HEALTH INFORMATION MANAGEMENT AND HEALTH RECORDS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook provides basic health information procedures for managing the patient's 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 ISSUES: VHA Handbooks 1907.03, 1907.04, and 1907.06.

4. RESPONSIBLE OFFICE: The Assistant Deputy Under Secretary for Health for Informatics and Analytics (10P2) is responsible for the content of this Handbook. Questions may be referred to 217-649-3691.

5. RESCISSIONS: VHA Handbook 1907.01, dated July 22, 2014, is rescinded.

6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the last working day of March, 2020.

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HEALTH INFORMATION MANAGEMENT AND HEALTH RECORDS

1. PURPOSE: This Veterans Health Administration (VHA) Handbook provides 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. **AUTHORITY:** 38 U.S.C. 305, 5723(d), 5727(9); 44 U.S.C. 3102(1).

2. BACKGROUND:

a. Under Title 44 United States Code (U.S.C.) 3102(1), VHA, by statute, must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient health records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education, research, and facilitate performance improvement processes and legal requirements.

b. The most current standards of The Joint Commission must also be followed, unless specifically otherwise stated.

c. The health 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 printed patient information is subject to the same medical and legal requirements as handwritten information in the health record.

d. 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 (5 U.S.C. 552a), the Freedom of Information Act (5 U.S.C. 552); Federal Information Security Management Act (44 U.S.C. 3541); Office of Management and Budget (OMB) Circulars A-123 and A-130; VA Directive and Handbook 6500 Managing Information Security Risk: VA Information Security Program; Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules (Title 45 Code of Federal Regulations (CFR) 160, and 164); VHA Handbook 1605.1, Privacy and Release of Information; and The Joint Commission standards for privacy and security.

e. In accordance with Department of Veterans Affairs (VA) Handbook 6500, regarding the Information Security Program, local safeguards must be established concerning patient record security and confidentiality.

3. SCOPE: This Handbook provides guidance for managing health information and the health record.

4. DEFINITIONS: See Appendix A.

5. CONFIDENTIALITY OF INFORMATION:

a. All staff with access to patient information in the performance of their duties needs to know their responsibilities in maintaining the confidentiality of VA sensitive information, especially patient information, by completing the annual Cyber Security and Privacy training.

b. Under 5 U.S.C. 552a, patient health records are confidential regardless of medium. The privacy of patient information must be preserved and the information must not be accessible to, or discussed with, any unauthorized persons, nor is the information to be discussed in public areas.

c. Every VA employee with access to patient health records in any medium is responsible for the proper use, disclosure, and handling of the patient health records (see VHA Directive 1605, VHA Privacy Program, and VA Directive 6500, Managing Information Security Risk: VA Information Security Program). VA employees are also accountable for safeguarding patient confidentiality and privacy; failure to do so will result in administrative action, up to and including, termination or other legal adverse action.

d. VA employees must transport patient paper health records within the health care facility using a secure means, such as locked bags. Patient names and Social Security Numbers (SSN) located on the outside of the paper health record must be protected from incidental viewing by the public while in transport. Patient health records must be in control at all times by the VA employee and not left unattended in any public area. Where resources are not available, the patient may transport the patient's own health record, as long as reasonable safeguards, approved by the Chief, Health Information Management (HIM), or facility Privacy Officer, are in place to ensure confidentiality and to maintain integrity of the health record. ***NOTE:*** *VHA is minimizing the risk of identity theft and fraud by eliminating the unnecessary use of the SSN as an identifier, when possible.*

6. ACCESS TO HEALTH RECORDS AND INFORMATION:

a. Access to health information is controlled, based upon specific criteria, to ensure integrity, minimize the risk of compromising confidentiality, and increase reliability. Only minimal access necessary to perform official job functions must be provided to employees.

b. Access to health records and health record file areas is limited to authorized personnel. Only authorized personnel are allowed to print extractions from the patient's electronic health record or to make copies from the paper chart.

c. Active or inactive health records must be readily accessible to authorized clinical and administrative staff.

