Department of Veterans Affairs **VHA HANDBOOK 1907.01**
Veterans Health Administration
Washington, DC 20420 **August 25, 2006**

HEALTH INFORMATION MANAGEMENT AND HEALTH RECORDS

1. REASON FOR ISSUES. This Veterans Health Administration (VHA) Handbook is issued to provide basic health information procedures for managing the patient health record.

2. SUMMARY OF MAJOR CHANGES. Procedures have been revised to delineate new and additional specificity for health record documentation requirements, management of the health record, and management of health information.

3. RELATED DIRECTIVE. VHA Directive 1907 (to be published).

4. RESPONSIBLE OFFICE. The VHA Chief Health Informatics Officer is responsible for the contents of this Handbook. Questions may be referred to 760-777-1170.

5. RESCISSIONS. VHA Handbook 1907.1, dated April 15, 2004, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of August 2011.

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HEALTH INFORMATION MANAGEMENT HANDBOOK

1. PURPOSE

This Veterans Health Administration (VHA) Handbook is issued to provide basic health information procedures for managing the patient health record. Procedures have been revised to delineate new and additional specificity for health record documentation requirements, management of the health record, and management of health information.

2. BACKGROUND

a. VHA, by Federal policy, must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient records which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education and research, facilitate VHA performance improvement processes and legal requirements.

b. The most current standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) must be followed, unless specifically otherwise stated.

c. The record must be standardized with regard to content, creation, maintenance, management, processing, and expected quality measures. Electronic capture and storage of patient health information must be implemented to enhance access to patient data by health care practitioners and other authorized users. Electronically stored and/or printed patient information is subject to the same medical and legal requirements as handwritten information in the health record.

3. AUTHORITY

Title 38 United States Code (U.S.C.) 7304(a) is the statutory authority for the Under Secretary for Health to promulgate regulations concerning the custody, use, and preservation VHA of records and papers.

4. DEFINITIONS

The following terms are defined, as used in this Handbook:

a. **Active Record**. An active record is the health record of a patient who is currently receiving VHA authorized care.

b. **Addendum**. An addendum is the inclusion of additional information to a source document.

c. **Administrative Correction.** Administrative correction is the documentation by administrative personnel with the authority to correct information previously captured by, or in, error.

d. **Administrative Record.** See subparagraph 4nn,Health Record.

e. **Advance Directive.** An Advance Directive is a specific written statement made by a patient who has decision-making capacity, regarding future health care decisions. This information is available to instruct the surrogate and practitioners about the patient's wishes when the patient can no longer make health care decisions.

f. **Alerts.** See subparagraph 4ddd, Notifications.

g. **Ambulatory or Outpatient Care.** Ambulatory or outpatient care is defined as health care services provided to patients who are not classified as inpatients.

h. **Amendment.** An amendment is alteration of health information by modification, correction, addition, or deletion.

i. **Authentication.** Authentication may include a written signature, written initials, or electronic signatures. Authentication can be used in the following contexts:

(1) To authorize or validate an entry in a record by a unique identifier that allows identification of the responsible individual;

(2) To corroborate that the source or sender of the data received is as claimed; and

(3) To provide assurance of the claimed identity of the entity or receiver.

j. **Authorization Subscription Utilities (ASU)**

(1) ASU are rules that execute facility policy; they list and describe those categories of personnel authorized to make entries into Computerized Patient Record System (CPRS) and they determine the levels of required authentication. They also provide tools for creating business rules that apply to documents used by members of those authorized personnel groups.

(2) Strict maintenance of ASU and User Class software packages at facilities is required to ensure security and integrity of health record documentation.

k. **Boilerplate.** A boilerplate is a pre-defined Text Integration Utilities (TIU) electronic overprinted form that displays required data elements, whether completed or not; it is filled in with pre-defined text that is associated with an electronic document title. ***NOTE:*** *Use of boilerplates is strongly discouraged.*

l. **Business Rules.** Business rules authorize specific users, or groups of users, to perform specified actions on documents in particular statuses (e.g., a practitioner who is also the expected signer of the note may edit an Unsigned Progress Note). ***NOTE:*** *Sites can modify or add to these rules to meet their own local needs.*

m**. Clinical Applications Coordinator (CAC).** The CAC is a person at a hospital or clinic assigned to coordinate the installation, maintenance, and upgrading of CPRS and other Veterans Integrated and Systems Technology Architecture (VistA) software programs for the end users.

n. **Clinical Reminder.** A clinical reminder is a notation to remind clinicians of an action that is generally required for an individual patient or patients in particular groups.

o. **Cloned Notes.** See subparagraph 4x, "Copy and Paste."

p. **Collateral.** Collateral is a spouse, family member, or significant other who receives services relative to the patient's care.

q. **Community-based Outpatient Clinic (CBOC).** A CBOC is a Department of Veterans Affairs (VA)-operated clinic (in a fixed location), or a VA-funded or reimbursed health care facility or site that is geographically distinct or separate from the parent medical facility.

r. **Compliance.** Compliance is an oversight process, supported by appropriate organizational conditions (culture, regulations, policies, procedures, controls, etc.), which, over time, are most likely to ensure that employee actions and character are consistent with VHA core values. As an oversight process, compliance is used by all levels of the organization to identify high-risk areas, and to see that appropriate corrective actions are taken.

s. **Computerized Patient Record System (CPRS).** CPRS is the primary patient record system that stores information in VistA, or other automated systems using electronic storage. CPRS supports entry of notes and orders, rules-based order checking, and results reporting. Also integrated into CPRS is VistA imaging which permits display of radiological images, Electrocardiograph (ECG) tracings, imaging from other sources, and document scanning.

t. **Confidential.** Confidential is the status accorded to data or information indicating that it is protected for some reason, and therefore it needs to be guarded against theft, disclosure, or improper use, or both, and must be disseminated only to authorized individuals or organizations with a need to know. Patient health records are sensitive due to the requirements of confidentiality as they contain restrictive information about the individual. Per the Security Rule, confidentiality is the property that data or information is not made available or disclosed to unauthorized persons or processes.

u. **Consolidated Health Record (CHR).** See subparagraph 4nn, "Health Record."

v. **Consultant Report.** A consultant report is a signed (authenticated) opinion of the consultant's findings for making a diagnosis or providing treatment advice on a specific patient.

w. **Consultation.** A consultation is a service performed when an opinion or advice regarding evaluation and/or management of a specific problem is requested.

x. **Copy and Paste.** Copy and paste are duplicating selected text or graphic(s) and inserting it in another location, leaving the original unchanged.

y. **Crises, Warnings, Allergies and/or Adverse Reactions, and Directives (CWAD).** CWAD are displayed on the Cover Sheet of a patient's computerized record, and can be edited, displayed in greater detail, or added to (see subpar. 4jjj, Patient Postings).

z. **Delinquent Record.** A delinquent record is an incomplete record that has not been finished within the timeframe specified in the facility's medical staff By-laws, rules, and regulations.

aa. **Demographic Data.** Demographic data is information used to identify an individual such as name, address, gender, age, and other information specifically linked to a specific person.

bb. **Dialog Template.** See subparagraph 4ooo, Point and Click Template.

cc. **Document Definitions.** Document definitions are a subset of TIU that provide structure for electronic documents, by organizing the documents into a hierarchy of document classes and titles that inherit characteristics from the higher levels, Class and Document Class. They also allow the creation and use of boilerplate text and embedded patient VistA database objects into electronic templates.

dd. **Domiciliary.** A domiciliary is a residential rehabilitation program that provides short-term rehabilitative and long-term health maintenance care for veterans who require minimal medical care.

ee. **Electronic Signature.** An electronic signature is a computer data compilation of any symbol or series of symbols executed, adopted, and/or authorized by an individual to be the legally binding equivalent of the individual's handwritten signature.

ff. **Electronic Signature Block.** The electronic signature block is a field that prints underneath the name of the author of a document that designates the position of the individual at a facility.

gg. **Encounter.** An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating, and/or treating the patient's condition (adapted from American Society for Testing and Materials (ASTM), 1999, p. 2).

hh. **Erroneous Entries.** Erroneous entries are incorrect data within the content of a note or are information entered on a wrong patient document.

ii. **Extended Care.** See subpar. 4eee, Nursing Home Care**.**

jj. **Facility.** Facility includes a hospital, medical center, nursing home, domiciliary, outpatient clinic, and/or CBOC (satellite clinic), unless otherwise specified.

kk. **Fee Basis Record.** A fee basis record is a record of treatment by non-VA health care providers authorized and paid for by VA.

ll. **Fellows.** See subparagraph 4uuu, Resident.

mm. **Health Information Administrator or Manager**. A Health Information Administrator or Manager is the professional title of practitioners, usually certified by the American Health Information Management Association (AHIMA), with recognized health information management credentials, who have primary responsibility for the management of the health record and health information program, computer-based or otherwise. ***NOTE:*** *Henceforth the Health Information Manager is referred to as a health information professional.*

nn. **Health Record.** A health record includes the electronic medical record and the paper record, combined, and is also known as the legal health record. A health record can be comprised of two divisions, which are the:

(1) **Health Record.** This is the documentation of all types of health care services provided to an individual, in any aspect of health care delivery. It includes individually identifiable data, in any medium, collected and directly used in and/or for documenting health care. The term includes records of care in any health-related setting used by health care professionals while providing patient care services, to review patient data or document their own observations, actions, or instructions. The health record includes all handwritten and computerized components of the documentation.

(2) **Administrative Record.** This is an official record pertaining to the administrative aspects involved in the care of a patient, including demographics, eligibility, billing, correspondence, and other business-related aspects.

oo. **Health Record Review.** Health record review is the process of measuring, assessing and improving the quality of health record documentation; i.e., the degree to which health record documentation is accurate, complete, and performed in a timely manner. This process is carried out with the cooperation of relevant departments or services. The function includes the oversight of the development of document titles, computerized templates, overprinted forms, order sets, boilerplates, and note titles for standardization in the health record.

pp. **Health Summary.** Health summary is the compilation of components of patient information extracted from other VistA applications.

qq. **Inactive Record.** An inactive record is the record of a patient who has not received VHA authorized health care in a 3-year period.

rr. **Incomplete Record.** An incomplete record is a patient record that is missing content, reports, and/or authentications, as defined by medical staff By-laws and/or facility policy.

ss. **Inpatient.** An inpatient is a recipient of medical services who is admitted to a VA facility and receives health care services, room, board, and continuous nursing service in a unit or area of the hospital where patients generally stay overnight. ***NOTE:*** *This excludes admission for observation.*

tt. **Inter-service and/or Inter-ward Transfer.** Inter-service and/or inter-ward transfer is the formal transfer of an inpatient during an episode of inpatient care from one nursing care unit, clinical service, or supervising practitioner to another.

uu. **Legal Health Record.** The legal health record is the documentation of the health care services provided to an individual in any aspect of health care delivery by a health care provider organization. The legal health record is individually-identifiable data, in any medium, collected and directly used in and/or documenting health care or health status.

vv. **Lodgers.** Lodgers are persons who are housed in the facility for non-medical purposes and who are not receiving health care services while lodged; they are not considered inpatients. Nursing home beds may not be used for lodgers.

ww. **Long-term Care.** See subparagraph 4eee, Nursing Home Care.

xx. **Master Patient Index.** VHA's Master Patient Index (MPI) is the enterprise-wide database that uniquely identifies all active patients who have been admitted, treated, or registered in any VHA facility, and assigns a unique identifier to the patient. The database contains patient-identifying information and correlates a patient's identity across the enterprise, including all VistA systems and external systems, such as the Federal Health Information Exchange (FHIE) at any VHA facility since 1996. ***NOTE:*** *At some point in the future, the database may also incorporate persons other than patients, including employees and providers and may be used throughout VA to uniquely identify persons.*

yy. **Medical Record.** See subparagraph 4nn, “Health Record.”

zz. **Medical Staff Member.** Medical staff members are physicians and dentists, or other licensed individuals, permitted by the health care facility's By-laws to provide patient care services independently, i.e., without supervision or direction.

aaa. **National Patient Care Database.** The National Patient Care Database (NPCD) is VHA’s principal national repository of patient care data. NPCD is a patient-centered, relational database (a data warehouse) that receives encounter data directly from VHA clinical systems via Health Level 7 messaging. It holds records of all VHA outpatient encounters since October 1996 and all inpatient admissions since October 1998.

bbb. **Need to Know.** Need to know is access to health information by authorized clinical or administrative users based on the user's role and a specific reason the information is needed to perform the user's job function.

ccc. **Note Title.** The note title is the designation given to an electronic document in CPRS or a paper form that enables a user to retrieve information from the health record.

ddd. **Notifications.** Notifications are electronic messages that provide information or which prompt staff to act on a clinical event. Clinical events, such as unsigned or un-cosigned documents, critical laboratory value, or a change in orders, trigger a notification to be sent to all recipients identified by the corresponding package (Laboratory, CPRS, Radiology, etc.). ***NOTE:*** *In CPRS, notifications are located on the bottom of the Patient Selection screen. In VistA, notifications are located with a prompt "View Alerts" when the user logs onto the system.*

eee. **Nursing Home Care.** Nursing home care consists of a dynamic array of services, such as, but not limited to: short stay skilled nursing, rehabilitation, hospice or an array of longer stays such as dementia or maintenance care for veterans who have sufficient functional impairment and/or nursing and medical needs that can not be provided in other non-institutional settings. Short-stay nursing home care is for admissions that are 90 days or less, and long-stay is for admissions greater than 90 days.

fff. **Observation Status or Patient.** An observation patient is one who presents with a medical condition, with a significant degree of instability or disability, and who needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. An observation patient can occupy a special bed set aside for this purpose, or a bed in any unit of a hospital, i.e., urgent care, medical unit. These types of patients need to be evaluated against standard inpatient criteria. These beds are not designed to be a holding area for emergency rooms. The length-of-stay in observation beds must not exceed 23 hours and observation patients are not considered inpatients. ***NOTE:*** *Routine post-surgery recovery is not observation.*

ggg. **Outpatient.** An outpatient is a recipient of medical services who is not admitted to a bed.

hhh. **Patient.** A patient is the recipient of VHA-authorized care. Veterans admitted to nursing home care units may also be referred to as “residents”. For the purposes of this document, “patient” will include reference to nursing home residents.

iii**. Patient Care Encounter (PCE).** PCE is a data repository that captures clinical data resulting from ambulatory care patient encounters.

jjj. **Patient Postings.** Patient postings are a component of CPRS that includes messages about patients; it is an expanded version of CWAD.

kkk. **Patient Record.** See subparagraph 4nn, Health Record.

lll. **Patient Treatment File (PTF).** PTF is an Automatic Data Processing (ADP) system for inputting, maintaining, and presenting personal, demographic, and clinical data related to care and treatment episodes of individuals who are patients or members:

(1) In VA hospitals, domiciliaries, nursing care units, and restoration centers, or

(2) Are provided care or treatment under VA auspices in a non-VA hospital or non-VA nursing home.

mmm. **Perpetual Medical Record (PMR).** PMR are specific documents on specific patients from inpatient episodes of care that were maintained at the facility after retirement of the health record. Documents originally included: the autopsy, if appropriate; discharge summaries; pathology reports; operation reports; and the most recent VA Form 10-10, Application for Medical Benefits. Health records are no longer perpetualized. ***NOTE:*** *On August 17, 1992, the National Archives and Records Administration granted approval to discontinue the creation of PMR.*

nnn. **Person Class.** Person class is a profession and/or occupation code defined by Medicare that is assigned to individual providers. It reflects training, licensure, and scope of practice for that individual. Person Class associations are part of the minimum data set reported to the NPCD.

ooo. **Point and Click Template.** ***NOTE:*** *Also referred to as a Dialog Template.* Point and Click Templates are only available in the Graphical User Interface (GUI) version of CPRS; they permit rapid entry of information for Progress Notes and Consult Requests through the use of radio buttons, check boxes, and free-text fields. These templates are used with any appropriate note title; only the selections made within the dialog template appear in the note.

ppp. **Practitioner**

(1) **Licensed Practitioner.** A Licensed Practitioner is an individual at any level of professional specialization who requires a public license and/or certification to practice the delivery of care to patients. A practitioner can also be a provider.

(2) **Licensed Independent Practitioner.** A Licensed Independent Practitioner is an individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually-granted clinical privileges.

(3) **Non-licensed Practitioner.** A non-licensed Practitioner is an individual without a public license or certification who is supervised by a licensed and/or certified individual in delivery of care to patients. Physician residents may be licensed or non-licensed practitioners, but must be supervised by a supervising practitioner when functioning as part of an accredited residency training program.

(4) **Supervising Practitioner.** Supervising practitioner refers to licensed, independent physicians, dentists, podiatrists, and optometrists, regardless of the type of appointment, who have been credentialed and privileged at VA medical centers in accordance with applicable requirements.

