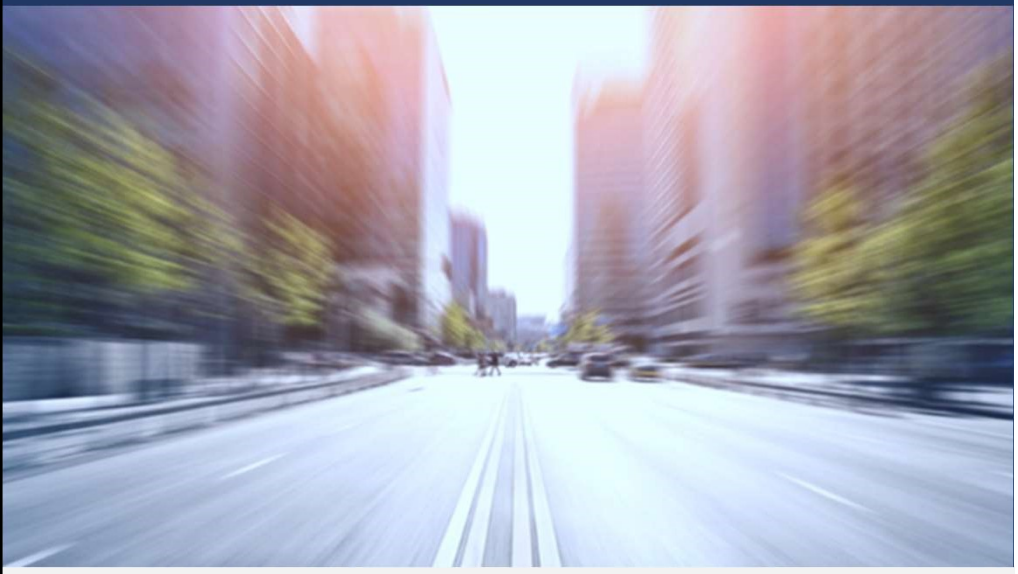
Secure PHI Transfer Solutions & Technology



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DRS vs. LHR – what we need to know and why

May 21, 2020, 2:00 – 3:00 pm ET

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VP, Compliance and Education for RRS Medical

Agenda

Note: This is not meant to be legal advice. Consult with your legal team to ensure compliance with organizational standards.

- Compare and contrast Legal Health Records (LHR) and a Designated Record Sets (DRS)
- Understand the current and potential importance with interoperability
- Identify tools that could help ID and document LHR and DRS

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What do you do now??

Request for ‘any and all’ (Discoverable)

- What do you do to clarify?
- What do you send?
  - —Billing records?
  - —E-mails/patient communication?
- Where - is process documented?
  - —Is information missed in ‘certified complete’
  - —Consistency?
  - —Audited?
  - —Documentation of Education

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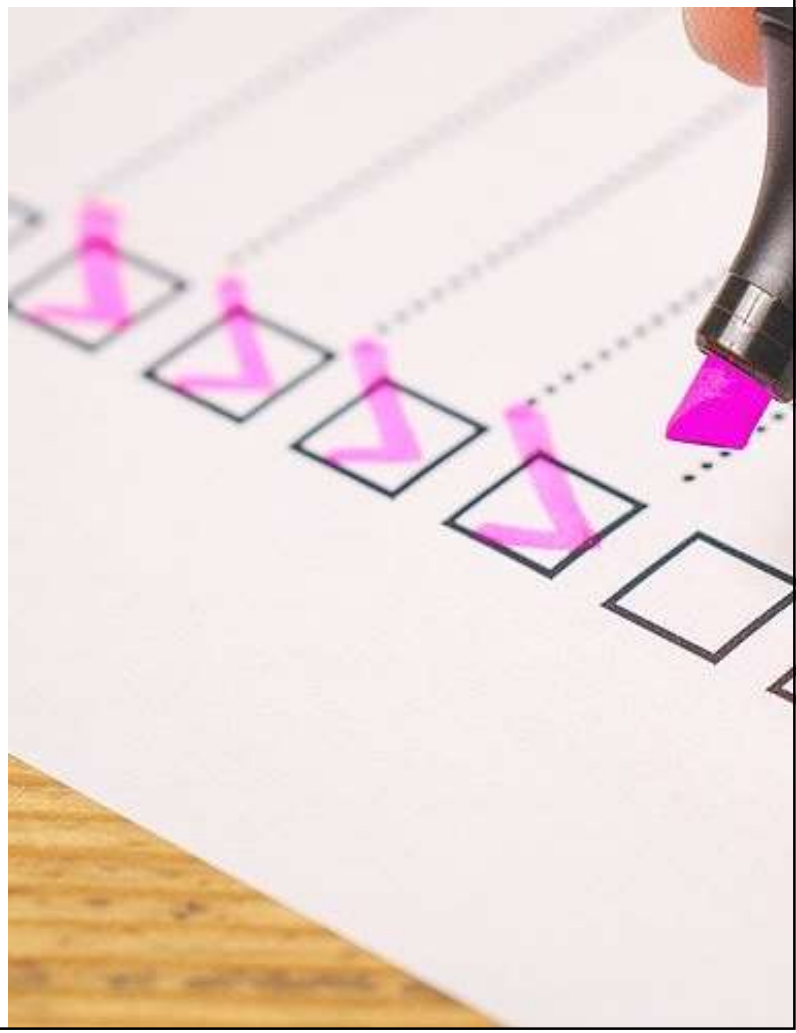
What needs to be in place….