7. INFORMATION SECURITY:

a. Security measures for authorizing access to the patients' health record must be delineated in local policy. VA requires that all individuals requiring access to VA information and information systems complete VA's approved VA Privacy and Information Security Awareness Rules of Behavior training before such individuals are authorized access to patients' health record and complete the training annually thereafter (see VA Directive 6500 and Handbook 6500 Appendix D, Risk Management Framework for VA Information Systems - Tier 3: VA Information Security Program, Appendix D, Department of Veterans Affairs National Rules of Behavior Introduction**)**.

b. As custodian of the health record, only the Chief, HIM, or designee, can approve the physical removal of original health records from the treating facility.

c. 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 designated authorized personnel are not present to ensure the security of the area and to ensure health records are not accessible to unauthorized individuals. Documents and health records show that the facility monitors physical access to information systems to detect and respond to incidents. VA requires that facilities control physical access to information systems by authenticating visitors before authorizing access to facilities or areas other than areas designated as publicly accessible (see VA Handbook 6500, Appendix D).

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

e. 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. ***NOTE:*** *For more information refer to the VA Directive 6371, Destruction of Temporary Paper Records, which establishes VA policy to ensure that Personally Identifiable Information (PII) and other sensitive agency information contained in paper records is disposed of properly. Shredders that are compliant with this Handbook are specified in the National Security Agency (NSA) Central Security Service (CSS) Evaluated Products List for High Security Crosscut Paper Shredders EPL-02-01-AB at: http://www.nsa.gov/ia/_files/Government/MDG/NSA_CSS_EPL_02_01_AB.pdf.* Paper shredders can be used to destroy flexible media, such as diskettes, once the media are physically removed from their outer containers. The shred size of the refuse must be small enough that there is reasonable assurance in proportion to the data confidentiality that the data cannot be reconstructed (see National Institutes of Standards and Technology (NIST) 800-88, Guidelines for Media Sanitization, http://csrc.nist.gov/publications/nistpubs/800-88/NISTSP800-88_with-errata.pdf).

f. 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 VA Handbook 6500, Appendix D. This disaster plan must include provisions for recovering health care records on different types of storage media and emphasize that the goal is to prevent damage first, and then focus on recovery if health records are damaged or destroyed.

8. SECURING E-MAIL AND FACSIMILE TRANSMISSION:

a. **E-mail.**

(1) According to VA Handbook 6500, Appendix D, electronic mail must be used for authorized government purposes and contain only non-sensitive information, unless the information is appropriately encrypted. All encryption modules used to protect VA data must be validated by NIST to meet the currently applicable version of Federal Information Processing Standards (FIPS) 140-2.

(2) For Outlook or E-mail, both Public Key Infrastructure (PKI) certificates and Microsoft Rights Management Services (RMS) are FIPS 140-2 certified and VA approved for transfer of PII and protected health information (PHI). The Office of Information Technology (OIT) issues

PKI certificates to use when sending sensitive information; encryption ensures that the message and its attachments cannot be read or tampered during transmission.

(a) Personnel must follow the national PKI policies and procedures issued by OIT.

(b) Requests for PKI certificates are to be directed to the Local Registration Authority (LRA), who typically serves as the Facility Information Security Officer (ISO) at VHA facilities and program offices. A complete listing of Trusted Agents (including LRAs) can be accessed at: https://vaww.portal.va.gov/sites/PKI/Lists/VA%20Trusted%20Agents2/AllItems.aspx. ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

(c) When the national deployment of the RMS product is complete, it can be used interchangeably with PKI to send sensitive information. ***NOTE:*** *For details on the RMS rollout, contact the facility ISO.*

(3) Auto-forwarding of email messages to addresses outside of the VA network is strictly prohibited.

b. **Facsimile.**

(1) Information received by facsimile (fax) is acceptable and may be included in the patient's health record. Fax machine transmittals must not include information on drug, alcohol, Human Immunodeficiency Virus (HIV), or sickle cell anemia, unless the transmittal is directed to medical personnel, to the extent necessary, in a bona fide medical emergency.