(5) **VA Special Fellow.** The term VA Special Fellow refers to a VA-based physician or dentist trainee who has enrolled in a VA Special Fellowship Program for additional training, primarily in research. Physicians in VA Special Fellowships have completed an ACGME-

accredited core residency (medicine, surgery, psychiatry, etc.) and may also have completed an accredited sub-specialty fellowship. They are board-eligible or board-certified, and consequently, are licensed independent practitioners. Dentists in VA Special Fellowships have completed a Commission on Dental Accreditation (CDA)-accredited residency and are licensed independent practitioners. All VA Special Fellows must be credentialed and privileged in the discipline(s) of their completed (specialty or subspecialty-training) programs. VA Special Fellows may function as supervising practitioners for other trainees, and billing may occur in their name.

qqq. **Provider.** A provider is a business entity that furnishes health care to a consumer; it includes a professionally-licensed practitioner who is authorized to operate within a health care facility.

rrr. **Query Form.** A query form is a written communication tool sent by clinical coding personnel to a physician when medical record documentation is unclear or conflicting.

sss. **Redact.** Redact is to remove, hide from view and/or obliterate those parts of an otherwise releasable document that contains individual identifiers or other information that the Government is authorized or mandated to withhold under applicable provisions of the Freedom of Information Act, Privacy Act, or other applicable confidentiality provisions, such as 38 U.S.C. 7332.

ttt. **Referral.** Referral is a request to evaluate and assume the responsibility for care.

uuu. **Resident.** The term 'resident' refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties, e.g., internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), dentistry, podiatry, or optometry, and who participates in patient care under the direction of supervising practitioners. ***NOTE:*** *The term "resident" includes individuals in their first year of training often referred to as "interns" and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as "fellows" by some sponsoring institutions.*

vvv. **Resident Assessment Instrument Minimum Data Set (RAI MDS).** Standardized instrument specifically designed for nursing home initial assessment, regular assessment and treatment planning. Use of the electronic version of the RAI MDS is required for all nursing home admissions.

www. **Retired Record.** A retired record is a record stored off site at an authorized records and storage facility, or archived to electronic storage medium.

xxx. **Retract.** Retract is to withdraw, call back, or indicate an item when validity and/or integrity is no longer in place.

yyy. **Scan or Scanning.** To scan is to digitalize documents and data via imaging and/or pictorial technology.

zzz. **Information Security.** Information security is protecting information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide:

(1) **Integrity**, which means guarding against improper information modification or destruction, and includes ensuring information non-repudiation and authenticity;

(2) **Confidentiality,** which means preserving authorized restrictions on access and disclosure, including means for protecting personal privacy and propriety information; and

(3) **Availability,** which means ensuring timely and reliable access to, and use of, information

aaaa**. Templates.** See subparagraph 4nnn, Point and Click Template. Templates can also include overprinted paper health record documents.

bbbb. **Terminal Digit (TD) Order.** TD order is the filing system for the health record system; it is a method of filing in which a number is divided into two digit pairs and read in those pairs from right to left rather than left to right for filing purposes.

cccc. **Telemedicine.** Telemedicine is telecommunications technology as a medium to provide medical services to sites that are a distance from the provider. Telemedicine telecommunications link providers and patients together from diverse geographic locations, and they transmit text and images for medical consultation and treatment.

dddd. **Text Integrated Utilities (TIU).** TIU is a VistA document management application. TIU documents include, but are not limited to: discharge summaries, progress notes, operative reports, and consult reports.

eeee**. Update.** An update is current information entered in place of existing data, for example, an address change. Data meant to be frequently updated is considered to be transient, i.e., by nature, bound to change.

ffff. **User Class.** User Classes (e.g., attending physician, dentist, optometrist, podiatrist, resident physician, provider, medical record technician, nurse, Chief, Health Information Management Service (HIMS)) and sub-classes are defined in the VistA User Class File (8930). Responsibilities and privileges (for accessing, entering, signing, co-signing, editing, deleting, etc.) are defined through this file.

gggg. **Veterans Equitable Resource Allocation (VERA).** VERA is a patient classification system developed by VHA and used to allocate funds based on classification.

hhhh**. View Alerts.** See subparagraph 4ddd, Notifications.

iiii**. Veterans Health Information Systems and Technology Architecture (VistA).** Software applications previously known as the Decentralized Hospital Computer Program (DHCP).

jjjj. **VA Sensitive Information.** VA sensitive information is all VA data, on any storage media, or in any form or format, which requires protection from inadvertent or deliberate disclosure, alteration, or destruction of the information. The term includes information whose improper use or disclosure could adversely affect the ability of an agency to accomplish its mission, proprietary information, records about individuals requiring protection under various confidentiality provisions, such as the Privacy Act, the Health Insurance Portability and Accountability Act Privacy Rule, and information that can be withheld under the Freedom of Information Act. Examples of VA sensitive information include: individually-identifiable medical, benefits, and personal information; financial, budgetary, research, quality assurance, confidential commercial, critical infrastructure, investigatory, and law enforcement information; information that is confidential and privileged in litigation, such as: information protected by the deliberative process privilege, attorney work-product privilege, and the attorney-client privilege; and other information, which, if released could result in violation of law, harm, or unfairness to any individual or group; or could adversely affect the national interest, or the conduct of Federal programs.

5. PRIVACY, CONFIDENTIALITY, AND INFORMATION SECURITY

a. **Authority**

(1) The privacy and security of patient information stored in any media must be protected in accordance with, but not limited to, the Privacy Act of 1974, Freedom of Information Act, Federal Information Security Management Act, Office of Management and Budget (OMB) Circulars A-123 and A-130, VHA Directive 6210, Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title 45 Code of Federal Regulations (CFR) Parts 160 and 164, VHA Handbook 1605.1 and JCAHO standards.

(2) In accordance with the Privacy Act and VHA Directive 6210, Automated Information Systems (AIS) Security, local safeguards must be established concerning patient record security and confidentiality.

b. **Confidentiality**

(1) All staff with access to patient information in the performance of their duties are informed of responsibilities in maintaining the confidentiality of patient information. ***NOTE:*** *Emphasis needs to be placed on the annual VHA Privacy Policy training requirement, as well as other applicable privacy awareness education.*

(2) Patient records are confidential regardless of medium. The privacy of patient information must be preserved and the information will not be accessible to, or discussed with, unauthorized persons.

(3) Every employee with access to patient records in any medium is responsible for the proper handling of the patient records. Each employee is accountable for safeguarding patient confidentiality and privacy, and failure to do so may result in disciplinary or other adverse action up to, and including, termination.

(4) VHA employees must transport patient records within the medical center. Where resources are not available, the patient may transport the patient's own health record as long as good judgment is exercised and appropriate measures are taken to ensure confidentiality and integrity. ***NOTE:*** *The use of locked bags is strongly encouraged.*

c. **Access**

(1) Access to health care information is controlled to ensure integrity, to minimize the risk of compromising confidentiality, and to increase reliability.

(2) Access to health records and health record file areas is limited to authorized personnel. Only authorized personnel are allowed to print extractions from the electronic record or to make copies from the paper chart.

(3) Active records must be readily accessible to authorized clinical staff.

d. **Security**

(1) Security measures for authorizing access to the patient's health record must be delineated in local policy.

(2) Only the Chief, HIMS, or designee, can approve the physical removal of original health records from the treating facility.

(3) Health records in file areas and other areas where health records are temporarily stored (clinic or treatment areas, record review areas, quality assurance areas, release of information, etc.) must be locked when responsible personnel are not present to ensure the security of the area and to ensure records are not accessible to unauthorized individuals.

(4) Precautions must be taken by staff to ensure that patient records on computer screens cannot be seen by individuals who do not have a legitimate need-to-know.

(5) All patient-identifiable waste paper, or discarded materials, from any department must be shredded or disposed of in accordance with approved disposal policies and procedures. Locked containers or shredders must be provided in employee work areas for disposal of sensitive patient information.

(6) A disaster plan for protecting and recovering health records damaged or destroyed by fire, flood, or by other means must be in place in accordance with VHA Directive 6210. The disaster plan must include provisions for recovering health care records on different types of storage media. The plan needs to emphasize that the goal is to prevent damage first, and then focus on recovery if records are damaged or destroyed.

e. **Provider to Provider E-mail Communication**

(1) Electronic mail and information messaging applications and systems can only be used for authorized government purposes and must contain only non-sensitive information unless the data, and are protected with a VA-approved encryption mechanism.

(2) For Outlook/Exchange mail, the Office of Cyber and Information Security (OCIS) issues Public Key Infrastructure (PKI) certificates to encrypt communications between a sender and receiver. ***NOTE:*** *Personnel must follow the national PKI policies and procedures issued by 005.* Requests for PKI certificates are to be directed to the local ISO, who typically serves as the Local Registration Authority (LRA) for VAPKI deployment.

f. **Employee Health Records**

(1) The health records of employees are under the management of human resources and are maintained in a separate location from veteran health records. If documented electronically in CPRS, they may be secured utilizing appropriate business rules and note titles to limit access to identified personnel; all employee health records in CPRS must be designated as sensitive.

(2) The records of employees who receive care as a veteran are under the auspices of Health Information Management (HIM) and are maintained with other veteran records. These records may be sequestered in a special location if directed by local policy. The electronic documentation of these records must be secured by identifying them as "sensitive" records in CPRS.

g. **Facsimile**

(1) Information received via facsimile is acceptable and may be included in the patient's health record. Fax machine transmittals must not include drug, alcohol, Human Immunodeficiency Virus (HIV), or sickle cell anemia patient information. The fax machine transmittals must be limited to immediate need to render patient care. All established fax protocols must be strictly observed.

(2) A confidentiality statement must be attached to the cover page when transmitting individually-identifiable health information. For example, when transmitting outside VA:

"The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled and in accordance with agency destruction and retention requirements. If you are not the intended recipient, you are hereby notified that any disclosure, copying, or distribution is strictly prohibited as this information is protected by Federal Privacy law (e.g., HIPAA Privacy Rule). If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents."

NOTE: *See VHA Handbook 1605.1, Privacy and Release of Information, for more information.*

h. **Compliance.** There must be periodic review, or audit, of access to patient records to ensure compliance with record privacy and confidentiality standards.

6. GENERAL GUIDELINES

a. **Responsibility.** Administrative management of health records is the responsibility of HIM. Clinical management of health records is ultimately the responsibility of the Chief of Staff, or designee, with each clinician and professional service contributing to the content of the patient record.

b. **HIM Professional**

(1) Health information professionals serve as a resource to the facility and are active in the facility's decision-making activities related to health information systems, health record content, authentication of record entries, correction of documentation errors, documentation approaches, information system backup, and disaster recovery. Health information professionals play an active role along with administration and the clinical staff in the development of future strategies for initiatives based on the organization's health information. The health information professional may serve as the Privacy Officer.

(2) Health information professionals at the facility level are responsible for planning, managing, advising, and directing the health information program in accordance with applicable Federal laws, facility By-law, VHA policy, JCAHO standards, the Rehabilitation Accreditation Commission (CARF) formerly known as the Commission on the Accreditation of Rehabilitation Facilities, and other regulatory and accrediting agencies. Health information professionals at the facility level are responsible for creating and monitoring systems to ensure accurate, timely, and complete health records, in accordance with VHA policy and JCAHO health information protocols. The health information professional is involved in all decisions, both technical and administrative, that impact, define and/or control access to patient health records.

c. **Health Record Creation.** A separate, unique health record is created and maintained for every individual assessed or treated by VHA, as well as those receiving community or ancillary care at VHA expense. It is not required to print and file paper documents from electronic media for active records.

d. **Types of Patients.** Patient records must be maintained on the following:

(1) The inpatient admitted to any level of care (hospital, domiciliary, Nursing Home Care Unit (NHCU)).

(2) The applicant who is found not to be in need of care or ineligible for care.

(3) The individual who is dead on arrival (authorized and/or unauthorized admission).

(4) The person who is rendered ambulatory care for humanitarian reasons.

(5) The veteran whose State Home or non-VHA hospital care or treatment is provided at VHA expense.

(6) The veteran whose community nursing home care is provided at VHA expense.

(7) The veteran examined for possible exposure to herbicides (includes Agent Orange), radiation, asbestos, and environmental contaminants.

(8) Veterans undergoing Compensation and Pension (C&P) or Persian Gulf examinations.

(9) The individual placed in pre-bed care, on ambulatory care and/or outpatient status or on fee-basis status.

(10) The non-veteran patient who is evaluated and/or treated in a VHA facility under a sharing agreement (e.g., TRICARE, Civilian Health and Medical Program of VA (CHAMPVA)).

(11) A collateral or family member of a veteran attending individual counseling.

(12) A veteran who is being treated at a CBOC under VA auspices or at VA.

(13) Patients examined for Military Sexual Trauma (MST).

e. **Health Record and/or Health Information Availability.** During the transition from paper health record systems to full implementation of CPRS, there must be a local policy and process that describes how the facility assembles all relevant health information when a patient is admitted to inpatient or nursing home care, seen for a prescheduled or unscheduled ambulatory care visit, or presents for emergency services. In addition, there must be processes in place that ensure health information is available during scheduled and non-scheduled downtime of the computer systems. Health records must contain original signed documents, or electronically-authenticated documents.

f. **Ownership.** The health record and the health information within the health record are property of VA, as specified in 44 U.S.C. § 3301.

g. **Legibility.** Legibility refers to the quality of penmanship used when recording data, including a clear, written signature, as well as content and appearance of dictated, copied, and/or scanned information. Patient safety and the general usefulness of the paper record depend on the legibility and the readability of the entries. Paper entries must be made in black ink to ensure permanent recording. ***NOTE:*** *Handwritten entries are being phased out and need to be limited only to those documents that current technologies cannot yet support.*

h. **Patient Identification.** The patient name, SSN, and date of birth are used to identify the patient. In the event the identity of a patient is unknown and the moniker of John Doe is assigned, a pseudo SSN and the date of birth (DOB) of 1/1/1900 will be used. The patient is then treated as a non-veteran, humanitarian emergency. ***NOTE:*** *If a patient is admitted under an incorrect name, once the name correction is made in VistA, all electronic documentation must*

be linked to the correct patient (see subpar. 7g) including health information in packages other than TIU and CPRS (i.e., laboratory, radiology). Any paper health information must also be corrected to reflect the correctly identified patient.

i. **Language.** All entries must be in English and must conform to acceptable English grammar.

j. **Retention, Disposition, and Transfer**

(1) **Policy.** The retention policy applies equally to both paper and electronic records. VHA health record retention policy is 75 years after the last episode of care. Retention policies and guidelines are detailed in VHA Records Control Schedule (RCS) 10-1. Disposal procedures are set forth in 44 U.S.C. Chapter 33.

(2) **Facility Storage.** Records must be stored at the treating VHA facility for 3 years following last patient activity. Paper records may be retired to the VA Records Center and Vault (VA RC&V).

(3) **Retirement of Records**

(a) Permission may be obtained from the VA RC&V to retire records earlier due to storage space. As of April 1, 2002, new accessions are sent to:

VA Records Center
11693 Lime Kiln Drive
Neosho, Missouri 64850

NOTE: *Printing of electronic and digitized (scanned) records at the time of retirement is not necessary if it can be ensured that the computerized system retention period is consistent with current health record retention requirements, and if there is a quality control process in place to ensure that: electronic and digitized records can be efficiently identified for authorized use; the images are retrievable and legible; and that the integrity of digitized records is maintained.*

(b) Electronic and digitized (scanned) records may not be purged.

(4) **Previous Inpatient and Outpatient Records.** Previous inpatient and outpatient records existing at the facility must be made available upon specific request for treatment purposes. When there is evidence that a record exists at another VA facility, or the VA RC&V, the record must be ordered upon specific request.

(5) **Loaning Health Records.** Health records may be copied, loaned, or transferred to other VHA facilities that have a need for the information in the performance of their duties (treatment, examination, research, adjudication, and other related purposes). ***NOTE:*** *Loaning or mailing original health records is strongly discouraged. Facilities are encouraged to utilize available electronic means for viewing and/or copying for record transfer. If it is necessary to loan or mail original health records, VA Directive 7179 is to be followed sending the records by either Federal Express, Inc. or the U.S. Postal Service (USPS). The sender must track the shipment via the Federal Express Tracking Number when using Federal Express, Inc., or by certified priority*

mail, if using USPS, validating that the record(s) is received the following day. Records must not be sent with a weekend delivery.