No ‘one-size-fits-all’ program available ☹

- Pre-planning for requests to HI is necessary (especially w/interoperability)
- Use an organized methodology to define your LHR and DRS for routine disclosure
- Develop, Document and Distribute corresponding Policies & Procedures
- Educate Educate Confirm Educate



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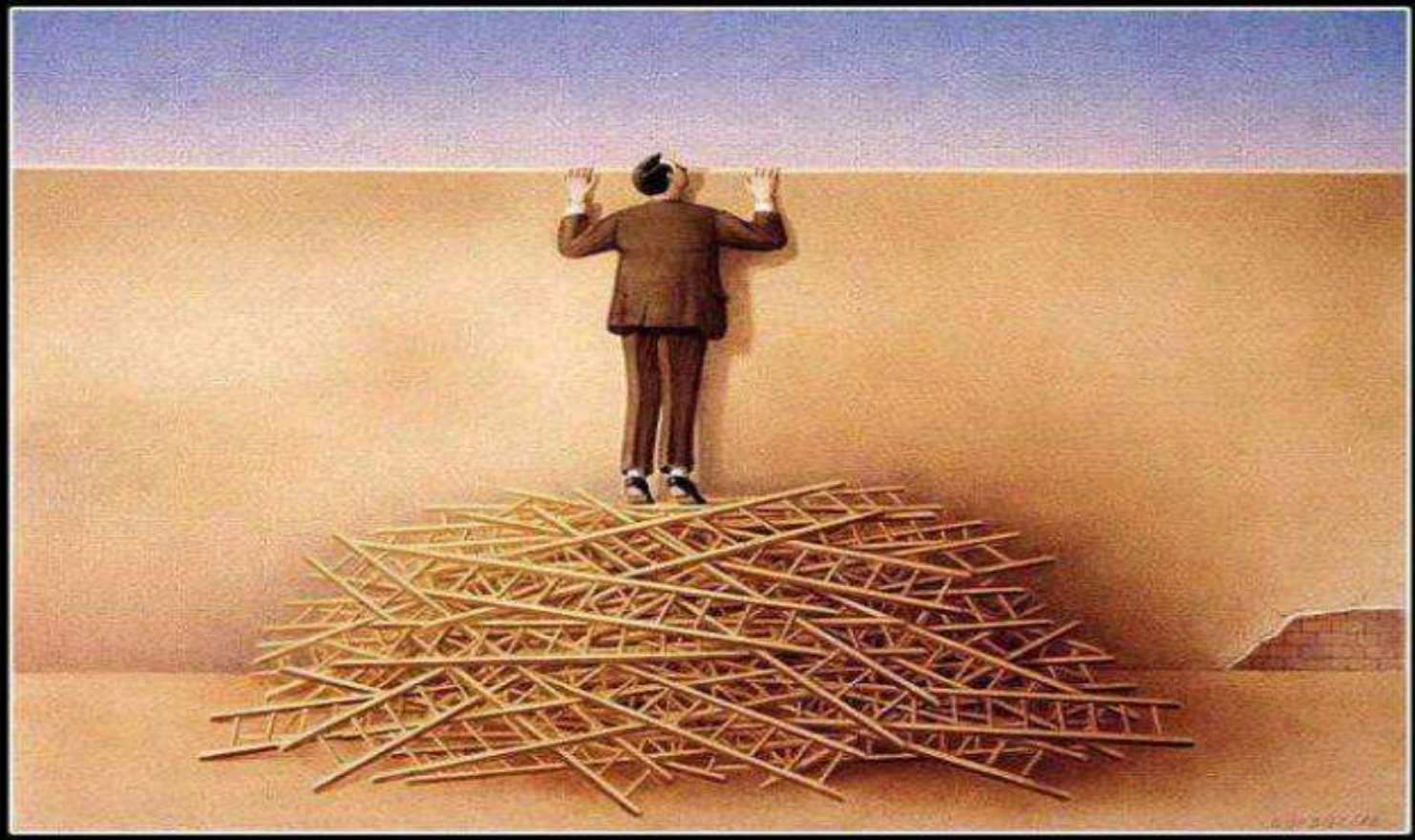
It doesn't matter how many resources you have.