(2) Fax machine transmittals may be used when no other means exists to provide the requested information in a reasonable manner or time frame and the fax machine is in a secure location and reasonable steps (i.e., verifying the fax number and notifying the individual prior to faxing) have been taken to ensure the fax transmission is sent to the appropriate destination.

(3) Fax machine transmittals may also be used for non-patient care (i.e. instructions for travel or to facility; meeting minutes); however, all established fax protocols must be strictly observed.

(4) A confidentiality statement must be attached to the cover page when transmitting individually-identifiable health information. For example, when transmitting outside VA: "This fax is intended only for the use of the person or office to which it is addressed and may contain information that is privileged, confidential, or protected by law. All others are hereby notified that the receipt of this fax does not waive any applicable privilege or exemption for disclosure and that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please notify this office immediately at the telephone number listed above." ***NOTE:*** *See VHA Handbook 1605.1, Privacy and Release of Information, for more information.*

9. EMPLOYEE HEALTH RECORDS:

a. The health records of employees are under the management of human resources and, if on paper, must be stored in a separate and secure location from Veteran health records, and access should be granted only to those designated individuals with a need-to-know. If documented electronically in the Computer Patient Record System (CPRS), they must be secured

utilizing Authorization Subscription Utilities (ASU) and the Veterans Health Information and Technology Architecture (VistA) Sensitive Flag must be set to "sensitive" to ensure that access to these health records is limited. All employee health records in CPRS must be designated as "sensitive." ***NOTE:*** *For information on the Occupational Health Record-keeping System (OHRS), refer to the User's Guide on the VA Documentation Library at: http://www4.va.gov/vdl/application.asp?appid=186. This is an internal VA web site and is not available to the public.*

b. The health records of employees who receive care as Veterans are under the auspices of HIM and are maintained with other Veteran health records. If on paper, these health records may be sequestered in a special location if directed by local policy. The electronic documentation of these health records must be secured by identifying them as "sensitive" health records in CPRS.

10. COMPLIANCE: There must be periodic review, or audit, of access to patient health records to ensure compliance with health record privacy and confidentiality standards. ***NOTE:*** *See VHA Handbook 1605.03, Privacy Compliance Assurance Program and Privacy Compliance Monitoring, for more information.*

11. RESPONSIBILITIES:

a. **Medical Facility Director.** The medical facility Director, or designee, is responsible for establishing policies and processes in compliance with this Handbook, to include ensuring:

(1) The security and integrity of health record documentation through strict maintenance of ASU software applications.

(2) The health information professional (see paragraph 12.b.) is involved in all decisions, both technical and administrative, that impact, define, and control access and disclosure of patient health records.

(3) All relevant health information is assembled when a patient is admitted to inpatient or Community Living Centers (CLC) care, seen for a prescheduled or unscheduled ambulatory care visit, or presents for emergency services.

(4) Health information is available during scheduled and non-scheduled downtime of the computer systems.

(5) Authentication and authorization requirements are enforced (see paragraphs 13 and 14 of this Handbook).

(6) Health record completion and delinquency policies are consistent with accreditation standards, regulatory requirements, and medical staff guidelines (see paragraph 16 of this Handbook).

(7) Tracking and completing unauthenticated documentation.

(8) An adequate disaster recovery and contingency plan for health records according to VA Directive and Handbook 6500, Appendix D, and it must be reviewed at least annually, and staff

must be oriented to the location of disaster manual materials (see paragraph 24 of this Handbook).

(9) The elimination or judicious use of the "copy and paste" electronic functionality.

(10) There are adequate security measures for identifying those users who can document in the health record with an electronic signature and for verifying the authenticity of user electronic signatures (see paragraph 25.f. of this Handbook).