(6) **Electronic Viewing.** For most cases where a patient is treated or seen at another VHA facility, the Patient Data Exchange (PDX), Network Health Exchange (NHE) or Remote Data View (RDV), VistA web, or Register Once software must be used to expedite the transfer of needed health information between facilities; however, scanned documents are not yet viewable through these technologies. Facilities must use the PDX encryption feature when transmitting data to other VHA facilities. If additional information is required, it may be copied and sent via overnight mail or fax machine when absolutely necessary.

(7) **Permanent Transfer.** For permanent transfer, all electronic and digitized portions of the health record must be identified, printed, and filed appropriately prior to permanent transfer of the record. ***NOTE:*** *Once scanned documents can be viewed across all VHA sites, printing will no longer be required.*

(8) **External Source Documents.** Only those external source documents that are authenticated may be maintained as part of the patient's VHA permanent health record at the practitioner's written request. Practitioners must indicate which documents need to be retained and limit this to pertinent, present, and/or continued care. A summary progress note written by an appropriate clinician after a review of the external source documents may be used in lieu of filing and/or scanning any external source documents.

(a) Any documents or information filed, maintained, or scanned into a patient's health record, including external source documents, are deemed to be part of the patient's VA health records. These records are subject to all applicable Federal regulations concerning maintenance and disclosure including the Privacy Act of 1974 (5 U.S.C. 552a) and VA confidentiality statutes. Once a document is filed, absent Federal law or regulation to the contrary, it becomes a VA record subject to protection and release under Federal law.

(b) A request to amend an external source document must be referred back to the original source.

k. **Symbols and Abbreviations.** While there is no JCAHO requirement for a list of approved symbols and abbreviations, if they are used in the health record there must be an explanatory legend or standardized list available to decipher their meaning. There must be a list of unapproved symbols and abbreviations which must be made available to all those who make entries in the health record and to others who use health records in the course of their official duties. Symbols and abbreviations are not to be used when documenting final diagnoses and procedures on patients released from inpatient and ambulatory and/or outpatient services.

l. **Forms and Template Management**

(1) A local process for initiating, developing, and approving new electronic templates and overprinted paper health record documents must be established under the auspices of the health record review function.

(2) All internally-generated forms and shared templates that become part of the health record must receive prior approval. Requests for new forms and templates are to be limited to those that can be developed in an electronic format.

(3) As part of the health record review function, proposed templates must be reviewed for legal, policy, regulatory compliance, and ease of use. Requests must be approved prior to implementation.

(4) All components must reflect patient identifier information (full name and full SSN), date of documentation, date of service, and facility name.

(5) VHA paper forms for specific components of the record are no longer mandated; however, they are encouraged to be used as a guideline for developing electronic templates.

m. **Authentication.** Authentication demonstrates that the entry has not been altered. Authentication includes the time, date, signature or initials, and the professional designation of the practitioner (credentials).

(1) Standardized and current electronic signature blocks for all authorized users based on the person class taxonomy file must be maintained at each facility. This ensures non-repudiation and that appropriate billing occurs. Authentication functionality must include the identity and credential and/or professional discipline of author, the date signed, and the time signed, if required. If the title block is used, it needs to accurately reflect the functional position of the user as defined by the service. As employees enter, leave, or transfer to a different position, the person class file and the title block must be edited to appropriately reflect job status. Monitors to ensure person class files are correct must be established at each facility.

(2) In those facilities still in transition to CPRS, a method of identifying the author must be established; e.g., stamps with the printed name and professional designation of the clinician, or a requirement of the clinician to print the clinician's name to ensure legibility. Any initialed entries must be substantiated by at least one entry with the signature of the individual made during the episode of care.

(3) All entries must be recorded and authenticated immediately after the care event or the observation has taken place to ensure that the proper documentation is available. This ensures quality patient care.

(4) Electronic signatures cannot be utilized for Schedule II drug prescriptions for outpatient prescriptions according to the CFR pursuant to Drug Enforcement Agency (DEA) regulations. ***NOTE:*** *At the time the DEA permits such electronic authentication, it will be permitted in VHA health records. Electronic signatures can be utilized for Schedule II drug prescriptions for inpatient prescriptions.*

n. **Authorized Entries**

(1) Policies, procedures and ASU rules must be established at each facility to ensure only authorized individuals document in the health record and that the author(s) and any required

cosigner(s) are identified. ASU rules must be in concert with facility By-laws and facility policy.

(2) Only those individuals authorized by facility policy are allowed to make entries into the health record.

(3) The practitioner who treats a patient is responsible for documenting and authenticating the care provided. Where multiple practitioners treat during the same encounter, additional signers are strongly encouraged (for example, multidisciplinary notes in rehabilitation and psychiatry). Addenda may also be used to facilitate the documentation of multidisciplinary care.

(4) All clinical staff authorized to document in a health record must record in CPRS, except for those instances where technology is not available for electronic entry.

(5) The respective clinical staff, as defined by their scope of practice, must document every episode of clinical care.

(6) Health record entries must be completed, processed promptly, signed and/or cosigned as necessary, and transmitted, filed, and/or uploaded to ensure the information is available for patient care. Health care practitioners are responsible for completing their respective notes within prescribed timelines for patients under their care (see par. 8).

o. **Sensitive Records**

(1) Some specific record types are deemed sensitive and may be maintained under direct supervision of the health information professional, or be flagged as "Sensitive" in VistA, or other facility computerized record repositories. These include, but are not limited to:

(2) VA veteran employee patient records;

(3) Regularly scheduled veteran volunteers;

(4) Individuals engaged in the presentation of claims before VA, including representatives of veterans' organizations, or cooperating public or private agencies, or Administrative Tort Claims; and

(5) Records involved in Administrative Tort Claim activities.

NOTE: *With the concurrence of Information Security Officer (ISO), or designee, similar security measures may be applied to other patient records.*

p. **Complete and Incomplete Records**

(1) **General**

(a) Patient records must be timely, relevant, necessary, complete, and authenticated.

(b) Completeness implies that all required data is present and authenticated; all final diagnoses are recorded without use of abbreviations; and transcription of any dictated information is completed and inserted and/or uploaded into the record.

(c) Health record completion and delinquency policies must be developed and must be consistent with accreditation standards, regulatory requirements, and medical staff guidelines. These policies must:

1. Specify time standards for content, authentication, and completion as required by JCAHO and/or medical center policy.

2. Describe procedures for ongoing monitoring and reporting of individual delinquent records, responsible clinicians, and re-occurring delinquency patterns to the appropriate staff and committees as outlined in the facility By-laws.

3. Define when health record deficiency patterns become part of the individual's (including residents) evaluation and placed in that clinician's credentials file.

4. Address whether or not students in teaching institutions can record in the official record and the accuracy requirements for their entries.

5. Define those entries in the health record by residents, or non-physicians, that require countersignatures by supervising practitioners.

6. Designate how the supervising practitioner records findings or pertinent observations that are not in agreement with the data already recorded; i.e., by an authenticated addendum or separate note.

7. Ensure the presence and authentication of, at least, the following entries when appropriate:

a. History and physical examinations;

b. Operative reports;

c. Diagnostic and therapeutic procedures;

d. Consultations; and

e. Discharge summaries.

8. Ensure that the discharge summary and the operative reports are signed and/or co-signed by the supervising practitioner.

9. Define when an inpatient record becomes delinquent; however, in no case can the time period detailed in the medical staff rules and regulation exceed 30 calendar days. ***NOTE:*** *Completion as close to the date of discharge is strongly encouraged.* To determine delinquency,

note the average acute care health record delinquency rate. This includes records delinquent for any reason. The total average is the total of all quarterly averages ÷ 4.

***NOTE**: The total average is compared to the Average Monthly Discharge Rate (AMD). The AMD is the total number of inpatient discharges in the 12 months prior to survey ÷ 12. This number represents all inpatients (and can include other records such as observation beds, ambulatory surgery, endoscopy, cardiac catheterization, or emergency department. The records included for delinquency counts need to be included in both the numerator and denominator of the calculations.). It does not include any other type of ambulatory or outpatient encounter.*

(2) **Responsibility**

(a) The Chief of Staff, or designee (equivalent), has ultimate oversight responsibility for health record timeliness, accuracy, and completion.

(b) The author of the entry is responsible for completing, authenticating, and correcting any health record deficiencies within the time frame defined by the facility policy or medical staff By-laws.

(3) **Authenticating Documents**

(a) No medical staff member is to be required to authenticate entries that are not the staff member's own in order that a record on an unfamiliar patient may be filed.

(b) A supervising practitioner or medical staff member may, however, summarize a course of treatment based on existing patient record documentation, or review a summary for consistency with existing patient record documentation, if the original supervising practitioner or medical staff member responsible for the patient's care is no longer available to do so. In such cases, a notation must be made in the record to the effect that the summarization (review) is being done from existing documentation in the absence of the supervising practitioner or medical staff member responsible for the patient's care and without personal knowledge of the patient.

(c) The completed summarization must be authenticated and dated by the medical staff member preparing the summary and/or the supervising practitioner.

(4) **Unauthenticated Documents**

(a) Unauthenticated documentation is considered “Incomplete” and, in CPRS, is subject to revision and potential deletion by the author.

(b) Incomplete documents are not to be purged from CPRS.

(c) Facilities must establish policy and procedures to track and complete unauthenticated documentation.

(d) Paper documents must be authenticated prior to document imaging (scanning). Scanning is an administrative process which does not require the document author’s re-authentication.

(5) **Declaring a Record "Complete for Filing"**

(a) An inpatient record is declared "Complete" for the purpose of filing when all required documentation is present. If unusual circumstances prevent proper completion, the record must be referred to the appropriate medical staff committee for review and/or completion.

(b) When the appropriate medical staff committee declares an incomplete record to be filed as complete, the record must be so noted with portion(s) known to be incomplete, and reason(s) normal completion could not be accomplished, and must be documented in an administrative progress note, and signed by the HIM professional, or designee.

(c) A sample statement such as "Approved for filing incomplete on (date) by Medical Staff Committee due to (reason)" may be used to note the record as incomplete. This statement does not legally imply that the signer is validating the contents of the document, but is only administratively completing the health record. This statement must not be used on a routine basis to close records due to the failure of an available physician to sign the documents.

(6) **Preparing Records for Litigation.** Records for litigation with unsigned, or with incomplete entries, must be presented for court in exactly the same manner the records existed at the time the facility received the court order for the records. The same applies for records requested by Regional Counsel. If the facility needs to complete and/or sign the records in order to comply with VHA and facility policy, it needs to be done after providing the unsigned copy to the requestor.

q. **Master Patient Index (MPI)**

(1) A local MPI is maintained on each local VistA system that is a subset of the National MPI. The role of the MPI is to assign a unique identifier to active patients; this unique identifier is used across the system to link patient data. Historically, each site has maintained an MPI within their local VistA system, designated by site. ***NOTE:*** *Prior to implementation of VistA in 1984, facilities had manual MPI card systems.*

(2) Active patients are enumerated at the MPI nationally as information is entered into VistA at local sites. Accuracy of patient demographic data is essential. Patient name, SSN, and DOB are key elements used to uniquely identify patients. Inaccurate entry can mean that a new Integration Control Number (ICN) is generated, when, in reality, the patient already has an existing ICN.

r. **Adverse and Sentinel Events and Close Call Reporting**

(1) Adverse and sentinel events and close call reporting is the reporting, review, or analysis of incidents involving patients that cause harm or have the potential for causing harm. The reporting of such events is prescribed in VHA Handbook 1050.1.

(2) Only factual notation about the incident along with clinical observations, including vital signs of the patient before and after the incident, clinical actions taken, and identification of any staff involved, must be documented in the patient record.

(3) Copies, notes, or documentation of any investigation concerning patients are confidential, privileged, and are not to be filed or become part of the patient's health record.

s. **Fee Basis**

(1) Patient record notations concerning medical fee-basis care must be filed in the ambulatory and/or outpatient care portion of the health record.

(2) The requesting physician must document in the health record a justification for using fee status in lieu of providing staff treatment. Justification for extending short-term, fee-basis services must also be documented in the health record.

(3) Decisions to continue the use of fee basis must be documented in the health record by the reviewing physician.

(4) Copies of reports submitted by physicians and other reports (laboratory, X-ray, etc.) must be filed or scanned in the health record. ***NOTE:*** *Electronic or scanned entry is preferred over paper records.*

(5) Claims for travel expenses must be filed in the administrative portion of the record.

(6) Paid fee claims are retained in the VistA Fee software package, therefore, a paper copy does not need to be filed in the administrative record.

(7) Fee-basis dental records must be filed in the health record. ***NOTE:*** *Documentation requirements for fee-basis dental records are contained in the provisions of M-1, Part I, Chapter 18, Outpatient Care-Fee.*

t. **Research, Clinical Trials, and Experimentation.** Research approved by a VA Research and Development (R&D) Committee and conducted by VA investigators may require access to individual patient health records and/or individually-identifiable health information. In addition, certain research activities may require the creation of health records. ***NOTE****: VHA Handbook 1605.1, VHA Directive 1200, and the VHA 1200 series Handbooks contain additional VHA polices relating to research.*

(1) Health records must be accessible for VHA investigators for preparing and conducting research protocols and pilot studies. Only those records necessary to prepare a research protocol or conduct the approved research may be accessed.

(2) Approval for access to paper or electronic health records for research purposes must be obtained prior to accessing the records. All research protocols and pilot studies must first receive the required approvals from the appropriate R&D Committee and Institutional Review Board (IRB). Once all applicable research approvals have been obtained, the approval for access to the records is through the same process that is required for access for non-research purposes.

(3) Prior to accessing health records or individually identifiable health information, VHA investigators must obtain either a written authorization signed by the individual prior to accessing the individual's health record or obtain a waiver of authorization from the IRB (serving in the capacity of a Privacy Board). Guidance on access and other privacy laws affecting research can be found in VHA Handbook 1605.1. The investigator must also obtain an informed consent for research from each individual whose health records will be accessed if the IRB has not waived the requirement.

(4) If access to health records is needed preparatory to research, it must be in compliance with all applicable privacy regulations and policies; however, it does not require approval from the facility's R&D or the IRB. Information from records obtained during the preparatory to research review may not be used to recruit subjects for the research. Recruitment of subjects is not part of the preparatory to research activity. ***NOTE:*** *See VHA Handbook 1605.1 for further information on polices related to preparatory.*

(5) Once access has been approved, the investigator must retain the IRB approval number with the list of records accessed for the study. The list of required records, along with who is authorized to review them, and the IRB approval forms (including approval of waiver of authorization and consent, if applicable) for all studies, must be kept in a designated file that is readily accessible to the Health Information Manager and others who are required to audit or review such information. These files must receive the same level of security as the other research records.

(6) VHA investigators may obtain and use health, technical, and administrative records from the investigator's facility. When records are to be accessed at the investigator's facility, the investigator must provide sufficient written notice to the Health Information Manager for access or retrieval of records. The notice to access or retrieve records must indicate the reason for the request, the purpose of the review, and the IRB approval number.

(7) If access to health records or databases containing health information located at remote VHA medical or administrative facilities is needed, the investigator must follow all applicable research policies found in VHA Handbook series 1200. Permission for remote access must also be obtained from the Information Security Officer (ISO) of the facility that maintains the records.

(8) A VHA health record must be created or updated for all research subjects who are admitted as in-patients, treated as outpatients, or when research procedures or interventions are used in the medical care of the research subject, or as required in the Office of Research and Development (ORD) 1200 series Handbooks.

(a) A record must also be created when the research requires use of any clinical resources such as radiology, cardiology (e.g., EKG, stress test etc.), clinical laboratory, and pharmacy.

(b) The research intervention may lead to physical or psychological adverse events.

(9) The patient's health record must contain the following information for approved research protocols:

(a) A copy of the signed and dated VA Form 10-1086, VA Research Consent Form, which may include the authorization for data use or disclosure.

(b) A copy of the authorization for data use or disclosure if separate from the research informed consent.

(c) A copy of the initial enrollment progress note and other applicable progress notes.

(d) Information on possible drug interactions and/or toxicity of the pharmaceutical agents that are being administered to the patient-research subject because of the research (i.e., investigational drugs as defined in VHA Handbook 1200.5).

(e) VA Form10-9012, Investigational Drug Information Record, or superseding forms for investigational drugs as required in M-2, Part VII, Chapter 6, or superseding policies.

(f) A copy of any research results that are used for medical care.

(g) Information on all research and experimental interventions including potential risks, indications, and applicable progress notes.

(10) In accordance with VHA Handbook 1200.5, the IRB may determine that the patient record must be flagged. If the IRB does determine that the patient's health record must be electronically flagged in CPRS as participating in a research study, then the health record must:

(a) Identify the principal investigator as well as contact information for a member of the research team that would be available at all times. ***NOTE:*** *The research team must have an appropriate member available (on-call) at all times.*

(b) Contain information on the research study or identify where this information is available.

