Corrections within the Health Record**

1. **Addendum:** An addendum is new documentation used to add information to an original entry.

2. **Amendment:** An amendment is documentation meant to clarify health information within a health record. An amendment is made after the original documentation has been completed by the provider.

3. **Deletion:** A deletion is the action of eliminating information from previously closed documentation without substituting new information.

4. **Retractions:** A retraction is the action of correcting information that was incorrect, invalid, or made in error, by preventing display or hiding the entry or documentation from future general views.

5. **Late entries**: A late entry only applies to documentation within the electronic health record that is entered after the point of care.

I. **High-risk Procedure & Process-** a process that, if not planned, or if not implemented correctly, has a significant potential for impacting the safety of the patient.

J. **Medical-Dental Staff-** the formal organization of all allopathic physicians, dentists, and other medical specialists as required by law who are privileged to attend to patients.

K. **Hybrid Health Record-** a record that consists of both paper and electronic media (film, video, or imaging).

L. **Limited Healthcare Practitioner-** a healthcare specialist such as an optometrist , psychologist, pharmacologist, or a biochemist, who is appropriately licensed, certified, or legally authorized under the laws of the State of Texas to provide patient care services within the scope of the license, certificate or legal authorization.

M. **Health Record-** individually identifiable data in any medium, collected directly for the purpose of documenting health care or health status.

N. **Health Record Cloning-**copying and pasting the patient information in an Electronic Health Record (EHR) from one date of service to another for the same patient. Documentation is also considered "cloned" when the medical documentation is the same for different patients as may be documented through the use of templates.

O. **Electronic Access**- "Electronic access" means a web based method that makes EHI available at the time the EHI is requested and where no manual effort is required to fulfill the request.

P. **Electronic "Health Information"**- In the Final Rule, the ONC sought to align the definition of EHI with HIPAA'S electronic protected health information (EPHI) that would be included in a designated record set. Thus, electronic health information (EHI) means EPHI as defined in 45 CFR §160.103 to the extent that it would be included in a designated record set as defined in 45 CFR§164.501, regardless of whether the group of records are used or maintained by or for a covered entity as defined in 45 CFR §160.103. However, EHI shall not include : Psychotherapy

notes as defined in 45 CFR§164.501 (i.e., notes recorded in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record); or Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. Until May 2, 2022, EHI is limited to the EHI identified by the data elements represented in the United States Core Data for Interoperability standard adopted in 45 CFR§ 170.213.

Q. **Patient Portal**- a secure online website that gives patients convenient, 24-hour access to personal health information from anywhere with an Internet connection.

R. **Student-**a person affiliated with University Health enrolled in a healthcare related education program.

S. **Nurse Practitioner/Midwife-** a registered nurse approved by the Texas Board of Nurse Examiners to practice as an advanced practice nurse based on completion of advanced educational program.

T. **Physician Assistant-** a person licensed as a physician assistant by the Texas State Board of Physician Assistant Examiners.

U. **Practitioner/Provider-** a physician, dentist, podiatrist or any other person appropriately licensed under the laws of the state of Texas to provide patient care services within the scope of the license.

V. **Scribe-**an un-licensed person who enters information into the health record at the direction of a physician or licensed independent practitioner.

W. **Inpatient**- A patient whose condition requires "admission" to a hospital and at least one overnight stay.

X. **Outpatient**- (Is sometimes called Ambulatory) A patient who receives care without being admitted to a hospital and does not require an overnight stay.

II. ELECTRONIC HEALTH INFORMATION ACCESS

Authorized users may access electronic health information using the Patient Portal in accordance with the Electronic Health Information Access Attachment VI.

III. MEDICAL RETENTION AND DESTRUCTION

The Health Information Management Department retains and destroys health record information according to federal and state guidelines.

Destruction criteria are as follows:

A. **Inactive Records**: Patient records with no activity for 10 or more years and at least 21 years of age.

B. **Active Records:** Patient records with activity within the past 10 years.

C. **Adult Charts:** The health record of any patient may be destroyed on or after the tenth (10^{th}) anniversary of the patient's last date of treatment.

D. **Pediatric Charts:** If the patient was under eighteen years old when he/she was last treated, the record may not be destroyed until the date of the patients twenty-first (21^{st}) birthday or after the tenth (10^{th}) anniversary of the date on which he/she was treated, Whichever date is later in accordance with the Records Retention Schedules.