(11) The proper procedure for correcting erroneous patient information is entered electronically or on paper (see paragraph 26 of this Handbook).

(12) Who has the authority to reassign an "erroneously entered progress note," and under what circumstances these options are utilized (see paragraph 26.c.(2) of this Handbook).

(13) Who has the authority to change a patient note title, and under what circumstances these options can be utilized (see paragraph 26.c.(4) of this Handbook).

(14) That the Advance Directive is maintained in both the paper outpatient record and the paper inpatient record to accommodate patient movement from one setting to another, or from one facility to another (see paragraph 27.z.(2) of this Handbook).

(15) The maximum control of active and inactive patient paper record folders.

(16) The appropriate use of the health record charge-out system (see paragraph 30.d. of this Handbook).

(17) The proper annotation on the outside of the most current volume of the patient health record folder is labeled, "Do Not Resuscitate" or "Advance Directive," when appropriate (see paragraph 31.a.(8) of this Handbook).

(18) Health information is filed in terminal digit sequence according to SSN.

(19) Access to health records and information (see paragraphs 6 and 12.j.) is controlled and limited to authorized staff.

(20) Information security (see paragraph 7).

(21) Confidentiality of records is maintained regardless of medium (see paragraph 5).

(22) That only authorized and identified individual's document in the health record.

(23) Physical access to patient systems and records is controlled by authenticating visitors (see paragraphs 14 and 17.c.).

(24) MVI is maintained in the local VistA system (see paragraph 21).

(25) The proper retention, disposal, and transfer of patient health records (see paragraph 17).

(26) Non-VA medical care is documented.

(27) Adverse and sentinel events and close-calls are reported and documented (see paragraph 21).

(28) Research, clinical trials, and experimentation have appropriate approvals and documentation (see paragraph 23).

(29) Proper management and maintenance of the paper health record (see paragraphs 29 and 30).

(30) All documentation meets The Joint Commission standards.

(31) There is a policy in effect for correcting or rectifying health records.

(32) All electronic health care records are completed with confidentiality and integrity (see paragraph 25).

(33) Procedures are in place for the duplication, transfer, or loan of health records (see paragraph 28 and paragraph 29.f.).

b. **Chief of the Clinical Service.** The Chief of the clinical service, or designee, is responsible for the clinical management of health records, with each clinician and professional service contributing to the content of the patient health record.

c. **Health Information Manager.** The Chief of Health Information Manager (HIM) is responsible for the administrative management of health records, which includes planning, managing, advising, and directing the health information program in accordance with applicable Federal laws, facility by-laws, VHA policy, The Joint Commission standards, the Commission on Accreditation of Rehabilitation Facilities (CARF), and other regulatory and accrediting agencies. The Health Information Manager also creates and monitors systems to ensure accurate, timely, and complete health records, in accordance with VHA policy and The Joint Commission health information protocols. The HIM professional is responsible for:

(1) **Managing Processes.** The HIM professional:

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

(b) 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;

(c) Creates, maintains, and revises HIM staff position descriptions and functional statements as changes occur;

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

(e) Ensures there is a VA medical facility-wide process in place to correct erroneous health information (see paragraph 26); and

(f) Ensures there is a VA medical facility-wide process in place to allow only authorized individuals to document in the health record (see paragraph 14).

(2) **Reviewing and Monitoring Records.** The HIM professional:

(a) Establishes and schedules performance monitoring and measuring activities to assess quality and timeliness of health information services in order to:

1. Identify variances from standards;

2. Ensure accuracy and consistency of information; and

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

(b) Reviews the health record in order to assess presence, proper format, authentication, timeliness, and documentation supporting patient care, as reflected by the patient health record.

(c) Establishes criteria for reviews utilizing, at a minimum, current The Joint Commission 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. ***NOTE:*** *Where possible, reviews need to utilize technology to assist in identifying instances or patterns of documentation (or lack of) risk.*

(3) **Evaluating Processes.** The HIM professional needs to evaluate the following topics:

(a) Quality of HIM Services.