(11) A method to identify clinic visits solely for research (such as a note title) must be used to differentiate those visits from any other clinic visits. The research titled note may be included in the CWAD alerts. Care also needs to be taken to ensure that research visits (or inpatient care for research) are coded as non-billing events.

(12) Except as listed in the preceding, investigators' research records (Investigators Case History) should not be stored with the patient health record. Research records include: IRB and R&D Committee records, records of all observations, other data pertinent to the investigation, progress notes, research study forms, surveys, questionnaires, or other documentation regarding the study.

(13) When access to patient health records is no longer required, the study has been completed, or when authorization is revoked, the Principal Investigator (PI), or designee, must notify the facility HIM program manager and, if applicable, the ISOs.

u. **Disaster Recovery Plan**

(1) An adequate disaster recovery plan for health records must be established at each facility. Staff must be knowledgeable of the overall plan, as well as their particular responsibility, in the event of natural or man-made disaster impacting normal operations. Focus of the plan needs to include: preparation, response, and recovery with issues for consideration including, but not limited to:

(a) Identification of possible disasters causing interruption of services, such as loss of electricity, flood, fire, or earthquake;

(b) Identification of key services (work processes) required to support patient care until normal operations can be resumed, and the development of contingency plans to provide these services;

(c) Contingency methods to provide access to records, as in back up of MPI, in electronically stored or paper form;

(d) Identification of required immediate HIM staff action, according to the disaster, such as: moving records, turning off electricity to areas, closing doors, etc.;

(e) Coordination with ancillary departments, such as admitting, Emergency Room (ER), risk management, and nursing;

(f) Identification of contract vendors offering disaster recovery services; and

(g) Identification of equipment on hand, or in need of purchase, such as: back up generators for lighting, waterproof boxes, carts for transporting records to alternate location, etc.

(2) Area disaster recovery services must be contacted and the scope of their offerings must be documented; advance arrangements must be made, where possible, for the facility to receive priority service.

(3) Staff must be oriented to the location of disaster manual materials.

(4) Routine disaster drills must be conducted.

(5) Following a disaster, document any portion(s) of patient records deemed irretrievable or lost, by noting date, data, and reason for loss in the patient record, or in the newly “created” patient record, if disaster is of that proportion.

(6) The disaster recovery plan needs to be reviewed at least annually.

7. ELECTRONIC HEALTH RECORD

a. **General.** CPRS is considered Electronic Protected Health Information (EPHI); as such, the HIPAA Security Rule requires covered en, that it creates, receives, maintain or transmits.

(1) CPRS is the primary electronic health record where patient information is documented. Because it is a computerized system, the software is constantly being updated and improved. ***NOTE:*** *Documentation on paper media is being phased out.* Although electronic functionality provides many enhancements for active patient documentation, it presents significant areas of risk. Particular emphasis and attention, therefore, needs to be placed on the policies, procedures, and guidelines governing the use of the electronic health record.

(2) As technology allows, all patient care documentation must be stored in VistA and entered by direct data entry, through CPRS, TIU, VistA Imaging (or other VistA interfaces that facilitate dictation, transcription, uploading, voice recognition, document scanning), and other emerging technologies deemed appropriate by VHA.

(3) In CPRS, the following terms apply:

(a) Date of Note. The date (and time) by which the clinician references the document. For Progress Notes, this will likely be the date of the provider's encounter with the patient. For documents that have been dictated and transcribed (e.g., discharge summaries), it corresponds to the dictation date of the record. In all cases, this is the date by which the document is referenced and sorted.

(b) Date of Entry. The date and time at which a document was originally entered into the database.

(c) Date of Signature. The date and time at which the document was signed by the author.

(d) Visit Date. The date of the provider’s encounter with the patient to which an outpatient progress note is linked.

(e) Admission Date. The date of the admission to the hospital for which a note is written and linked.

b. **Standards of Electronic Notes**

(1) Electronically stored and/or printed patient information is subject to the same medical and legal requirements as the hand-written information in the health record.

(2) Entries must be accurate, relevant, timely, and complete.

(3) Extraneous text needs to be omitted.

(4) Succinct notes are more readable than verbose, lengthy notes.

(5) Plagiarized data, without attribution, in the patient record is prohibited.

(6) Standardized note titles facilitate the retrieval of specific patient information. Issues regarding note title standardization are part of the health record review function. ***NOTE:*** *As nomenclature evolves, note titles will be standardized. Proliferation of note titles makes retrieval difficult and cumbersome.*

(7) Appropriate note titles must be matched to note content and the credentials of the author. This enhances the ability to find a note quickly and easily.

(8) Notes must be reviewed and signed promptly, as defined by facility policy.

(9) Viewing unsigned notes is not allowed until such time as technology provides an audit trail of the note status. When viewing unsigned notes, there is a risk of clinical decision-making based on data that may be changed or deleted. Limited access to certain unsigned note titles (as determined by the facility) may be granted after review and approval by the appropriate medical staff committee to ensure that the viewing of these unsigned notes is consistent with ongoing patient care needs.

(10) Viewing of un-cosigned documents is determined on a case-by-case basis depending on the nature of the document and how critical the information is to patient care.

(11) CPRS users must respond promptly (as defined by facility policy) to View Alerts, which notify them of documents requiring authentication.

c. **Copy and Paste,"Cloned Notes," Imported Text, Objects, etc.**

(1) The electronic functions that allow importing of text from other sources by copy and paste or use of objects are powerful tools; however, this functionality must be used with caution and according to strict and enforceable policy. Clinical, ethical, financial, and legal problems may result when text is copied in a manner that implies the author or someone else obtained historical information, performed an exam, and/or documented a plan of care when the author or someone else did not personally collect the information at the time the visit is documented.

(2) Copying information from other documents in VistA, or otherwise importing information such as objects (i.e., medication or problem lists) is unnecessary duplication of information that does not assist those reading the record. Repeating information does not provide any advantage, but instead makes reading the charts more difficult and time consuming; copied portions of notes and other data is overwhelming to the reader and dwarfs the remaining information within the note.

(3) A policy that ensures the elimination and/or judicious use of this electronic functionality must be developed at each facility. This policy needs to be strictly enforced and must address the following:

(a) Rules for Importing and/or Copying Text

1. Never copy the signature block into another note.

2. Never copy data or information that identifies a health care provider as involved in care that the health care provider is not involved in.

3. Do not copy entire laboratory findings, radiology reports, and other information in the record verbatim into a note when it is not specifically addressed or clearly pertinent to the care provided.

4. Do not re-enter previously recorded data, unless specifically required for the assessment of a specific patient problem.

5. Use the functionality of importing data objects into progress notes and other documents judiciously. Facility policy needs to state that any imported object, dialog, etc., if used, must be reviewed and corrected at the source as well as in the document if there is any inaccuracy, and it must be pertinent to the patient assessment.

(b) Accountability

1. The authors are liable for the content of copied items within the notes they authenticate. As part of the health record review function, use of copy and paste functionality must be monitored, and where violations occur, findings must be reported to the appropriate Medical Staff Committee for disciplinary or other adverse action. ***NOTE:*** *Criminal charges may be filed when in violation of Federal law.*

2. Failure to comply with these standards may be deemed a violation of the:

a. Privacy Act requirement (5 U.S.C. Section 552a(e)(5)); or

b. Standards of Ethical Conduct for Employees of the Executive Branch (5 CFR Part 2635).

3. Disciplinary action may be taken if violations of these standards are validated per VA Directive 5021. Violations are:

a. Charge 05 - Careless or negligent workmanship resulting in waste or delay.

b. Charge 11 - Failure to safeguard confidential information.

c. Charge 12 - Deliberate failure or unreasonable delay in carrying out instructions.

d. Charge 25 - Falsifying official agency records.

d. **Clinical Postings.** At present, postings consist of crisis notes, clinical warnings, allergies, and advance directives. These are entered with an appropriately titled progress note and may be rescinded by changing the note title (for example, "Rescinded Advance Directive"). ***NOTE:*** *Future developments may allow the capability to inactivate a posting without changing the title of the note.*

e. **Clinical Reminder**

(1) A clinical reminder is a notation to remind clinicians of an action that is generally required for an individual patient, or patients in particular groups. Clinical reminders are dynamic; i.e., they are a function of CPRS, not stored data elements. Clinical reminder behavior changes with time; e.g., some reminders apply only to certain age ranges, which is clearly a function of time. Clinical reminders are also influenced by what diagnosis(es) a patient carries, which can change, etc.

(2) Clinical Reminders are a clinical decision support tool to assist health care staff; they are not a part of the clinical record. The reminders are recommendations, based on clinical and administrative policy, and are always to be interpreted in the context of the practitioner's knowledge of the patient. When a clinical reminder is triggered inappropriately due to an improper code selection, facility policy determines how a correction will be done.

f. **Electronic Signatures**

(1) Local policy must provide adequate security measures identifying those users who can document in the health record and verifying the authenticity of user electronic signatures. An author is responsible for the sole use of the author's access and verify codes. The person whose signature the electronic code represents must sign a yearly statement that this individual is the only one who will use it. An annual agreement is signed that it is related to system access, not specifically to a user's electronic signature.

(2) Authentication includes the identity and professional discipline of the author in the signature block, the date, and the time signed. Notes made and authenticated by health care team members must be individually identified either by the use of the individual's title, or by appropriate professional credential designation. Once affixed, authentication on electronic documents cannot be rescinded or repudiated.

(3) No edit, reassignment, deletion or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the HIM professional or the Privacy Officer.

(4) Different signatures on the same electronic document in the health record have distinct, separate purposes depending on the role of the signer. For example: author, transcriptionist or recorder, supervising practitioner, witness, etc.

(5) Currently, there are three types of signatures in the electronic health record:

(a) A "signer" is the author of the document. Once a document is signed, it cannot be edited; additional documentation can be added to the original document by addenda.

(b) A "co-signer" is the supervising practitioner. A co-signer may also be a service chief, or designee, as defined by the organization's By-law and/or policies. A co-signer may edit and authenticate a document if the author has not already signed the document.

(c) "Identified signer" and "additional signer" are synonymous and are a communication tool used to alert a clinician about information pertaining to the patient. This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. Being identified as an additional signer does not constitute a co-signature. This nomenclature in no way implies responsibility for the content of, or concurrence with, the note. ***NOTE:*** *"Identified signer" is nomenclature used by CPRS, VistA, and TIU; "additional signer" is nomenclature used by GUI.*

g. **Health Record Alterations and Modification**

(1) Electronic progress notes, operative reports, and discharge summaries are occasionally entered in the TIU and the CPRS software packages by practitioners for the wrong patients or sometimes the information within the document(s) may be incorrect or erroneous. A local procedure must be established for correcting erroneous patient information entered electronically or on paper. When an alteration of a health record includes an image, the image must also be altered in the same manner to be congruent with the change in the note. It is the responsibility of the HIM professional to ensure there is a process in place to correct erroneous health information.

(2) There are four types of health record changes:

(a) Administrative Update. An administrative update is current information entered in place of existing data, i.e., an address change or other registration data, etc. Data meant to be updated frequently is considered to be transient (by nature, bound to change). Most transient data is obtained through requests to update VA files. Changes to demographic data, which is information used to identify an individual such as name, address, gender, age, and other information specifically linked to a specific person, are generally considered to be administrative in nature and may be initiated by the veteran.

(b) Administrative Correction

1. An administrative correction is remedial action by administrative personnel with the authority to correct health information previously captured by, or in, error. Administrative corrections include factual and transient data entered in error or inadvertently omitted. Administrative corrections are not initiated by the veteran.

2. Examples of items that can be handled in this manner include, but are not limited to: incorrect date, association and/or linking data to wrong patient, association and/or linking data to wrong clinician or facility, and other designated clinical data items impacting the integrity of a patient's record.

3. Any retraction or rescission of entry must be initiated by the author or originating discipline. Laboratory, radiology, and pharmacy are examples of disciplines that may initiate retractions or rescissions within their own packages.

(c) Addendum

1. An addendum to a patient note or summary is made when a clinician deems it important to clarify information recorded in the original document or to add to the original document. The addendum option can be utilized by practitioners to continue ongoing treatment discussions, or by supervising practitioners to validate the plan of care.

a. Addenda are linked to originally created documents;

b. Addenda must be authenticated in an approved manner; and

c. Addenda may be entered by someone other than the author. The original author may be alerted to this action if appropriate TIU functionality is activated, specifically the "SEND ALERTS ON ADDENDA" parameter within the TIU DOCUMENT PARAMETERS file (8925.95). For note titles where addenda are routinely added, such as discharge plans, resident physician notes with supervision comments, or initial assessment notes, this parameter would typically be turned off.

2. A new note by the practitioner must be initiated for each new patient contact rather than using an addendum.

(d) Amendment

1. Amendment is the alteration of health information by modification, correction, addition, or deletion at the request of the patient or veteran. A request to amend any data contained in VHA records must be submitted in writing to the facility Privacy Officer, or designee, by the veteran stating explicitly what information is in contention and why, i.e., inaccurate or erroneous, irrelevant, untimely, or incomplete.

2. When a request to amend a record is approved, the disputed information must be corrected or deleted using the TIU AMEND action. The TIU AMEND action automatically keeps the original, un-amended document with status retracted. Requests for amendments must be tracked and information recorded appropriately for disclosure purposes.

3. VHA may deny the request to amend the health record, as indicated in VHA Handbook 1605.1, if the health information that is the subject of the request:

a. Is not part of the individual's health record; or

b. Is accurate, relevant, timely, and complete in the present health record.

4. The TIU AMEND action automatically includes the notation “Amended–Privacy Act” on the new, amended document. The document is authenticated with the date, signature, and title of the person making the amendment. The date, signature, and title should not be made

within the body of the electronic document, as they will be included automatically when the document is printed or displayed.

5. When a statement of disagreement or the amendment process documents are requested to be filed with the disputed information by the veteran, the statement or documents must be appended or otherwise linked to the veteran's record. This is accomplished by adding an addendum to the disputed information indicating where the statement or documents are filed or scanned.

(3) The following electronic options for correcting data are currently available:

(a) Deletion

1. An author may delete a patient document prior to electronic signature. Electronically signed documents may never be administratively deleted except under certain limited circumstances as designated by the Privacy Officer or HIM professional. A specific instance where this may occur is when an electronically signed document is totally blank.

2. Once data has been linked to a patient, and is viewable to practitioners, it must not be "deleted," except in rare cases by specially-designated personnel using the TIU DELETE action. The TIU DELETE action, when used on completed documents, maintains the original document, but with the status retracted. Possible instances include:

a. A document that is written for the correct patient, but is erroneous in content requires entry of a new document and the deletion of the old, erroneous document using the TIU DELETE action.

b. When a document automatically generated by another package, such as converted Medicine Notes, must be corrected. In some cases, the best solution is to regenerate the document correctly and use the TIU DELETE action to delete the old incorrect document.

(b) Reassign

1. This option is used when the correct data is entered on the wrong patient. These notes need to be retracted immediately upon discovery of an erroneous entry in a patient's health record. When this occurs, the author must notify the appropriate personnel as identified by local policy, e.g., by sending an electronic mail message to a designated VistA mail group. If an electronic mail message is used, the body of the message must contain:

a. Patient's name and the SSN of the patient under whom the note was entered;

b. Patient's name and the SSN of the patient for whom the note was intended;

c. Full progress note title of the erroneously entered note;

d. Date and time of the erroneously entered note; and

e. Reason the note is to be reassigned.

2. The appropriate personnel must reassign the note. The body of the note, the author, and the date and time the note was created must remain unchanged. ***NOTE:*** *Local facility policy delineates who has the authority to reassign and under what circumstances these options are utilized.*

3. When the reassign action is complete, the user is prompted to clean up the encounter data. When the author authenticates the unsigned copy, if it is for an outpatient, VistA prompts for the appropriate encounter information.

(c) Reassignment of Addenda (Promote)

1. This option is used only when the addendum needs to be reassigned. When this occurs, the author notifies the appropriate personnel as identified by local policy, e.g., by sending an electronic mail message to the designated VistA mail group. Addendum reassignment takes place when any of the following four scenarios occur:

a. An addendum must be moved to a different document, or

b. An addendum must be moved forward as a document for another visit, or

c. A parent document is to be replaced with an addendum, or

d. An addendum needs to be swapped with its parent document.

2. The TIU software behaves consistently regardless of the action selected. It retracts the original document, generates an unsigned copy, and updates the status of the addendum. The one exception is when an addendum is swapped with the parent document. When a document is swapped, the addendum content is substituted for the original content and vice versa, making the addendum the parent and the parent the addendum.