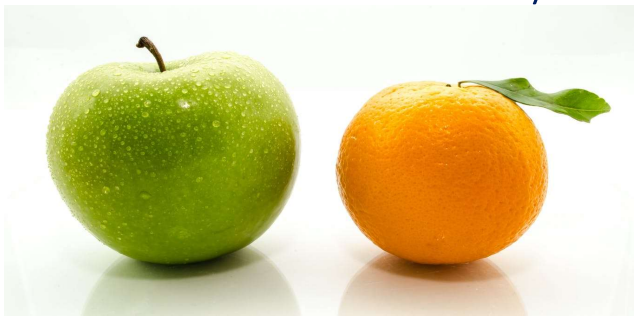


If you don't know how to use them,
it will never be enough.

What is the LHR and DRS?

- Open to interpretation – needs to be defined by each organization
  - —No statutory definition for 'Legal Health Record'
  - —Often used synonymously
  - —Often overlap in both sets
  - —Need to define for yourself vs. OCR

- Complicated by the movement to electronic records with fragmentation of data and documents across healthcare systems, including hybrid with other EHR's and/or paper records
- Healthcare attorney's are becoming more aware of electronic records and eDiscovery rules,



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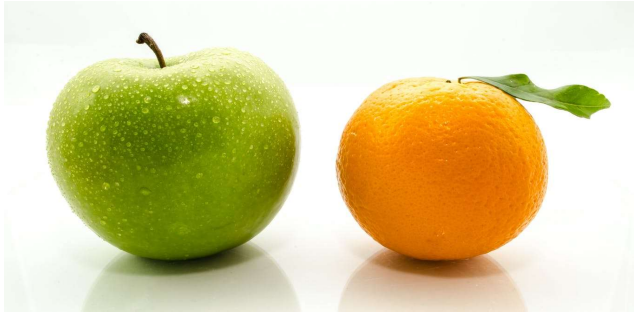
What is the LHR and DRS?

- DRS – basically information used to make treatment decisions about a patient, including info created by provider
  - —Support revenue, research, business decision making, legal testimony….

- May not be all records with PHI – need to determine (in all formats)
  - —Records from other providers?
    - Keep? If so, keep cover sheets and other info
    - Destroy?
    - Determine by use or not? VERY COMPLICATED –by provider = BAD idea
  - —Where is 'original'
  - —Labs and other diagnostics (report, films, video, digital, etc.)
  - —'Paper' with written documentation
  - —Financial/billing info?



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HIPAA Privacy Rights - DRS

1. Right to confidential communication
2. Right to access, view and receive copies of their PHI contained within the Covered Entities **DRS (Designated Record Set).** Exceptions: Psychiatric, Research
3. Right to request an amendment to their PHI (Protected Health Information) within **DRS**
4. Right to request restrictions on disclosure of PHI for operational / payment reasons, not treatment within **DRS**
5. Right to control PHI use for marketing, sales and research\
6. Right to be notified of privacy breaches
7. Right to be notified of the CE's privacy practices
8. Right to receive an accounting of disclosures from their **DRS (Designated Record Set)**
9. Right to file a complaint with OCR (Office for Civil Rights)

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DRS HIPAA Definition §164.501

Designated record set means: (1) A group of records maintained by or for a covered entity that is:

(i) The medical records and billing records about individuals maintained by or for a covered health care provider;

(ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

(iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

For purposes of this paragraph, the term 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

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Common principles in defining LHR/DRS

HIPAA defines DRS as a group of records maintained that may include patient medical and billing records….payer interaction….information used in whole or in part to make care-related decisions.