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

2. Health record completion reporting.

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

4. Timeliness, productivity, and quality of health 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 productivity and quality of filing or scanning of reports.

(b) Data Validation.

1. Validation of the clinical and administrative information reported in the PTF, including the PTF Average Length of Stay (401) and PTF Disposition in Master File (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 procedures, if applicable.

(c) Compliance with Health Record Privacy, Confidentiality, and Security Standards. This includes:

1. Access to patient health records to ensure compliance with health 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.

(4) **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 Applications Coordinator(s) need to work collaboratively with respect to the set-up, maintenance, access, and use of the CPRS system.* Orientation and education must include, but is not limited to, the following:

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

(b) The Joint Commission and VA requirements for clinical staff entries, including authentication, and other documentation requirements outlined in this Handbook.

(c) Set up and formulation of ASU 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.

(d) Format of proper documentation.

(e) Time standards for documentation.

(f) Error correction or addenda to health records.

(g) Acceptable use of copy and paste.

(h) Required diagnostic information when ordering.

(i) Applicable medical necessity requirements.

(j) Chart deficiency protocols.

(k) Dictation and transcription protocols.

(l) Patient encounter form completion.

(m) Resident supervision requirements.

(n) HIM operational services, including hours and staff availability.

(o) Clearance procedures.

(5) Release of Information (ROI). The HIM Professional is responsible for the day-to-day activities of releasing health records in accordance with VHA Handbook 1605.1, Privacy and Release of Information, and working closely with the facility Privacy Officer, or in serving as the alternate Privacy Officer, in:

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

1. 5 U.S.C. 552a, the Privacy Act of 1974;

2. 45 CFR parts 160 and 164, the HIPAA Privacy and Security Rules;

3. 5 U.S.C. 552, Freedom of Information Act (FOIA);

4. 38 U.S.C. 5701, which protects Veterans' information in claims files, specifically names and addresses;

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

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

(b) Developing procedures relating to the duplication of medical, administrative, and perpetual medical records to ensure continuity of care and, 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.

(c) Developing policies, processes, and procedures, designed to protect the privacy of patient health information and the confidentiality of health records maintained by VA; this includes monitors that both safeguard and appropriately disclose protected health information by ROI staff. HIM policies and procedures must adhere to the facility Privacy Policy to:

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. Provide for the prompt identification and indexing of incoming requests for Veteran individually-identifiable health information.

7. Conduct a comprehensive systematic review of the release of information activity within the VA health care facility not less frequently than once every 12 months.

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

9. 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.

10. Evaluate periodically factors such as workload, processing times, etc. to identify backlogs and expedite responses to requests for information.

11. 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.

(6) **Coding.** The HIM professional is responsible for the coding functions, which includes:

(a) Oversight. The oversight responsibilities include:

1. 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.

2. Providing training and consultation to staff assigning or analyzing diagnoses or procedure codes outside of HIM.

3. Supporting and endorsing the AHIMA Standards of Ethical Coding, which are found in the following Web link: (http://library.ahima.org/xpedio/groups/public/documents/ahima/bok2_001166.hcsp?dDocName=bok2_001166).

(b) Professional Staffing.

1. Coding requires specialized training, education, and skills. Specific guidelines and criteria 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.

2. 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 and timeliness.

12. MANAGEMENT OF HEALTH RECORDS:

a. **Ownership.** A health record and the health information within the health record are property of VA, as specified by 5 U.S.C. 552a(a)(4) and 44 U.S.C. 3301.

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

(1) Patient health records must be maintained on the following individuals:

(a) The individual admitted to any level of inpatient care (medical facility, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), CLC, etc.).

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

(c) The individual who is dead on arrival (authorized or unauthorized admission).

(d) The individual who is provided with ambulatory care for humanitarian reasons.