(d) Change Title. When a note title is electronically modified, the title is changed from the previous title to the new title; a change history of the title name is not maintained. Local facility policy delineates who has the authority to change a patient note title and under what circumstances these options are utilized. The change title option must be used:

1. If the title of an unsigned note is incorrect, the author may change it to the appropriate note title, if the appropriate business rule has been applied.

2. If the title of a signed note is incorrect, appropriate personnel (usually not the author except for Patient Postings) may change it to the appropriate note title at the request of the author.

(e) Amend. Once a request for amendment has been approved, the amend option in TIU is used to make the change or correction. ***NOTE:*** *See the CPRS TIU Clinical Coordinator and User Manual, Search for Selected Documents section for instructions on the amend option.* Only

the Privacy Officer, or designee, and/or the Chief, HIMS, or designee, is authorized to make amendments.

COMPARISON OF:

UPDATE, ADMINISTRATIVE CORRECTION, ADDENDA, and AMENDMENT REQUESTS

UPDATE	ADMINISTRATIVE CORRECTION	ADDENDUM	AMENDMENT
An **update** is current information entered in place of existing data. Data meant to be frequently updated is considered to be transient (by nature bound to change).	An **Administrative correction** is corrective action by administrative personnel with the authority to correct health information previously captured by, or in, error.	An **Addendum** is the inclusion of additional information to the source document.	An **amendment** is the alteration of health information by modification, correction, addition, or deletion. A request can be made to amend any data contained in VA patient records.

COMPARISON OF: UPDATE, ADMINISTRATIVE CORRECTION, ADDENDA, and AMENDMENT REQUESTS

Most transient data is solicited from the patient to update VA files; the patient may initiate an update without having been solicited.	Administrative corrections include factual and transient data entered in error or inadvertently omitted. Administrative corrections are <u>not</u> initiated by the veteran.	Addenda clarify information in the source document by adding details or information left omitted from the original document.	Amendment requests must be submitted in writing by the patient, stating explicitly what information is in dispute and why: inaccurate, erroneous, irrelevant, untimely, or incomplete.

COMPARISON OF:

UPDATE, ADMINISTRATIVE CORRECTION, ADDENDA, and AMENDMENT REQUESTS

Solicited updates are updates to transient data that are requested of patients by various VA organizations on a periodic basis.		An addendum is <u>not</u> initiated by the veteran.	Addresses a dispute a patient has about information in their permanent medical record.
<u>Examples</u>: a. Solicitations from Health Eligibility Center (HEC) mail outs, means test requirements, registration activities, etc. b. An address change	<u>Examples</u>: a. Progress note entered on wrong patient's chart. b. Pasting part of one patient's note into another patient's progress note. c. Placing lab value in the wrong record. d. Transcription typing the wrong word or diagnosis.	<u>Examples</u>: a. An supervising practitioner adds information on the physical exam omitted by the Resident. b. A nurse indicates education was provided, omitted from the original document.	<u>Example.</u> Signed (legally binding) subjective comments or interpretations found in: a. Progress Note, b. Discharge Summary, c. History and Physical (H&P), d. Autopsy, e. Consult Note, and f. Comments.

h. **<u>Document Scanning</u>**

(1) Scanned, wet-signed documents may be linked to TIU documents and displayed with the TIU document.

(2) Only those documents that cannot be created in or interfaced with CPRS will be scanned. Development of document scanning policies is a shared responsibility among HIMS and other appropriate services.

(3) Document scanning, or document imaging, is a process by which a paper document is converted to an electronic file. The National Archives and Records Administration (NARA) disposition authority for electronic health records allows VA to destroy source documents after scanning, but only if record retention and retrieval requirements can be met, and quality control processes are in place. In accordance with the NARA disposition authority, imaged records must

be retained to satisfy the "75-year after the last episode of care" retention requirement. Original source documents may be destroyed after scanning as long as record retention and quality control processes are met. Source documents may also be retained if there is a compelling business reason to do so.

(4) Local policy needs to address:

(a) Quality control processes for:

1. Image quality and alternative means of capturing the data when the quality of the source document cannot meet image quality controls,

2. Integrity of data capture,

3. Accurate linking of scanned items or documents to correct record, and

4. Accurate indexing of the document.

(b) Correction process of erroneously scanned documents.

(c) Staffing issues such as who is authorized to create administrative progress notes for scanning, who is given permissions to scan documents after meeting competencies, and where scanning will take place (centralized versus decentralized scanning).

(d) The handling of external source documents (see par. 6).

(e) How a scanned image will be annotated to identify that it has been scanned; for example, using a stamp on the scanned document.

8. DOCUMENTATION

a. **General.** Health record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The health record documents the care of the patient and is an important element contributing to high quality care. The health record facilitates:

(a) The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor the patient's health care over time;

(b) Communication and continuity of care among physicians and other health care professionals involved in the patient's care;

(c) Accurate and timely claims review and payment;

(d) Appropriate utilization review and quality of care evaluations;

(e) Collection of data that may be useful for research and education; and

(f) Accurate coding of diagnosis and procedures performed.

b. **Documentation Principles**

(1) **Standards**

(a) JCAHO standards regarding documentation pertinent to care and treatment records apply to both paper and electronic records.

(b) The primary medium for documentation of all patient care activities within VHA is CPRS.

(c) The supervising practitioner or attending physician is ultimately responsible for the accuracy of the health record for each patient under the physician's care. The Chief of Staff, or designee (equivalent), has oversight responsibility for health record timeliness, accuracy, and completion.

(d) Opinions requiring medical judgment must be documented or authenticated only by supervising practitioners or medical staff members, and other individuals who have been granted such clinical privilege within their scope of practice.

(e) Health care practitioners must document according to regulatory standards and generally accepted documentation practices for completeness and timeliness.

(f) Health care practitioners involved with the patient's care must enter documentation of each event of a patient's care into the health record.

(g) The practitioner who treats the patient is responsible for documenting and authenticating the care provided.

(2) **Scope of Documentation**

(a) The health record needs to reflect honest and candid statements; derogatory or critical comments are to be avoided. Individual employee names are not to be included in health record documentation unless the purpose is to identify practitioners for continuing care.

(b) Emphasis is placed on relevant day-to-day entries. Timely entries must be made on appropriate documents following examination and treatment as specified in VHA and facility policies.

(c) Each patient event must include or provide reference to: the chief complaint and/or reason for visit and, as appropriate, relevant history, examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the health care professional; and identification of appropriate risk factors.

(d) The scope of documentation must be comprehensive enough to: provide continuity of care; be concise and complete; reflect any treatment for service-connected condition(s), including agent orange, ionizing radiation, MST, or external contaminants; support reported workload; and bill for services.

(3) **Timeframes**

(a) Each entry in the record must be completed (including authentication) within the timeframes delineated by facility policy. Such policy needs to include guidance on disciplinary action when timeframes are not met.

(b) Late entries must be noted with the actual date the event occurred versus the date of documentation. ***NOTE:*** *Notation as to the reason for the delay should also be made.* In CPRS, the date of entry identifies when the documentation actually occurred.

(c) Physicians and other caregivers must monitor and take appropriate action on their computerized prompts for signature, currently known as "View-Alerts."

(4) **Resident Supervision.** The patient record must document adequate supervision of residents in the care of patients according to the most current VHA policy (see VHA Handbook 1400.1, for additional information).

c. **Medical Alert.** Allergy or adverse reaction information must be entered in CPRS through the order tab. ***NOTE:*** *It must be available for view in CPRS in the top right corner of every tab in the Patient Posting box and on the cover sheet in the Postings box.* Allergies are also available on the cover sheet under the "Allergies/Adverse Reactions" box.

d. **Evaluation and Management (E&M) Services.** For E&M services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. The three key components of an E&M service, which are considered or validated to determine the appropriate level of the E&M service, are history, examination, and medical decision-making.

e. **Inpatient Health Care.** Health records must be complete and available for the provision of patient care according to the facility's By-laws, but not greater than 30 calendar days from the date of discharge for inpatients. The current paper health record of an inpatient receiving care (if applicable) needs to be maintained intact, unless it is advantageous to separate a portion. Such separation is to be kept at the minimum required for efficient operation, and in no instance must the separated portion be located so that there would be a delay in its availability for use in an emergency by professional or administrative personnel.

f. **Emergency and Urgent Care**

(1) **Components.** Urgent care and/or emergency documentation contains the following components:

(a) Time and means of arrival.

(b) Presenting problem(s), i.e., the reason for visit.

(c) History and objective data relevant to the presenting problem. ***NOTE:*** *When not possible for patient to give history, the reason for this is documented.*

(d) Assessment of the problem.

(e) Treatment plan for the problem.

(f) Primary and secondary diagnoses; i.e., only those dealt with at this encounter.

(g) Basis for ordering test, consult, or changes in medication.

(h) Care received prior to arrival.

(i) Condition at discharge.

(j) Discharge instructions.

(2) **Emergency Care Patient Records.** Emergency care patient records must contain additional information as required by JCAHO. Additional documentation requirements include information regarding leaving Against Medical Advice.

(a) Emergency care rendered for humanitarian reasons to a person who is not admitted must be documented in a patient record.

(b) When emergency care is provided, a copy of the record of emergency services provided must be made available to the practitioner or medical organization responsible for follow-up care.

(3) **Documentation on Emergency Transfers.** Documentation on emergency patient transfers to other organizations include:

(a) Reason for transfer;

(b) Stability of patient;

(c) Acceptance by the receiving organization;

(d) Responsibility during transfer; and

(e) Processing Dead on Arrival (DOA) Cases. ***NOTE:*** *A person who is DOA is not to be shown on hospital records either as a gain or a loss. All administrative and medical documents prepared for the person who is DOA must be filed in the person's health record.*

(4) When a patient reports for care and leaves after triage by nursing staff and before examination by a Licensed Independent Practitioner (LIP), a LIP must review the triage documentation and determine whether an emergency existed and contact the patient when intervention must be rendered to protect the patient. In all cases, the triage note must be added to state that the patient left.

g. **Outpatient and/or Ambulatory Care**

(1) The health care practitioner must document a pertinent progress note at the time of each ambulatory and/or outpatient care visit. Cancelled appointments or no-shows are viewable on the CPRS cover sheet.

(2) By the third visit, a summary and/or problem list must be initiated and maintained by the health care practitioner and must include known significant diagnosis, conditions, pertinent past procedures, drug allergies, medications, and significant procedures performed outside VHA.

(3) The physician or health care practitioner must document only those diagnosis(es) treated during an encounter or that require further treatment. An assessment as to whether continued care, on an ambulatory or outpatient basis, is required must be documented following the diagnosis.

(4) Elements for chronic disease indicators and prevention measures must be documented when appropriate.

(5) The practitioner must document a termination of care summary note when it has been determined that care is no longer required. The termination of care summary note must include: the condition on discharge, any patient instructions, and any relevant diagnoses, operations, and findings.

(6) Outpatient progress notes must contain the following components:

(a) Presenting problem(s) (reason for visit);

(b) History and objective data relevant to the presenting problem(s);

(c) Assessment of the problem(s);

(d) Treatment plan for the problem(s);

(e) Diagnosis(es) treated during an encounter or that require further treatment;

(f) Reason (i.e., the medical necessity) for ordering tests, consults, or changes in medications; and

(g) Follow-up treatment and patient instructions.

h. **Initial Assessments**

(1) Members of the patient's care team must document initial assessments. Contents must meet the applicable JCAHO requirements and/or specific VHA program regulations.

(2) An initial screening and/or assessment (i.e., nutrition, nursing, social work, functional, cultural, occupational and physical therapies, psychosocial, spiritual, legal, etc.) must be completed within 24 hours of admission, except for nursing home care. Nursing home care requires the Minimum Data Set be completed within 5 days for a designated short stay admission (90 days or less) and 14 days for a designated long-stay admission (greater than 90 days). Initial discipline specific screening and assessments must be completed as required for each discipline by facility policy and JCAHO standards for nursing home care.

(3) Educational needs, preferences, abilities, and readiness to learn are assessed on admission. The education process is interdisciplinary, as appropriate, to the care plan. Documentation of education related to nutrition, nursing, and rehabilitation is required.

i. **History and Physical (H&P)**

(1) A complete inpatient admission H&P examination must be available within 24 hours of admission. The medical staff member's, or supervising practitioner's, note or addendum may be entered within 1 calendar day of admission. In a nursing home, an H&P must be available within 48 hours of admission.

(2) An H&P, whether for admission or surgery, that is over 30 calendar days old is not acceptable and a new H&P must be documented.

(3) When documenting the physical exam, a check-off format is not acceptable.

(4) When recording the history, opinions of the interviewer ordinarily are not to be recorded in the body of the history.

(5) H&P examinations must be completed by clinical staff as delineated in facility By-laws or by scope of practice.

(a) Prior to Admission. A durable legible copy of a physical exam performed within 30 days prior to admission may be used in the patient's record, if there have been no changes in the patient or if the changes are documented at the time of admission. When the patient is readmitted within 30 days for the same or a related problem, an 'interval' physical exam reflecting any changes may be used, provided the original exam is readily available. In either case, an interval note must be completed indicating the following:

1. The H&P is still accurate;

2. An appropriate assessment was completed on admission confirming that the necessity for the procedure or care is still present; and

3. The patient's condition has not changed since the H&P was originally completed, or any changes are documented.

(b) Prior to Surgery. An H&P must be available prior to surgery. When the H&P is done within 30 calendar days prior to surgery, the prior H&P may be used, but an interval note must be completed indicating:

1. The H&P is still accurate.

2. That an appropriate assessment was completed prior to surgery confirming that the necessity for the procedure is still present.

3. That the patient's condition has not changed since the H&P was originally completed, or any changes are documented.

(c) Emergencies. In an emergency, when there is no time to record the complete H&P examination, a progress note describing a brief history and appropriate physical findings and the pre-operative diagnosis must be recorded in the health record before surgery.

(d) Annual Physical. An annual physical examinations must be completed for inpatients in acute care and nursing home care should the patient's length of stay exceed 365 days.

(e) Ambulatory Care H&P

1. When a patient is first admitted for VA care on an ambulatory and/or outpatient care level, a relevant history of the illness or injury and physical findings must be documented in the patient record.

2. If a patient is on ambulatory and/or outpatient care status for a year, at the time of the next visit, the patient must be given an annual physical or, as applicable, an assessment of the condition for which care is authorized. The mental status of psychiatric patients must also be re-evaluated at the time of the annual physical. The examining practitioner must determine the comprehensiveness of the examination based upon the age, sex, and previous and current health status of the patient. ***NOTE:*** *If the examining practitioner is a resident, then the documentation needs to reflect that the patient was seen by or discussed with the supervising practitioner (see VHA Handbook 1400.1 for documentation requirements).*

(f) Dental Surgery. Qualified oral surgeons may complete the H&P of dental and oral surgery patients admitted to Dental Service. For those patients admitted primarily for dental diagnoses and treatment, a history and clinical evaluation of the dental and/or oral problem must be completed by the admitting dentist. If the admitting dentist is a board-eligible or board-certified oral surgeon with H&P privileges, that person may perform and record the medical H&P examination for that admission. If the admitting dentist is not an oral surgeon with H&P privileges, then a supervising practitioner or member of the medical staff with admitting privileges must perform and record the H&P.

(g) Special Protocols

1. In addition to the H&P, special protocols, as prescribed in current directives, must be followed for certain patients, such as former prisoners of war (POWs) and those who have alleged exposure to:

a. Nuclear tests;

b. Ionizing radiation;

c. Agent Orange;

d. Environmental contaminants; and

e. Other events, chemicals, or substances as delineated by law.

2. The performance of such examinations must be documented on appropriate forms and filed in the patient's health record, or, if necessary, a record must be created.

j. **Re-assessments.** Re-assessments are completed at regularly specified intervals as outlined in facility policy and are related to the course of treatment, or when the patient's physical, psychosocial, functional, or nutritional status significantly changes. In nursing home care units, reassessments are conducted for short-stay and long-stay residents according to Resident Assessment Instrument Minimum Data Set (RAI MDS) policies.

k. **Treatment Plan and/or Care Plan.** An initial treatment plan, documented by the clinician, as part of the physical exam must be established on all patients within 24 hours of admission on acute care patients. In the nursing home, the initial treatment plan for short-stay residents must be completed within 21 days of admission. For long-stay residents, a plan of care must be completed within 21 days after admission.

(1) The care is planned and coordinated by an interdisciplinary team consisting at a minimum of a registered nurse, social worker, recreation therapist, and dietician. Other members of the interdisciplinary team include, but are not limited to the: medical provider, pharmacist, mental health professional, and rehabilitation therapist. Members responsible for providing care are identified in the care plan. The care plan indicates the goals and frequency of interventions to achieve those goals. Care planning recognizes Advance Directives and evidence of resident and/or family participation in developing and reviewing the care plan. Documentation in the health record includes the resident's response to care.