E. Records that cannot be destroyed: Include records of matters in litigation, those that have been requested by Legal Services to be placed in a "sensitive" status ("legal hold") or records with a permanent retention requirement. In the event of a lawsuit, legal hold or government investigation, the applicable records that do not have a permanent retention requirement shall not be destroyed until the lawsuit or investigation has been completed, or the legal hold released by Legal Services. Upon notification by legal Services that the litigation or investigation has been completed or the legal hold released, the non-permanent records may be destroyed in accordance with established record retention schedules.

University Health records must be destroyed in a manner that ensures the confidentiality of the records and renders the information no longer recognizable and cannot be reconstructed. The approved methods to destroy University Health records include, but are not limited to shredding, burning, pulping, and pulverizing. A Certificate of Destruction form must be approved and signed by the appropriate management staff and the Health System's Records Management Officer prior to the destruction of records. University Health records cannot be placed in trash receptacles.

IV. Health Record Content and Completion Requirements

Unless there is a pre-approved exception by the University Health Chief Information Officer, all University Health record entries must be transcribed, dictated or typed directly into the University Health electronic medical record using black ink only. Documentation must follow current regulatory accreditation standards and be in accordance with established electronic health record content and timeline requirements (See Attachment I- Electronic Health Record Content Requirements and Attachment IV- Electronic Health.

V. DICTATION AND TRANSCRIPTION

Dictated documents must be transcribed, reviewed, approved and signed by the author. Documents dictated but not transcribed and available in the Health record within established documentation

timelines, will not meet the intent of regulation standards. Dictation is the responsibility of the treating provider and may not be delegated.

VI. USE OF CLONED DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD

The Electronic Health Record environment allows the function of copying and pasting information from one source to another. Providers must use this function with caution, as documentation should always be recorded for each individual patient encounter. When copying and pasting information, the information must be evaluated and validated in accordance with Attachment II.

VII. RELEASE OF HEALTH INFORMATION

University Health will release patient information in the format requested and in accordance with University Health policy on Uses and Disclosures of Protected Health Information. The methods for releasing health records will include electronic access through a Web based method, giving patient access to electronic health information. When applicable, the written consent of the patient, or legal guardian of a minor or an incompetent adult, will be required for the release of medical information to any person, agency, or facility, including practitioners and other hospitals, unless otherwise specified by law. University Health will respond to requests within Fifteen days state mandate, and charge a reasonable fee for provision of medical records to requestors in accordance with state law.

VIII. OWNERSHIP AND CONTROL OF RECORDS

Health records are the property of University Health and may only be removed from University Health jurisdiction and safekeeping in accordance with a court order, subpoena, or statute. No one may falsify or inappropriately alter information in the health record, to include electronic devices containing health information.

IX. Information Entered By a Scribe-(Attachment III).

X. Copy and Paste Guidelines-(Attachment II).

XI. Health Record Content Timelines-(Attachment IV).

XII. Health Record Content-(Attachment I).

XIII. Release of Information-(Attachment V**).**

XIV. Electronic Health Information Access-(Attachment VI).

REFERENCES/BIBLIOGRAPHY:

The Joint Commission 2022 Hospital Accreditation Standards 2017

Bylaws of the Medical-Dental Staff, University Health.

TEX. HEALTH & SAFETY CODE §§ 241.151 et seq. 2018

TEX. OCC Code ANN. §§ 4495b-1 (Vernon 2004)

VHA Handbook 1907.01 (August 25, 2006) pages 27 – 29
Amatayadul, Margaret, Mary Brandt, and Michelle Dougherty "Cut, Copy, Paste: EHR Guidelines" Journal of AHIMA 74, no. 9 (October 2003): 72, 74

Center for Medicare and Medicaid Services Teaching Setting Guidelines 2022

University Health Policy No. 2.0802, Information Asset Security/Use.

University Health Policy No. 2.14.0, Uses and Disclosures of Protected Health Information.

University Health Policy No. 10.09, Consultative Services, 03/10/2017.

The Joint Commission Position on the Use of Scribes, April 2022

Downtime Epic Procedure

OFFICE OF PRIMARY RESPONSIBILITY:

Senior Vice President/Chief Revenue Officer