(e) The Veteran whose State Home or non-VA medical care or treatment is provided at VA expense.

(f) The Veteran whose community nursing home care is provided at VA expense.

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

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

(i) The individual placed in pre-bed care, on ambulatory care or outpatient status, or on non-VA medical care status.

(j) The non-Veteran patient who is evaluated or treated in a VA medical facility under a sharing agreement (i.e., TRICARE, Civilian Health and Medical Program of VA (CHAMPVA)).

(k) A family member or significant other of a Veteran attending individual counseling.

(l) A Veteran who is being treated at a Community Based Outpatient Care (CBOC) under VA auspices or at a VA medical facility.

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

(2) The primary traits used to uniquely identify a patient within the Master Veteran Index (MVI) include, but are not limited to, the patient's name, SSN, Date of Birth (DOB), and gender. Secondary traits that may be used include, but are not limited to, the mother's maiden name, address, and place of birth (city and state).

(a) The name entered into the patient's electronic health record must be the complete legal proper name, and include a full middle name when available.

(b) In the event the identity of a patient is unknown, a pseudo SSN is assigned with 1900 entered for the DOB, and the name entered as UU-UNRESPONSIVE, PATIENT. Subsequent patient health records must be entered as UU-UNRESPONSIVE, PATIENT A, UU-UNRESPONSIVE, PATIENT B, etc. The patient is then treated as a non-Veteran, humanitarian emergency, until the patient's identity can be established. Health records must be completed with appropriate identity data elements once the patient has been identified (see VHA Directive 1906, Data Quality Requirements for Healthcare Identity Management and Master Veteran Index (MVI) Functions, for more information regarding requirements for identity management and MVI functions).

(c) 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 paragraph 25g(1) of this Handbook) including health information in packages other than Text Integration Utilities (TIU) and CPRS (i.e., laboratory, radiology). If assistance is required in ensuring that all unique identifiers are correct at the enterprise level, the national Healthcare Identity Management (HC IdM) Data Quality Team should be involved in the resolution process. All paper health information must also be corrected to reflect the correctly identified patient.

(d) Official name changes to the electronic health record must be coordinated with the local site's MVI Point of Contact, Privacy Officer, and the national HC IdM Data Quality Team.

(e) Written requests for a name change, including removal of a middle name or middle initial from health records, are handled as a request for amendment of health records. Official documentation is required for all name change requests. ***NOTE:*** *The required documentation varies based on the type of modification being requested (i.e. correction, change, removal). Some requests are not granted.*

(3) Health records must contain original signed documents, or electronically-authenticated documents.

(4) Health Record data within the electronic health record system will not be purged from the electronic system.

c. **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, or scanned information. Paper entries must be made in black ink to ensure permanent recording. ***NOTE:*** *Handwritten entries are limited to those documents that current technologies cannot yet support.*

d. **Symbols, Abbreviations, and Acronyms.** While there is no requirement by The Joint Commission for a list of approved symbols, abbreviations, and acronyms, 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, abbreviations, and acronyms 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, abbreviations, and acronyms are not to be used when documenting final diagnoses and procedures on patients released from inpatient, ambulatory or outpatient services. When included in information provided to patients (e.g., consent forms), abbreviations and acronyms must be explained in language that the patient can understand.

e. **Language.** All entries must be in English, and must conform to acceptable English grammar. Documents that provide information to patients (e.g., consent forms) may include Spanish translations, when appropriate, provided that both Spanish and English translations are included in the document.

f. **Shadow Records.** Shadow records (see Appendix A) must be limited or non-existent.

(1) To ensure compliance with The Joint Commission standard RC.01.01.01, there must be a process to track the location of all components of health records, including shadow records.

(2) Facility HIM Managers must be aware of any use of shadow records and, with the advice of the Facility Records Manager and the Medical Record Committee or equivalent, each site must determine the need to continue the use of any shadow health records and document such action in the committee minutes.