(2) For short-stay admissions, the resident is reassessed every 14, 30, 60, and 90 days. For long-stay admissions, the resident is reassessed every 90 days or when there is a significant change in condition.

l. **Laboratory and Imaging**

(1) Order entry for laboratory tests must be completed in full, clearly identifying the: patient, location, requester, test date, special handling, and reason(s) for test.

(2) Requests for tissue examination must contain the preoperative diagnosis and a brief clinical history, including the reason for the examination.

(3) Requests for imaging services must contain a complete reason for the exam with a brief clinical history.

(4) Reports of imaging results must reflect: patient identity; date performed; date interpreted; type, route, and amount of contrast or radio-pharmaceutical agents used, if applicable; specific preparation of the patient; findings; and name of interpreter.

m. **Progress Notes**

(1) **General**

(a) Progress notes facilitate the communication among disciplines concerning the patient's care. Members of the patient care team must document observations, progress, response to and changes in treatment, subsequent assessments of the patient's response to care, other intervention, planned follow-up care, instructions, diagnosis, and pertinent findings from ancillary tests. Progress notes must give a pertinent chronological report of the patient's course, and may include, but are not limited to: a change in diagnosis(es), a change in condition, a patient's leave of absence, and any justification for patient limitations.

(b) Clinical care must be documented in a progress note by the respective clinical staff as defined by their scope of practice.

(c) Documentation in the progress notes is required when there is a history of allergies, adverse reactions, or other conditions. The appropriate title must be used to trigger patient postings, as in CWAD.

(d) Inpatient progress notes must be written and signed in the computer at the time of observation, at a frequency appropriate to the patient's condition, and in sufficient detail to permit continuity of care and transferability.

(e) Supervision for inpatients and outpatients must be documented by a supervising practitioner according to VHA Handbook 1400.1.

(2) **Admission**

(a) The admission progress note must include: the type of admission, i.e., elective, emergency; chief complaint; a brief summary of the patient's condition; and a tentative or

differential diagnosis. VA Form 10-10m, Medical Certificate, may qualify as the admission progress note when it is prepared on the day of admission or immediately prior to admission.

(b) The supervising practitioner in acute care must meet the patient within 24 hours of admission, including weekends and holidays. This must be personally documented in a progress note by the end of the calendar day following admission. Supervising practitioner admission progress notes may or may not refer to the resident's plan of care, but need to reflect the supervising practitioner's findings and recommendations regarding the patient and/or the treatment plan. Alternatively, the supervising practitioner may add an addendum to the resident's note that either references agreement with the resident's plan of care, or may recommend modifications or additions to the plan. The progress note must be properly signed, dated, and timed. Supervising practitioners are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the resident.

(3) **Initial Clinic Visit.** All new patients to the clinic seen by a resident must be seen by or discussed with the supervising practitioner at the initial visit. This must be documented by the supervising practitioner or reflected in the resident's notes to include the name of the supervising practitioner and the nature of the discussion.

(4) **Suicidal Observation.** The patient's actual or potential for suicidal behavior must be documented in a progress note. Any member of the health care team may place a patient on suicide observation, but the patient can only be removed from observation by the written order of a staff physician or Chief of Psychiatry.

(5) **Electro Convulsive Therapy (ECT).** The indications or contraindications for ECT must be documented in a progress note.

n. **Commitment.** In accordance with State law and VHA policy, the specific reasons for seeking termination or continuation of a patient's involuntary commitment status must be incorporated in the patient's health record. In those instances where continued commitment is judged by the review panel to be necessary, the reasons given must include a reference to the changes that are still needed before the patient would be legally entitled to have the commitment terminated. This statement of reasons must be documented in the progress notes and must be disclosed to the patient by the panel, except in those infrequent cases where doing so would substantially hinder the continuation of successful treatment progress.

o. **Seclusion and/or Restraints.** The appropriate licensed health care professional must clearly document the necessity for each restraint or seclusion order in the progress notes. The justification must include a description of the patient's behavior just prior to restraint, a description of trends in the patient's behavior which usually leads to restraint, alternate handling of the patient in an effort to avoid restraint, a description of the patient's behavior while in restraint, and the length of time in restraint. The patient's behavior, which merited release from restraints, must also be documented including documentation that the staff debriefed with the patient. ***NOTE:*** *The documentation is required in all health care facilities that use this type of intervention. In such cases, the decision and reason must be documented in the progress notes.*

p. **Inter-service or Inter-ward Transfer Note**

(1) An inter-service or inter-ward transfer is the formal transfer of an inpatient during an episode of inpatient care from one nursing care unit, clinical service, or medical staff member to another. When a patient is transferred to a different level of care, a transfer note must be entered into the health record.

(2) The content of this transfer note must provide a concise recapitulation of the hospital course to date, include the indications for transfer, and must be developed in a manner to assist the receiving unit, service, or medical staff member in providing continuity of patient care. The physician must document the transfer note prior to the patient's transfer. ***NOTE:*** *It is strongly recommended that a note title of Inter-service or Inter-ward Transfer Note be used (see VHA Handbook, 1400.1 for documentation requirements when residents are involved in the provision of patient care.*

q. **Discharge Progress Note and/or Discharge Instructions**

(1) The physician must complete a discharge progress note and/or instruction sheet for each period of hospitalization. It must contain date and the type of discharge, diagnoses, discharge medications, recommendations relative to diet, exercise, limit of disability, condition on discharge (to include character of surgical wound, if appropriate), place of disposition, recommendations for follow-up, and patient education. The involvement of the supervising practitioner in discharge planning may be reflected by co-signature, an independent note or addendum, or by reference in the resident's discharge note.

(2) When instructions are given to the patient or designee, the record needs to so indicate. A formal narrative summary (discharge summary) does not substitute for a discharge and/or instruction progress note.

(3) In cases involving death, the time and date when the patient expired, and the events leading to the death must be recorded by the physician.

(4) Any patient leaving against medical advice must have a final progress note written by a physician indicating any known reason for leaving and any special disposition arrangements.

r. **Consultations and Referrals**

(1) **Consultation**

(a) The written or verbal request for a consult may be generated by a LIP, or as otherwise defined by facility By-laws, and documented in CPRS by using the consult request option. The request for consultation must include:

1. A brief description of the patient's condition;

2. The reason for the consultation;

3. Other information of value, such as, medication which may affect the condition being evaluated; and

4. The electronic signature of the requestor.

(b) A consultation is a service performed for further evaluation and/or management of the patient (i.e., opinion and/or advice). The opinion or advice must be expressed in a report that follows health record documentation requirements, i.e., who requested the consultation, what tests were ordered, the diagnosis, and treatment recommended. If the consultant initiates a diagnostic or therapeutic service in order to provide the opinion or advice requested, the service still qualifies as a consultation. The supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. Documentation of supervising practitioner involvement must be by independent note, addendum, or in the resident's note. Consultation notes by a resident must reference the supervising practitioner's name, the nature of the discussion, and concurrence with the management plan.

(c) The consultant's report of advice, opinion, and any services that were ordered or performed must be documented in CPRS and then the consult is "complete." The authenticated consultation report must contain:

1. An opinion of the consultant's findings for making a diagnosis for a specific patient, or for providing treatment advice on a specific patient;

2. An indication that the patient was examined;

3. An indication that the patient's record was reviewed;

4. The date of the consult; and

5. The consultant's signature.

(d) Once the consultant assumes responsibility for the patient's continuing care, any subsequent services provided by the consultant are no longer a consultation. Further visits are billed as "established office visits." The key is whether:

1. The primary practitioner retains control over management of the patient's care for the condition related to the consult, or

2. The consultant assumes this responsibility.

(2) **Referral**

(a) A referral represents a situation in which the primary practitioner feels unable to treat the patient's condition and sends the patient to another practitioner for treatment.

(b) Referral for procedures, patient "walk-ins," and self-referrals are not considered a consultation. A practitioner cannot perform a consultation on the practitioner's own patient unless it is for a pre-operative clearance; for example: A patient scheduled for a prostatectomy has previously had a myocardial infarction. The surgeon requests a consultation for pre-operative clearance from the cardiologist.

s. **Informed Consent**

(1) Practitioners must document the informed consent discussion in the health record in accordance with 38 CFR 17.32 and VHA Handbook 1004.1. Separate, specific informed consent is required for any aspect of the treatment or procedure that involves research, e.g., participation in a research protocol or clinical drug trial. This consent is in addition to that obtained for the non-research aspect of the treatment or procedure and must meet the informed consent requirements set forth in 38 CFR Part 16 and VHA Directive 1200.5. In addition, documentation in the health record must comply with JCAHO standards.

(2) Written consent is not required to take a photograph or record video/voice for treatment purposes.

(3) Photographs or video/voice recordings made solely for non-treatment purposes require the specific and separate written permission of the patient. The patient must sign VA Form 10-3203, Consent for Use of Picture and/or Voice, to authorize this activity. Photography and/or recording must not occur prior to the patient granting such authorization.

(4) There are specific notice and documentation requirements for the release of evidentiary information from the health record when the practitioner suspects the patient may have been subject to abuse or neglect. ***NOTE:*** *These requirements are detailed in VHA Handbook 1605.1.*

t. **Anesthesia**

(1) **Pre-anesthesia Evaluation.** The pre-anesthesia evaluation must be documented by a qualified individual. The evaluation and documentation must include:

(a) Patient interview to review medical, anesthesia, and medication histories;

(b) Appropriate physical examination;

(c) Review of objective diagnostic data (e.g., laboratory, ECG, X-ray);

(d) Assignment of American Society of Anesthesiologists (ASA) physical status; and

(e) Formulation and discussion of an anesthesia plan with the patient and/or responsible adult.

(2) **Pre-Induction Evaluation.** The Anesthesiologist or Anesthetist must re-evaluate the patient immediately before anesthesia induction. This re-evaluation must be documented either in the Intra-operative Anesthesia Record or a progress note. Notes must be annotated with the date and time.

(3) **Anesthesia Plan.** The anesthesia plan must be done by or show concurrence by an LIP with appropriate clinical privileges. LIP concurrence can be accomplished at the plan stage or the pre-induction re-evaluation.

(4) **Post-anesthesia Care Unit (PACU) Note.**

(a) PACU documentation must include the patient evaluation on admission and discharge from the post-anesthesia care unit, a time-based record of vital signs and level of consciousness (either paper or electronic), all drugs administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post-procedural complications, and post-anesthesia visits. This documentation generally is done by the PACU nursing staff. The health record must document the name of the LIP responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.

(b) For inpatients, there needs to be at least one documented post-anesthesia visit after leaving the post-anesthesia care unit. The note needs to describe the presence or absence of anesthesia-related complications.

(c) For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery, to assess any complications, including anesthetic complications, as appropriate.

u. **Surgeries and Procedures.** All aspects of a surgical patient's care, including ambulatory surgery, pre-operative, operative and post-operative care, must be documented. Surgical interventions, diagnostic procedures, or other invasive procedures must be documented to the degree of specificity needed to support any associated coding data and to provide continuity of care.

(1) **Pre-operative and/or Pre-procedural Note.** In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising or staff practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed; discussion with the patient and family of risks, benefits, potential complications; and alternatives to planned surgery. When a resident completes the note, the supervising practitioner must write an addendum to the pre-operative note. Staff or supervising practitioners are responsible for authorizing and/or approving performance of procedures.

(2) **Immediate Post-operative Note.** A post-operative progress note must be written, or directly entered into the patient's health record, by the surgeon immediately following surgery and before the patient is transferred to the next level of care.

(a) The immediate post-operative note must include:

1. Pre-operative diagnosis,

2. Post-operative diagnosis,

3. Technical procedures used,

4. Surgeons,

5. Findings,

6. Specimens removed, and

7. Complications.

(b) The immediate post-operative note may include other data items, such as:

1. Anesthesia,

2. Blood loss,

3. Drains,

4. Tourniquet Time, or

5. Plan.

(3) **Operative Report.** An operative report must be dictated and completed by the operating surgeon immediately following surgery. ***NOTE:*** *Immediately is interpreted in some standards of practice as 6 hours following surgery. JCAHO defines immediately as "upon completion of the operation or procedure, before the patient is transferred to the next level of care." This is to ensure that pertinent information is available to the next caregiver. In addition, if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care."* The body of the report needs to contain the: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative diagnosis; names of the supervising practitioner, primary surgeon, and assistants; and the presence and/or involvement of the supervising practitioner.

(4) **Level of Supervision.** The "level" of supervision of such procedures must be documented according to the following:

(a) Level A. Attending Performing the Operation. The supervising practitioner performs the case, but may be assisted by a resident.

(b) Level B. Attending in OR, Scrubbed. The supervising practitioner is physically present in the operative or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.

(c) Level C. Attending in OR, Not Scrubbed. The supervising practitioner is physically present in the operative or procedural room. The supervising practitioner observes and provides direction. The resident performs the procedure.

(d) Level D. Attending in OR Suite, Immediately Available. The supervising practitioner is physically present in the operative or procedural suite and immediately available for resident supervision or consultation as needed.

(e) Level E. Emergency Care. Immediate care is necessary to preserve life or prevent serious impairment. The supervising practitioner has been contacted.

(f) Level F. Non-OR Procedure. Routine bedside and clinic procedure done in the OR. The supervising practitioner is identified.

(5) **Recovery Room Note.** Post-operative documentation (i.e., Recovery Room Note) must include: vital signs and level of consciousness; medications and blood and blood components; any unusual events or post-operative complications, including blood transfusion reactions; and the management of such events.

(6) **Diagnostic and Therapeutic Procedure Reports.** Detailed reports of diagnostic and therapeutic procedures performed in other than the operating room must be documented in the progress notes by the practitioner performing the procedure, and must contain: the name of procedure; the name of the person performing procedure; details of performance; major findings and conclusions; whether or not tissue was removed; any complications; a signature, a title, and a date.

(7) **Emergency Procedure Note.** When residents are confronted with an emergency situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of, a patient and which involves a diagnostic or therapeutic procedure with significant risk to the patient, the resident is required to consult with the supervising practitioner to obtain approval and authorization to proceed, and to determine who will be available to assist or to advise, as appropriate. This discussion must be documented in a progress note. A procedural note must include details of the case, the name of and nature of the discussion with the supervising practitioner, and the proposed procedure.

v. **Orders**

(1) **General**

(a) All orders must contain the date, time the order was written, and the name of the practitioner placing the order; they must be signed and correspond to the individual's scope of practice as defined by the medical staff By-laws.

(b) Applicable diagnostic information to justify the service ordered must be documented.

(c) Patients can only be discharged by order of a physician.

(2) **Medications.** Medications must be identified by name, strength, route of administration, and frequency. Medication orders must be reviewed and rewritten when a patient is transferred between services and/or specialties, or is transferred to a critical care unit.

(3) **Verbal Orders.** Verbal orders by authorized individuals are accepted and transcribed by qualified personnel or category, as stated in the medical staff rules and regulations; this must be authenticated by the ordering individual.

(4) **Nursing Home Care.** The Nursing Home Care Program orders must be reviewed and/or rewritten monthly. Provided no changes are made to the orders, the monthly review may be documented by simply writing "continue" or "renew."

(5) **Use of Seclusion and Restraint.** Use of seclusion and restraint requires a time-limited order written by the appropriate licensed healthcare professional and must follow facility By-laws. The order must specify start and end times, indicate which extremities are to be restrained, and what type of restraint is to be used. The order must be dated and timed. Orders must never be given for the use of restraint and seclusion on an as needed, or as necessary, basis, i.e., as needed (Pro Re Nata (PRN)).

(6) **Service Orders.** Service orders are orders that are automatically generated in CPRS by clinical service personnel editing clinician-entered orders to better facilitate their execution without changing the clinician's intent. Service orders entered into CPRS by pharmacy, laboratory, or others must be in concert with standing protocols that have been approved by the medical staff.

(7) **Policy Orders.** Policy orders are orders entered into CPRS by clinical staff for items within their scope of practice. In such cases, the person entering the order is designated the ordering clinician and will be prompted to sign the order immediately after entry. These orders have the CPRS nature of order "policy." Policy orders entered into CPRS by pharmacy, laboratory, or others must be in concert with standing protocols that have been approved by the medical staff.

(8) **Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation (DNAR)** ***NOTE:*** *The terms DNAR, DNR, No-CPR are synonymous. For consistency, the acronym DNAR is used in this Handbook.* DNAR orders must be written, or at minimum countersigned, in the patient's health record by the attending physician. ***NOTE:*** *Requirements for DNAR orders and documentation are detailed in VHA Handbook 1004.3.*

w. **Advance Directive**

(1) When a patient completes or updates an Advance Directive, a copy must be filed and/or scanned in the health record in accordance with VHA Handbook 1004.2. The Advance Directive image must include a progress note with an Advance Directive title that appears in CWAD.