- Data on any medium and collected and directly used in documenting healthcare or health status
- Generally broader
- Need to ID where data exists
- DRS clarifies rights of individual to access, amend, restrict, etc.

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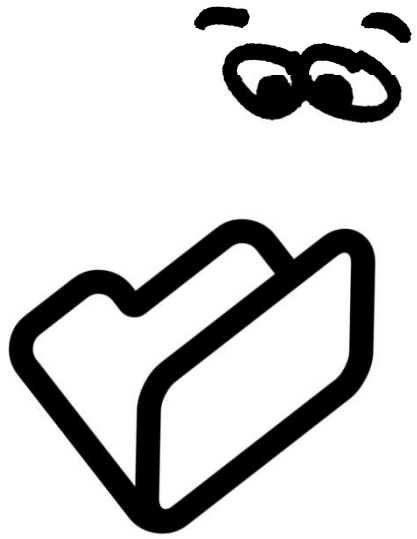
What's usually NOT in the DRS

- Info NOT used to make decisions about patient care
- Copies of documentation – unless updated with notes
- Quality/Compliance/Risk Mgt records including Incident reporting
- Cancer/tumor, birth and death registry
- Appointment and surgery schedules
- Duplicate records
- Pending reports



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Common principles in defining LHR/DRS

- The legal health record is comprised of information that constitutes the official business record of an organization for evidentiary purposes
  - —Vary by organization – need to define
    - External Records?????
  - —Supports patient care, revenue from payors,
  - —Documented support of services provided as legal testimony regarding the patient's illness or injury, response to treatment, and caregiver decisions
- Typically used for formal legal requests for evidence
- Can attest to accuracy, trustworthiness or reliability? that they are complete? or just that you kept them in the normal course of daily business? BEWARE of certification language – CORRECT as needed.

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Data – in both?

- EHR documents – not just ONE thing
  - —Smaller EHR's…does all info upload to main EHR?
  - —Images vs. interpretations (x-ray, Ultrasounds, EKG's, Monitor strips, interoperative px, video's….)
  - —Handwritten documentation/pictures
  - —Pathology (images vs. interpretation)
  - —Lab (office vs. specimen sent to lab
    - (hospital vs. independent)
    - Source of truth?
  - —Texts, e-mails, patient e-charts, phone messages
  - —Telemedicine documentation?
  - —Notes used for dictation

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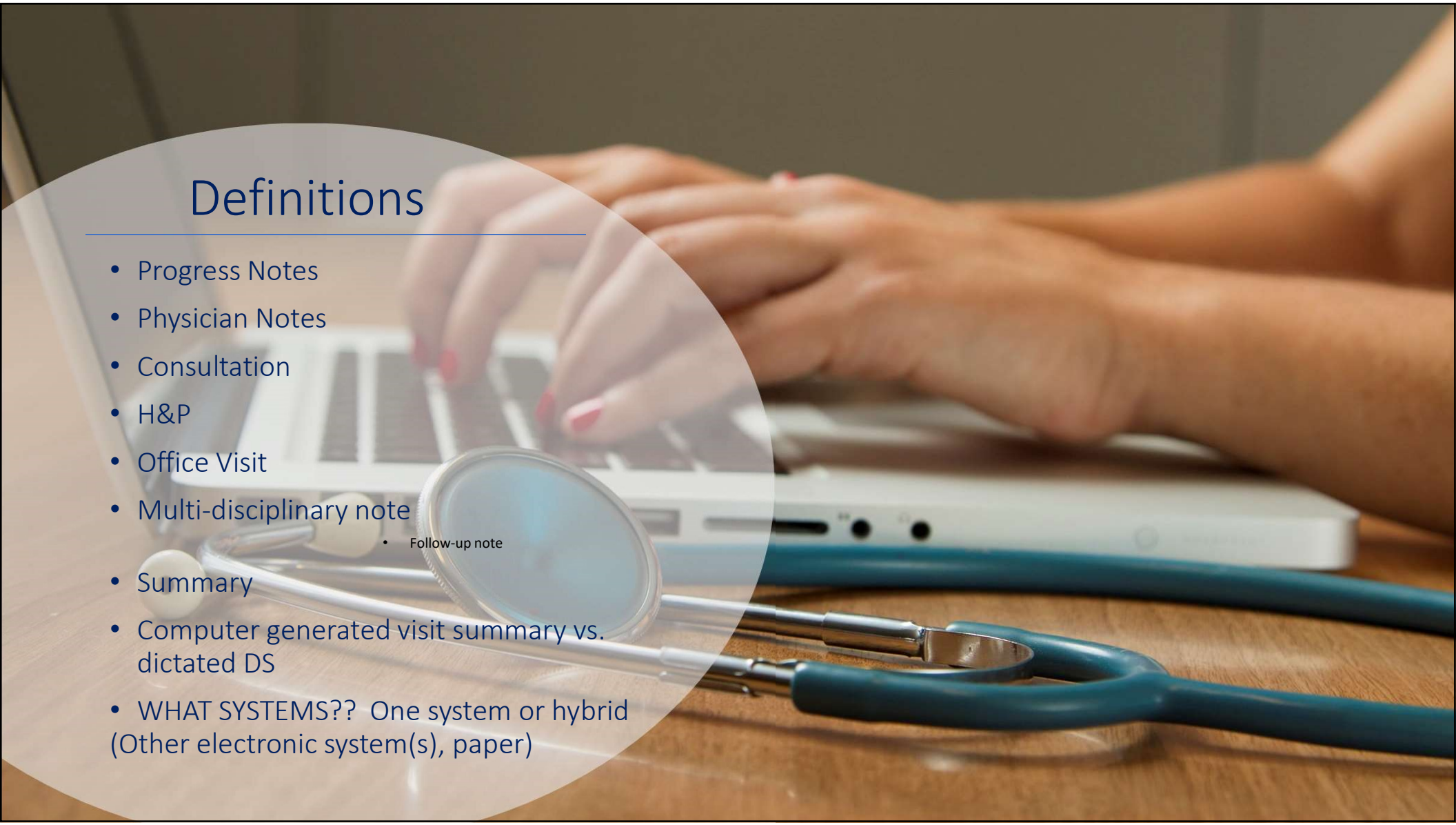