(3) Any use of shadow records must include a policy to address the privacy, security, and destruction of shadow records that may not be under the control of the HIM Manager.

g. **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 via the facility approval process prior to implementation.

(4) All components must reflect patient identifier information (full name and second unique identifier, such as Integration Control Number (ICN); when possible, the last four digits of the SSN are used instead of the 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.

h. **Health Record or Health Information Availability.** A local policy and process must be established ensuring health information is always available, as needed (see paragraph 11.d. of this Handbook).

(1) For most cases where a patient is treated or seen at another VA medical facility, the Patient Data Exchange (PDX), Network Health Exchange (NHE) or Remote Data View (RDV), Remove Image View, VistA Web, or Register Once software must be used to expedite the transfer of needed health information between facilities. Scanned documents and images are only viewable through Remote Image View in VistA Imaging. 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 using overnight mail or secure fax machine when absolutely necessary.

(2) Previous inpatient and outpatient health records must be made available upon specific request for treatment purposes or as support for claims benefits. When there is evidence that a health record exists at another VA medical facility or, at the VA Records Center and Vault (RC&V), the record must be ordered upon specific request (see paragraph 17.b. of this Handbook).

i. **Preparing Records for Litigation.** Records for litigation that are unsigned, or with incomplete entries, must be presented for court exactly as they existed at the time the VA medical facility received the court order for the records. The same applies for records requested by Regional Counsel. If the VA medical facility needs to complete 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. ***NOTE:*** *Refer to HIM Practice Brief #4, "Guidelines for Defining a Legal Health Record," for specific guidance on preparing a record for a Tort claim; it can be found at: http://vaww.vhahim.va.gov/index.php?option=com_content&view=article&id=13&Itemid=572. This is an internal VA Web site and is not available to the public.*

13. 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).

a. Standardized and current electronic signature blocks for all authorized users based on the person's class taxonomy file must be maintained at each facility. This ensures non-repudiation and that appropriate billing occurs.

b. Authentication functionality must include the identity and credential or professional discipline of the author, the date signed, and the time signed, if required.

c. If the title block is used, it needs to accurately reflect the functional position of the user as defined by the service.

d. 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.

e. Monitors to ensure person class files are correct must be established at each facility.

f. A method of identifying the author on paper must be established; i.e., 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. Signature stamps cannot be used.

g. 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.

h. Controlled substance outpatient prescriptions in Schedules II, III, IV or V may be electronically prescribed using the prescriber's PIV card to perform two-factor authentication using CPRS version 29 or later. This process will generate a digitally signed prescription that is compliant with Drug Enforcement Administration (DEA) rules found in the 21 CFR part 1311. ***NOTE:*** *Electronic signatures can be utilized for inpatient orders of controlled substance medications without two-factor authentication.*

14. AUTHORIZED ENTRIES:

a. Policies, procedures, and ASU (see Appendix A) rules must be established at each VA medical facility to ensure only authorized individuals document in the health record and that the author(s) and any required cosigner(s) are identified.

b. ASU rules must be in concert with facility by-laws and facility policy.

c. Facility by-laws must be reviewed regularly and updated, if necessary, to depict who is authorized to make entries in the health record.

d. Caution must be exercised to ensure that any documentation included in the health record represents work that is appropriate within an individual's scope; i.e., calls from patients that may include questions or comments that accompany the request for medication refills may be more appropriately documented by a nurse versus being captured by a clerk.

e. Only those individuals authorized by facility policy are allowed to make entries into the health record. This includes administrative documentation.

f. The practitioner who treats a patient is the individual responsible for documenting and authenticating the care provided. Interdisciplinary notes are used when multiple practitioners provide treatment during the same encounter.

g. 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.

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

i. Health record entries must be: completed, signed, and cosigned as necessary, transmitted, filed, 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 paragraph 28 of this Handbook).

j. A "Report of Contact" template can be used to document communications with patients. This practice must be reviewed by the appropriate health record committee and approved to ensure that the health record only includes information that supports the patient's treatment.