(2) For inpatients with a paper health record, the copy of the Advance Directive must be filed either behind a tab specifically designated "Advance Directive" or, at a minimum, as the first document in the current or open health record. The paper record must be annotated to indicate the presence of an Advance Directive (i.e., by stamp, sticker). A progress note in CPRS titled "Advance Directive" must also be made to annotate the presence of an Advance Directive.

(3) Each facility must develop a mechanism to ensure that the Advance Directive is maintained in the outpatient record and the inpatient record to accommodate patient movement from one setting to another or one facility to another. When scanned, the Advance Directive must be attached to the appropriately titled progress note.

(4) If a patient revokes an Advance Directive, the existing Advance Directive note must be re-titled: "Rescinded Advance Directive." ***NOTE:*** *Requirements for Advance Directive documentation are detailed in VHA Handbook 1004.2.*

x. **Discharge Summary**

(1) The discharge summary needs to be prepared for all releases from VHA care, including deaths. Transfers to other levels of care, such as: VHA domiciliary care, VHA nursing home, or other VHA medical centers, must be documented by a discharge summary.

(2) Responsibility for the preparation of the discharge summary and for its content rests exclusively with the member of the medical staff having primary care responsibility for the patient. The treating specialty from which the patient is discharged is responsible for completing the summary.

(3) The summary should be documented prior to discharge, or within 24 hours of death or irregular discharge. When the discharge summary is completed more than 24 hours prior to discharge, local policy determines the timeframe when an addendum is required.

(4) If not the author, the supervising practitioner must review the summary, make appropriate edits, and indicate approval by co-signature.

(5) Summaries must be prepared as follows:

(a) Diagnosis. List the principal diagnosis, i.e., that condition established after study to be chiefly responsible for the admission of the patient to the hospital for care; then, in order of clinical importance, list all other diagnoses for which treatment was given. Diagnoses must include post-operative complications or infections and drug or serum reactions. All diagnoses need to include a site and etiology, when applicable, and must be stated in full, without symbols and/or abbreviations, and in accordance with the latest edition of International Classification of Disease (ICD).

(b) Psychiatric Diagnoses. Diagnoses must be stated in accordance with the latest edition of Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis must be recorded in AXIS format and, if applicable, must include the Global Assessment of Functioning (GAF) score.

(6) Operations and surgical procedures must be stated in full, without symbols and/or abbreviations, and in accordance with the latest edition of CPT and/or ICD Procedural Index. The site involved and the procedures performed must be stated. The listing must include all operations, diagnostic and therapeutic procedures, and the date performed. All procedures need to be documented in the text of the summary.

(7) The body of the Discharge Summary must include:

(a) The name of the member of the medical staff responsible for patient's care and the primary physician, if applicable.

(b) The reason for admission (principal diagnosis, i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital).

(c) Other diagnoses and/or conditions treated.

(d) All operations and procedures performed and the treatment rendered during current admission, with dates.

(e) Pertinent past medical history.

(f) Pertinent points in review of systems (including allergies or drug sensitivities).

(g) Pertinent findings of laboratory and radiological data.

(h) Pertinent findings of the physical examination, particularly abnormalities.

(i) Brief course in hospital stay to include treatment received and condition on discharge. ***NOTE:*** *Condition must be more specific than "improved" and needs to permit measurable comparison with condition on admission.*

(j) Condition of wound, if applicable.

(k) Place of disposition, i.e., home, nursing home, etc.

(l) Discharge instructions to patient, or responsible other, to include:

1. Information regarding condition or proper home care.

2. Medical follow-up. ***NOTE:*** *If a private physician, state the name if possible.*

3. Medications on discharge.

4. Diet instructions.

5. Activity and/or limitations.

6. Specific date to return to work. ***NOTE:*** *State if a period of convalescence is required, if retired, or if any of this is to be determined at a later date.*

(m) If the patient has a psychosis or an organic mental impairment, there must also be a statement regarding the patient's competency to handle VA funds.

(n) If summary concerns a death case, there must be a statement that an autopsy was or was not performed.

y. **Autopsy**

(1) Preliminary or provisional anatomical diagnoses must be documented within 72 hours of autopsy.

(2) Final protocols must be completed, signed, and properly filed within 30 days of autopsy.

(3) The Death Certificate must be amended when the results of an autopsy require a change in cause of death.

9. HEALTH INFORMATION MANAGEMENT (HIM)

a. **HIM Functions.** HIM functions vary depending on facility, but may include Release of Information, the File Unit, Ward Administration, Medical Care Cost Recovery, Transcription, Coding, Compliance, etc.

b. **The Health Information Professional**

(1) Professional education and experience prepare credentialed health information professionals to: direct health information programs; develop systems that document, manage, validate, and use medical information; advise medical staff and management on medico legal and compliance, research, quality assurance, and other related issues.

(2) The AHIMA credentials both the Registered Health Information Administrator (RHIA) and the Registered Health Information Technician (RHIT) health information professionals. Health information professionals convey a positive, professional image and share expertise with administration and other departments, organization staff, medical staff, and health care professionals in the community. ***NOTE:*** *The term management should be synonymous with effectiveness.*

(3) Ethics, education, VHA regulations and directives, and other external regulations guide the health information professional's actions.

(4) In addition to internal departmental activities, the health information professional and staff participate in the ongoing measurement, evaluation and improvement of organization-wide performance by taking part in establishing priorities, identifying best practices, working on committees, preparing reports, empowering staff, and collecting and analyzing data.

c. **Management Processes.** The health information professional:

(1) Organizes the HIMS according to the facility's needs and updates the HIM organizational chart as changes occur;

(2) Measures ongoing intradepartmental performance by establishing priorities, collecting data, monitoring and reporting outcomes, using valid and reliable techniques to analyze trends and variation, and taking appropriate action based on findings;

(3) Creates, maintains, and revises HIM staff position descriptions as changes occur;

(4) Develops and maintains an historical guide to health record changes that have occurred over the life of the facility that would impact retrieval of health records;

(5) Ensures there is a facility-wide process in place to correct erroneous health information; and

(6) Ensures there is a facility-wide process in place to allow only authorized individuals to document in the health record.

d. **HIM Program Attributes.** Characteristics of an effective HIM Program include:

(1) Documented policies, processes, and procedures that address all VHA, Federal, regulatory and accrediting requirements for HIM.

(2) That a documented, implemented total data quality management plan includes validity and reliability checks for data accuracy, consistency, and uniformity. It ensures that these reliability checks are completed as a regular part of the clinical data and health record analysis and coding, abstracting, and data-reporting process.

(3) Development of short and long-range goals for the HIM Program that are developed, updated, and coordinated in tune with VHA's strategic plan and appropriate veterans Integrated Service Network (VISN) and/or facility goals and objectives.

(4) Continuous assessment of the HIM's expenditures.

(5) Provision of educational opportunities for all HIM professionals through in-service programs and the promotion of educational opportunities outside the organization.

(6) An atmosphere that promotes decision making and problem solving at the appropriate management level.

(7) Development of staffing and productivity requirements which meet the organization's needs.

(8) Training that ensures staff are competent to perform the duties outlined in their position descriptions.

(9) Qualitative and quantitative analysis of patient records performed on a concurrent basis.

e. **Reviews and Monitors**

(1) The HIM professional must establish and schedule performance monitoring and measuring activities to assess quality and timeliness of health information services in order to:

(a) Identify variances from standards,

(b) Ensure accuracy and consistency of information, and

(c) Capture the results of care rendered to provide both patient and clinician the best possible information.

(2) Reviews must be done to assess presence, proper format, authentication, timeliness, and documentation supporting patient care, as reflected by the patient record.

(3) Criteria must be established for reviews utilizing, at a minimum, current JCAHO standards and VHA initiatives, as appropriate, and must include all areas of patient care. With the ongoing implementation and improvement of the electronic health record, reviews must encompass new areas of risk that occur in an electronic health record system. Where possible, reviews need to utilize technology to assist in identifying instances and/or patterns of documentation (or lack of) risk.

(4) Topics for evaluation need to include:

(a) Quality of HIM Services

1. Record availability for ambulatory and/or outpatient care visits and inpatient scheduled admissions, if applicable. ***NOTE:*** *This may include unscheduled downtime when CPRS is not available.*

2. Record completion reporting.

3. Timeliness, productivity, and quality of coding activities.

4. Timeliness, productivity, and quality of record analysis.

5. Timeliness and productivity of release of information activities.

6. Quality and timeliness control of transcription services, this may include turnaround time, use of abbreviations, error rates, etc.

7. Timely filing and/or scanning of reports.

(b) Data Validation

1. Validation of the clinical and administrative information reported in the PTF, including the 401 and 419 reports;

2. Validation of the clinical and administrative information reported in the PCE data;

3. Inpatient and outpatient facility and professional services coding; and

4. Adequacy of billing processes and/or procedures, if applicable.

(c) Compliance with Health Record Privacy, Confidentiality, and Security Standards

1. Access to patient records to ensure compliance with record privacy and confidentiality standards.

2. Access to the electronic health record, including those using the PDX, NHE, or Remote Data View.

3. Appropriateness of disclosures of facility patient information from telehealth operations, if applicable.

(d) Training. Training effectiveness of health information personnel.

(e) Contracts. Contracts or contract review, if applicable (i.e., coding, transcription, etc.).

(f) Reviews. Reviews and other activities pertinent to the delivery of quality health information services.

f. **Health Record Review**

(1) HIM must define, develop, or in conjunction with facility Quality Management initiatives, ensure that health records are reviewed on an ongoing basis at the point of care by people who document in the record based on organizational defined indicators that address presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity, accuracy, completeness, and authentication. Results of record reviews, findings from record completion monitors, and monthly delinquent record statistics must be reported at least quarterly to the facility health record review committee, or its equivalent, as outlined in the facility By-laws. This committee provides oversight and coordination of the review process(es), assists with developing indicators, decides how often reviews will occur, receives and analyzes reports, decides what and when focused reviews are to be implemented, and documents follow-up for outliers until improvement reflects an acceptable level or rate. Such follow-up must include any additional reviews necessary, education and/or action taken. A representative sample of charts from each service or program, inpatient and outpatient, must be reviewed to ensure adequate, timely, complete, and properly-authenticated documentation is being accomplished in accordance with all JCAHO standards and all VHA policy.

(2) Qualitative and quantitative analysis of patient records must be performed, preferably on a concurrent basis.

(3) Monitoring unauthenticated documentation must be a part of the ongoing health record review process and must, at a minimum, include the following:

(a) No notes where an encounter exists in VistA;

(b) Unsigned and/or un-cosigned notes, addenda, discharge summaries, operative reports; and

(c) Unsigned orders.

(4) Examining inappropriate documentation may be included in the review process and may encompass some or all of the following areas:

(a) Copy and paste use within CPRS,

(b) Authenticity of user electronic signatures, and

(c) Unauthorized entries into the health record.

(d) Results of other facility inquiries, monitors, or concerns that stem from improper or inadequate documentation.

NOTE: *Facility policy determines who is responsible for tracking resident supervision requirements and reporting, no less than quarterly, to the appropriate medical staff committee.*

g. **Employee Orientation.** The HIM professional participates in, or contributes to, orientation of all new staff expected to have contact with, or access to, health records. ***NOTE:*** *The HIM professional and the Clinical Application Coordinator(s) need to work collaboratively with respect to the set-up, maintenance, access, and use of the CPRS system.* Orientation and/or education must include, but is not limited to, the following:

(1) Confidentiality of health records (including VHA disciplinary actions for violations of confidentiality) and the proper procedures for releasing information.

(2) JCAHO and VHA requirements for clinical staff entries, including authentication, and other documentation requirements outlined in this Handbook.

(3) Set up and formulation of Authorization Subscript Utilities consistent with facility By-laws, especially as they relate to the business rules for CPRS to include: documentation, authentication, security, access, and other business rules relating to health record documentation.

(4) Format of proper documentation.

(5) Time standards for documentation.

(6) Error correction or addenda to records.

(7) Acceptable use of copy and paste.

(8) Required diagnostic information when ordering.

(9) Applicable medical necessity requirements.

(10) Chart deficiency protocols.

(11) Dictation and transcription protocols.

(12) HIMS operational services, including hours and staff availability.

(13) Clearance procedures.

h. **Coding**

(1) **Oversight.** The credentialed HIMS Director or Chief, or designee, is responsible for:

(a) Supervising or providing oversight for any diagnosis and procedure coding done outside the program in order to ensure the complete and accurate description of patient services.

(b) Providing training and/or consultation to staff who assign or analyze diagnoses and/or procedure codes outside of HIMS.

(c) Supporting and endorsing the AHIMA Standards of Ethical Coding.

(2) **Professional Staffing**

(a) Coding is an art and science requiring specialized training, education, and skills. There are specific guidelines and criteria that must be followed to ensure proper code assignment, sequence, and reporting. While coding is performed for a variety of reasons, it is primarily done to permit the search and retrieval of information according to diagnosis or procedure associated with an assigned code number.

(b) To ensure that coded data accurately reflects the diagnoses and the services provided to patients, it is essential to recruit, hire, and provide continuing education to retain competent, credentialed (RHIT, RHIA, Certified Coding Specialist (CCS), Certified Coding Specialist – Physician-based (CCS-P), Certified Professional Coder (CPC), Certified Professional Coder-Hospital (CPC-H)) coders.

(c) Contract coding services must be monitored for quality.

(3) **Closeout**

(a) Monthly, semi-annual, and annual closeout of the patient data files (PTF and PCE) are directed by current VHA policy and must be followed accordingly.

(b) A quarterly census is conducted and must be validated. ***NOTE:*** *Refer to current VHA census policy for further information.*

(4) **Coding Systems**

(a) The coding methods used are monitored depending on the needs of the facility.

(b) The International Classification of Diseases-9th edition-Clinical Modification (ICD-9-CM) and the latest United States editions of the American Medical Association (AMA)'s CPT, and the American Psychiatric Association (APA)'s DSM must be used to provide uniform disease and operation terminology which is complete and scientifically accurate.

(c) Code assignment must be in accordance with National Center for Health Statistics (NCHS), Center for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), AMA, and APA guidelines. ***NOTE:*** *The Handbook for Coding Guidelines provides guidance on coding for VHA. The AHA Coding Clinic, CPT, and other publications may be used for training and reference purposes.*

(d) The use of encoders for both inpatient and outpatient coding is mandatory.

(e) ICD-9-CM and CPT coding books and any coding related software must be upgraded at least annually, but may be upgraded more often based on when updates are issued.

(f) Staff must have access to the most recent coding guidelines.

(5) **Encounter Forms.** The use of electronic encounter forms is mandatory. The diagnosis documented on the encounter form does not substitute for documenting the diagnosis in the note. Coding on the encounter form must be substantiated by the documentation in the practitioner's note. Encounter forms need to be reviewed and updated annually to reflect changes in ICD-9-CM and CPT codes.

(6) **Data Collection**

(a) Guidelines regarding performance measures, or required data elements, and reporting are disseminated to staff as updates are published.

(b) Complete and accurate data collection is required and the manner in which it is collected must consider efficiency and timeliness.

(7) **Physician Query.** All codes must be based on physician documentation contained in the body of the health record. Physician query forms are not to be filed in the body of the health record, but maintained in a separate file. Physician queries must be written clearly and concisely and not "lead" the physician to provide a particular response. ***NOTE:*** *Facilities need to establish policies and procedures for obtaining physician clarification, such as allowing the coder to directly contact the physician about a record being coded.* Communication tools such as summary forms, attestation sheets, and query forms must never be used as a substitute for appropriate physician documentation in the health record. Any response from the physician of a coding query that will be used to support a code assignment must be documented by the physician in the health record.

i. **Transcription.** Effective management of the clinical transcription unit directly affects the quality and timeliness of health information found in CPRS. Management activities may include:

(1) Developing dictation instructions and providing education for clinicians in the proper techniques for effective dictation.

(2) Ensuring timely assignment of clinician dictation access and verify codes.

(3) Providing on-the-spot assistance to clinicians having difficulty with dictation.

(4) Developing and monitoring quality standards for transcribed documents that are uploaded into CPRS, including turnaround time from completion of dictation until the document is ready for electronic signature.

(5) Providing adequate, current references for both in-house and at-home transcription staff.

(6) Specifying and monitoring turnaround time, quality, and confidentiality compliance when using outside transcription services.

(7) Ensuring that vendors for dictation and transcription equipment provide routine preventive maintenance, training, support, and software upgrades.