Definitions

- Progress Notes
- Physician Notes
- Consultation
- H&P
- Office Visit
- Multi-disciplinary note
  - Follow-up note
- Summary
- Computer generated visit summary vs. dictated DS
- WHAT SYSTEMS?? One system or hybrid (Other electronic system(s), paper)

AHIMA Definitions

	Designated Record Set	Legal Health Record
Definition	A group of records maintained by or for a covered entity that is the medical and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; information used in whole or in part by or for the HIPAA covered entity to make decisions about individuals.	The business record generated at or for a healthcare organization. It is the record that would be released upon receipt of a request. The legal health record is the officially declared record of healthcare services provided to an individual delivered by a provider.

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AHIMA Definitions

	Designated Record Set	Legal Health Record
Purpose	Used to clarify the access and amendment standards in the HIPAA privacy rule, which provide that individuals generally have the right to inspect and obtain a copy of protected health information in the designated record set.	The official business record of healthcare services delivered by the entity for regulatory and disclosure purposes.

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AHIMA Definitions

	Designated Record Set	Legal Health Record
Content	Defined in organizational policy and required by the HIPAA privacy rule. The content of the designated record set includes medical and billing records of covered providers; enrollment, payment, claims, and case information of a health plan; and information used in whole or in part by or for the covered entity to make decisions about individuals.	Defined in organizational policy and can include individually identifiable data in any medium collected and directly used in documenting healthcare services or health status. It excludes administrative, derived, and aggregate data.

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Sorting Record Types - AHIMA

Some record types belong in both the designated record set and the legal health record. Some belong in the designated record set only. Categorizing record types helps organizations set policies for each record set.

Clinical Record	Source Clinical Data	External Records and Reports
• History and physical • Orders • Progress notes • Lab reports (including contract lab) • Progress notes • Vital signs • Assessments • Consults • Clinical reports • Authorizations and consents • designated record set and legal health record	• X-rays • Images • Fetal strips • Videos • Pathology slides • designated record set and legal health record	• External records referenced for patient care: other providers? records, records provided upon transfer • Patient generated records • Personal health records • designated record set and possibly legal health record*

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Who needs to be involved in decisions?

- Record Custodian and/or HIM (Health Information Mgt/Medical Records)
  - state/federal topics, documentation, CDI, certifies complete and accurate records

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- IT – the how within the EHR's? *HELP* with definitions, storage options, tabs
- Providers (consistency important) - ID external info used in patient care
- Compliance, including privacy and security
- Legal team – what will be requested in litigation, discovery?
- Executive approval
- And then…..COMMUNICATE/EDUCATE your ROI vendor, staff, patients, etc.