(8) Remaining current on emerging dictation and transcription technologies to serve as a subject-matter expert in planning and decision-making activities related to this area.

j. **Release of Information**

(1) **HIM Professional.** HIM Professional is responsible for:

(a) Both safeguarding and disclosing, as appropriate, health information according to applicable VA standards:

1. The Privacy Act of 1974;

2. HIPAA;

3. Freedom of Information Act (FOIA);

4. Title 38 U.S.C. Section 5701, which protects veterans' names and addresses;

5. Title 38 U.S.C. Section 5705, which protects VA records and documents created by a VA medical center's medical quality assurance program activities; and

6. Title 38 U.S.C. Section 7332, which protects drug and alcohol abuse, Auto Immune Deficiency Syndrome (AIDS), HIV, and Sickle Cell Anemia patient treatment records.

(b) Developing policies, processes, and procedures, designed to protect the privacy of patient health information and the confidentiality of health records maintained by VHA; this includes monitors that both safeguard and appropriately disclose protected health information. These policies and procedures must:

1. Address appropriate methods of disclosure.

2. Define those circumstances that require patient authorization prior to disclosure of patient data and health care information, and when disclosure of patient health care information may be made without the patient's consent.

3. Differentiate between mandatory disclosure (for example reporting of elder abuse) and permissive disclosure (for example access by health care staff).

4. Identify the circumstances that require inclusion of a re-disclosure notice with the release of patient-identifiable data and health care information.

5. Define circumstances when the transmission of patient-identifiable data and health care information can be appropriately forwarded by facsimile machine.

6. Identify those communicable diseases and other public health threats that require reporting to an appropriate government agency, and the mechanism by which the reporting is accomplished.

7. Address the discriminating level of confidentiality provided to health care information pertaining to behavioral health, substance abuse treatment, HIV, AIDS, abortion, and adoption.

8. Establish policies and procedures to allow the patient to review, amend, and/or correct the patient's health record.

9. Establish policies and procedures to make administrative updates and corrections to the patient health record.

10. Establish agreements for any HIM home-based employees that state that the employees are under the same requirements as regular employees for protecting confidentiality of all patient-identifiable data and health care information to which they have access.

11. Ensure that contracts for outside services state that the companies providing the services are responsible for maintaining the confidentiality of all patient-identifiable data and health care information to which they have access.

12. Ensure that the confidentiality policies and procedures are part of new HIM employee orientation and are reviewed with the employee on an ongoing basis as part of each employee's continuing education.

(c) Developing, conducting, and evaluating the impact of education and training programs for the facility and/or for specific programs that encompass confidentiality and disclosure of patient-identifiable data and health care information.

(2) **Release of Information Unit.** Release of Information is organized and managed as a comprehensive, centralized unit that:

(a) Meets the requirements of FOIA, HIPAA, 38 U.S.C. Section 7332, and 38 CFR 1.460-1.499.

(b) Applies the appropriate, detailed provisions of VHA regulations.

(c) Honors the patient's right to consent to authorize disclosure.

(d) Ensures each request for patient data and health care information has a valid authorization prior to disclosure.

(e) Coordinates disclosures of protected health information (PHI) from intra-organizational units; ensures disclosures are handled by staff who possess knowledge of applicable VHA laws and regulations and who have had training in the legal ramifications of subpoenas and court orders.

(f) Applies routine administrative processes to all requests, records all disclosures, and accounts for any exceptions to routine processing.

(g) Safeguards the process through the application of quality controls.

NOTE: *Portions of paragraph 9 are adapted from the 1998 AHIMA Health Information Management Practice Standards: Tools for Assessing Your Organization.*

10. MANAGEMENT OF THE PAPER HEALTH RECORD

a. **Medical Record File Activity.** The management of the paper file activity affects the professional and administrative aspects of health care. Two important elements in the management of patient records are the maintenance of folders and file areas, and the service rendered by responsible personnel. Proper and adequate procedures must be established to maintain an efficient and effective patient record file service. Because of the wide variation in physical locations, space allocations and resources for patient record filing administrative procedures may vary. Local policies and guidelines need to be established and followed for the following:

(1) Promptness in manual and electronic filing of record documents.

(2) Consistent availability of patient records when needed and prompt delivery to the requester or user.

(3) Adequate control, requisition, and follow-up of records, including the security of files and limited access to files and file systems.

NOTE: *Centralization of records and 24-hour access for paper records is encouraged. Where 24-hour coverage of an HIM professional is not available, a secure method for location of*

needed records is in place. The filing system must be organized by SSN in terminal digit. Over time, full implementation of CPRS reduces the number of hours the file area must be open since CPRS ensures 24-hour 7-day a week availability of patient information.

(4) Overflow paper records storage areas must comply with the same standards established for access and security of records.

b. **Filing Medical and Administrative Records Folders**

(1) During an inpatient period of care, the health record must be maintained on the inpatient's assigned ward. ***NOTE:*** *The administrative record must be maintained according to local policy. Local procedures must ensure maximum control of active and inactive folders.*

(2) Following release of the inpatient, the administrative records folder must be inserted in the most recent volume of the patient record folder, thus becoming the CHR. The health record must be filed in terminal digit filing sequence according to SSN.

(3) Applications of individuals who are found not to be in need of care, along with a medical certificate and any accompanying medical record documents, and applications of individuals found ineligible for care, must be filed chronologically in the appropriate file section of the patient record (inpatient, ambulatory and/or outpatient care, domiciliary, or nursing home care).

(4) Records of subsequent periods of medical care must be added to the appropriate existing SSN folders. The filing order in the health records folder must be by period of care, treatment, or application for care with the most recent on top.

c. **Record Charge Out System**

(1) The principal rule for the file area is that no record is removed from file area to a qualified user without being charged out. The rule applies to all personnel and is strictly enforced.

(2) Local policy must be established and published regarding the length of time a record may be kept out of file. To the extent practicable, records sent to clinics must be returned before the close of business each day, so that if emergencies occur, the health care team has access to needed information.

(3) Records not returned to the file room must be maintained in an area that is accessible to authorized persons, but secure from unauthorized access.

(4) Record charge out or Record Tracking must be accomplished by the VistA Record Tracking Package. ***NOTE:*** *Local policies and procedures must be established and published for use of the system.*

d. **File Area Rules And Procedures**

(1) Patient record folders must be filed as promptly as possible, or at least once a day.

(2) Inpatient documents intended for filing, when forwarded to the file area, must bear the patient's complete name and SSN. All documents must be incorporated into the records as promptly as possible, having each day's filing completed by the end of the day to the extent possible.

(3) Documents pertaining to active outpatients receive priority processing.

(4) Documents must be fastened in the established filing sequence in the correct section of the respective patient and administrative folders.

(5) An appropriate mechanism must be initiated locally to ensure record availability for those patients who have multiple clinic appointments on the same day.

(6) Only authorized agency personnel with a need to see records, or perform maintenance work, or housekeeping will be allowed access to the file room.

(7) Proper use of filing equipment must be emphasized. Files are not to be jammed so tightly or records inserted so haphazardly that the top edge and right margin of the folder are not flush within the numerical guides.

(8) The supervisor of the file area is responsible for maintaining folders and storage equipment in a neat and orderly manner. Damaged and torn folders must be promptly repaired or replaced. Care must be exercised to ensure that significant markings on the old folders are carried forward to the new ones.

(9) Records being processed must remain on desktops, or in specified marked files, so they can be available at any time to authorized personnel.

e. **Duplication, Transfer, and Loan of Records**

(1) Facilities are encouraged to utilize available electronic means for viewing and/or copying for record transfer.

(2) Procedures relating to the duplication of medical, administrative, and perpetual records must be established and controlled by the HIM professional. To ensure continuity of care, the HIM professional must, when necessary, coordinate the prompt duplication of all medical data required; for example: records, slides, pacemaker records (including VHA Form 10-5548a, Pacemaker Surveillance), prosthetic records, and X-rays.

(3) Records to be sent through the mail must be packaged carefully to guard against damage to the record or improper routing.

(4) The patient record may be temporarily transferred to the Adjudication Division or Board of Veterans Appeals; however, copies of the original record must be maintained at the facility.

f. **Administrative Records.** The administrative folder or tab must contain the applications for care, documents pertaining to eligibility, file copies of pertinent correspondence, and other

administrative documents in conjunction with medical care. The administrative folder or tab may contain the Advance Directive and other administrative documents as defined by local policy. Until there is an administrative tab in CPRS, sites that wish to file administrative documents electronically should create a document class for administrative documents.

g. **Filing Arrangement of Administrative Records**

(1) Unless specifically determined necessary to document a completed action, non-record material such as reference and routing slips, diary forms, suspense copies, worksheets, informal notes, and extra copies of documents retained only for convenience or reference, are not to be filed in administrative record folders. Information filed in the administrative record is subject to the provisions of the Privacy Act as an integral part of the health record.

(2) To facilitate maintenance and to provide ease of reference, records of the most recent period must be maintained on top.

(3) If not maintained in CPRS and/or VistA, the following records must be filed in reverse chronological sequence by episode on the left side of the folder,:

(a) Application for care;

(b) Record material considered pertinent to the application or change of information entered on the application;

(c) All other documents relating to eligibility;

(d) VHA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action, or similar document; and

(e) A copy of all commitment papers.

(4) The right side of the administrative record folder is to contain all other material in reverse chronological order with the most recent documents on top.

(5) The administrative record folder of an inpatient who dies while receiving medical care must contain records necessary for completion of funeral arrangements and disposition of remains and effects.

(6) Folders of deceased individuals must be retained and filed in the same manner as other administrative record folders.

h. **Community-based Outpatient Clinic (CBOC) Records.** Satellite CBOC records, as a subsidiary record of the parent facility health record, are to be established and maintained in accordance with current guidelines for filing and storing ambulatory or outpatient records.

i. **Unit Numbering System.** A single permanent unit number, the SSN, is assigned to a person at the time of the person's first encounter at a VHA health care facility. The same unit number must be used for all subsequent periods of care. Both the administrative and health

record folders must be identified by the SSN; terminal digit filing must be used. This system includes inpatients and outpatients. In unusual circumstances when an individual's SSN cannot be determined, appropriate eligibility staff assigns a pseudo SSN to the individual using the VistA option, which calculates and assigns the pseudo SSN based on the patient's demographic information (name, date of birth,.

11. PAPER HEALTH RECORD MAINTANENCE

a. **General**

(1) When indicated, a VA Form 10-1079, Emergency Medical Identification Label, is used to identify multiple medical problems experienced by a patient and/or special medical program into which a patient has been entered (see M-2, Pt. I, Ch. 17). ***NOTE:*** *Attempted suicide is no longer to be documented on this label, but must be documented on the Problem List and in the progress notes.*

(2) A label must be affixed to the front of the inpatient chart holder to denote any allergies or clinical warnings. Upon release from inpatient care, the label must be reviewed and verified for accuracy, then removed from the chart holder and affixed to the front of the health record folder in the block titled "WARNING," if a label is not already present. If one is present, any needed updates must be made.

(3) When a new volume of the patient's health record is created, a new label must be affixed to the new volume. The HIM professional, or designee, is responsible for recording and validating the medical problem(s) and/or program(s) on the newly created labels of the patient records volumes. ***NOTE:*** *Patient confidentiality must be considered when documenting on this label.*

(4) VA Form 10-2198, Priority Service-Connected Veteran Label, must be affixed to the right side of the exterior cover of the health record of veterans who have a service-connected disability. The label must be affixed in a manner that will not obscure the printing on the form or other notations on the record.

(5) When an individual is identified as a former POW, either at the time of application for medical benefits or at a later time, VA Form 10-5558, POW label, must be affixed to the patient's health and administrative records. The POW label must be placed on the outside front cover of the patient folder on the left side, above the expansion seam and centered under the term "MEDICAL" (RECORDS). On the administrative folder, the POW label must be placed on the outside front cover on the left side, above the expansion seam and centered under the term “ADMINISTRATIVE" (RECORDS). When a health record involves multiple volumes, use of the POW label on any but the most current health record volume is optional. ***NOTE:*** *Records of active POW inpatients must be identified as prescribed locally.*

(6) VA Form 10-9009B, Persian Gulf Identification Label, must be affixed in the lower left-hand corner of the "service connected" block on the exterior cover of the health record for any Persian Gulf veteran participating in the Persian Gulf Registry.

(7) Other labels, such as MCCR and VIST, may be used based on local necessity.

(8) A procedure must be established at each facility for annotating the outside of the most current volume of the patient record folder with the label "Do Not Resuscitate" or "Advance Directive," when appropriate. This notation must be removed when it no longer applies (see subpar. 7w).

b. **Filing Sequence for Hospital Inpatients**

(1) Paper patient records must be filed in accordance with a uniform format approved by the appropriate medical staff committee.

(2) When possible, the patient records of multiple admissions of an inpatient must be filed in one folder. Patient records are not to exceed 2 inches in thickness. When indicated, volumes must be prepared and marked in sequence as "Volume 1 of 2," "Volume 2 of 2," etc. "Volume 1 of 2" indicates the first volume of two volumes prepared for the inpatient. When a third volume, "Volume 3 of 3" is prepared, previous designations must be changed to reflect "Volume 1 of 3," "Volume 2 of 3." Under certain conditions when a patient record involves multiple volumes, it may be practical during inpatient care to retain some volumes on the ward and some in the inactive storage area. When such circumstances exist, the volumes maintained on the wards must have a note attached for the professional staff regarding the location of the remaining volumes. ***NOTE:*** *A patient record of multiple volumes requires care in the control and handling of the volumes to provide promptness in retrievability, and to avoid misplacement of the volumes.*

(3) A standard folder divider must be used to separate each period of inpatient treatment. The name of the facility, the dates of care, and the type of care (hospital, nursing home, domiciliary) must be entered on the divider tab.

(4) Reports from non-VHA health care facilities provided at VHA expense, e.g., Computed Tomography (CT) scans, pathological tissue examinations, or other laboratory study, etc., must be filed with other reports in the appropriate locations of the patient's health record.

c. **Filing Sequence for Ambulatory and/or Outpatient Care Records**

(1) Paper patient record forms pertaining to ambulatory and/or outpatient care must be filed on the left side of the patient record volume of the health record. ***NOTE:*** *A separate outpatient volume may be maintained for the patient, if the appropriate medical staff committee deems it necessary.*

(2) All forms must be properly identified with the patient's full name and full SSN; it is recommended that the date of birth and the facility name be included.

(3) The patient Problem List for ambulatory and/or outpatient care must be clearly labeled as "Outpatient Care," and must be filed as the first form in the outpatient care section of the record. The outpatient Medication Flow Sheet or Medication Profile must be filed as the second document in the outpatient care section of the record. The filing sequence for all other forms is determined locally.

(4) Chart dividers, appropriately identified as progress notes, laboratory, X-ray, doctor's orders and others, as locally appropriate, may be used to separate other various sections of the active outpatient care record in the following general sequence:

(a) All progress notes must be written in chronological order and filed in reverse chronological order with the most recent progress note form on top.

(b) As applicable, if laboratory reports are filed, they must be filed together in reverse chronological order with the most recent report on top.

(c) As applicable, if X-ray reports are filed, they must be filed together in reverse chronological order with the most recent report on top.

(d) Other forms must be grouped by category and filed in reverse chronological order with the most recent form(s) on top.

(e) Anesthesia, operation, and tissue reports, such as, OF 517, Clinical Record - Anesthesia, SF 516, Medical Record - Operation Report, SF 515, Medical Record - Tissue Examination, must be filed together in sets.

(f) Copies of Compensation and Pension Examinations must be retained in the health record and are property of the Veterans Benefits Administration.

d. **Filing Sequence For Nursing HomeCare Records**

(1) **Procedure.** The record of nursing home/ care must be integrated into the health record and must be filed in the same general order as for hospital inpatients. Inpatient periods of care must be filed on the right side of the patient's health record and separate from the inpatient hospitalization. Staff must use a standard folder divider, marked with the facility name, the dates of care, and the type of care (NHCU, Community Nursing Home (CNH), domiciliary, etc.), to separate each period of nursing home care. Periods of inpatient hospitalization and nursing/ home care must be filed separately.

(2) **Absent Sick in Hospital (ASIH).** For nursing or home care purposes, a resident whose period of nursing home care is punctuated by periods where the patient is ASIH (30 days or less), must be considered as having only one episode of nursing or home care, regardless of the number of times the veteran was ASIH. Each inpatient hospital period, however, must be filed separately. Nursing or home care residents who return from a period of hospitalization of 31 calendar days or more must be considered as having a new period of nursing or home care.

12. REFERENCES

a. NIST Special Publication 800-66, An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPPA) Security Rule, Appendix A.

b. Title 5 U.S.C. 551a.

b. Title 44 U.S.C.33.

c. Title 44 U.S.C. 3542.

d. Title 5 CFR 2635.

e. Title 45 CFR 160 and 164.

f. HIPAA of 1996.

g. VA Directive 5021.

h. RCS 10-1.