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First Steps

- Identify all places where PHI is stored
  - —Electronic systems
  - —Paper (files in drawers?)
  - —Source data used for reports (diagnostics, etc.)
- Determine if information is created by the provider/entity.
- Determine if information is used for patient care.
  - —Classify external records
  - —Follow federal and state regulations (re-release)
- Use a tool to document each element as DRS and/or LHR
- Determine if consistency is needed within organizations (hospital, specialties)

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Document Process

- Definitions
- Documents by name and location/source
- P&P's to respond to;
  - —New documentation requests ('forms' committee)
  - —Litigation requests for records
    - Notification to legal team,
    - certification language,
    - E-discovery, including previous versions, screen vs. print versions, date/time, etc.
  - —Education (updates and ongoing)
  - —Auditing (internal and external)

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Document Process- con't

- Holds
- Requests for amendments?
- Retention (paper and electronic, source data)
  - https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/enforcement/examples/disposalfaqs.pdf
  - Discoverable after destruction date - FOLLOW
  - Copies pulled forward? External records – original destroyed
  - Dumpster Divers - beware
  - Source Data (specimens, strips, images)
- Maintain inventory of document and data in an organizational policy

- Note: There may be times an individual has a legitimate need to access source data

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Tools

* Use only work product from this office Visit Type/Documents	List Documents that are designated as 'Legal Health Record' for routine legal disclosure (includes all billing documentation)			DRS - List work product/documents of the providers/office, diagnostics (office vs. outside) Original/source of truth, other records (used/reference)			
Documents Defined as the LHR For Routine Legal Disclosure Prior to eDiscovery							
Document Name (specify for site) Data Set Report Name	**Document ID #**	**Location in EHR**	**Source System**	**Location of "orginal?"**	**LHR Set**	**HIPAA DRS**	**Comments**
Below are sample document names							
Advanced directives							
Consents							
Demographics							
Problem List							
Medication List							
Diagnostic imaging reports (Internal)							
Labatory results (Internal)							
Nurse/MA documentation							
H&P							
Consults/Letters							
Provider progress notes							
Physician Orders							
Patient Communication - e-mails, phone, mychart							
Bills							
Remits							
Notes							
Release of Information Requests							
External Records							
PT/OT Notes							
Physician							
ED Visits							
Discharge Summaries/Hospital Visit							
Operative Reports							
Pathology							
Substance Abuse/Behavior Health*							
Other: Specify							

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Related…

- Re-releasing information from other providers?*
  - Make sure patient is aware?
- Are turn-around-time requirements met?
  - Patient Requests – interoperability to 3 business days
  - Payers – less time/mailed vs. date of letter (denials?)
    - Save envelopes
  - Are all releases tracked? - What, to whom and when
    - Paper vs. electronic
    - Trending?
    - Rights to Accounting of Disclosures (except TPO)
      - May want to track payers/denials
  - Amendment Request Process? Incorrect info shared?

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Summary

- Know your state and federal laws around Healthcare records (including exceptions for certain dx/tx) , asking for HIM help as needed.
- Decide IF you will keep outside medical records and 'correspondence' as part of your patient record, and if so how to categorize and store.
- If you don't want it as a part of your record, return or destroy the content. Ideally, log and keep the logs for the same retention as your medical records per state law.
- If they are kept, make it a part of your Designated Record Set and Include in your Legal Health Record definition.
- Release it as is now a part of your record.
- Carefully review attestations and certifications for 'complete and accurate'
- Be sure to document your designations with supporting policies and procedures.
- Adjust as Interoperability practices may change how information flows between EHR's and providers.

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My Ask.....

- Evaluate your sites and practice(s) within a week
  - While information is fresh
  - Download Sample/updatable checklists and customize for your organization
  - See resources
  - Make sure any partners can help you ensure best practices

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References

Includes templates for Policies, tracking tools:

AHIMA. "Fundamentals of the Legal Health Record and Designated Record Set." *Journal of AHIMA* 82, no.2 (February 2011): expanded online version.

http://library.ahima.org/doc?oid=104008#.XsQVkS2ZNYg

Dougherty, Michelle; Washington, Lydia. "Defining and Disclosing the Designated Record Set and the Legal Health Record." Journal of AHIMA 79, no.4 (April 2008): 65-68.

http://mycourses.med.harvard.edu/ec_res/nt/F7B52995-FA3A-4572-98AA-D3C910E80DEC/legalrecord.htm

HIPAA

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

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