15. SENSITIVE HEALTH RECORDS:

a. Some specific health 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:

(1) VA Veteran employee patient health records;

(2) Regularly-scheduled Veteran volunteers;

(3) Individuals engaged in the presentation of claims before VA, including representatives of Veterans' Service Organizations, or cooperating public or private agencies or Administrative Tort Claims; and

(4) Records involved in Administrative Tort Claim activities.

b. Specific medical or psychiatric diagnoses must not be the sole basis for flagging a patient record as "sensitive." For example, records of patients should not be flagged "sensitive" solely because the patient is diagnosed as having HIV. ***NOTE:*** *With the concurrence of the ISO, or designee, similar security measures may be applied to other patient records.*

16. COMPLETE AND INCOMPLETE HEALTH RECORDS:

a. **Record Completion.** Patient health records must be timely, relevant, necessary, complete, and authenticated.

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

(2) 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:

(a) Specify time standards for content, authentication, and completion as required by The Joint Commission or VA medical facility policy.

(b) 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.

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

(d) Address whether or not students in teaching institutions can record in the official health record and the accuracy requirements for their entries.

(e) Define those entries in the health record that require countersignatures by supervising practitioners.

(f) 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.

(g) Ensure the presence and authentication of, at least, the following entries when appropriate:

1. History and physical (H&P) examinations;

2. Operative reports;

3. Diagnostic and therapeutic procedures;

4. Consultations; and

5. Discharge summaries.

(h) Ensure that the discharge summary and the operative reports are signed and co-signed, as necessary, by the supervising practitioner.

(i) Define when an inpatient health 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 of the health record as close to the date of discharge is strongly encouraged.* To determine delinquency, the average acute care health record delinquency rate needs to be noted. This includes health records delinquent for any reason. The total average is the total of all quarterly averages divided by four.

NOTE: *The total average is compared to the Average Monthly Discharge (AMD) Rate. The AMD is the total number of inpatient discharges in the 12 months prior to survey divided by 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.*

b. **Responsibility.** The Chief of Staff, or designee, has ultimate oversight responsibility for health record timeliness, accuracy, and completion; however, 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.

c. **Authenticating Documents.**

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

(2) A supervising practitioner or medical staff member may, however, summarize a course of treatment based on existing patient health record documentation, or review a summary for consistency with existing patient health 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 health 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.

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

d. **Unauthenticated Documents.** Unauthenticated documentation is considered "Incomplete" and, in CPRS, is subject to revision and potential deletion by the author.

(1) Policy and procedures to track and complete unauthenticated documentation must be established by each VA medical facility.

(2) 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.

e. **Declaring a Health Record "Complete for Filing."** A health record is declared "Complete" for the purpose of filing when all required documentation is present.

(1) If unusual circumstances prevent proper completion, the health record must be referred to the appropriate medical staff committee for review and completion.

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

(3) A sample statement such as "Approved for filing incomplete on (date) by Medical Staff Committee due to (reason)" may be used to note the health 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 health records due to the failure of an available physician to sign the documents.

17. RETENTION, DISPOSITION, AND TRANSFER OF RECORDS:

a. **Retention.** The retention policy applies equally to both paper and electronic health 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.

b. **Storage.** Health records must be stored at the treating VA medical facility for 3 years after the last patient activity. If space is an issue, active health records may be stored until retirement in National Archives and Records Administration (NARA) approved facilities or in facilities that meet the NARA guidelines. Previous inpatient and outpatient health records must be made available upon specific request for treatment purposes or as support for claims benefits. When there is evidence that a health record exists at another VA facility, or, at the RC&V, the record must be ordered upon specific request.

c. **Retirement of Records.**

(1) Paper records are retired to the VA RC&V at:

VA Records Center
11693 Lime Kiln Drive
Neosho, Missouri 64850

NOTE: *For more information on RC&V see http://www.rcv.va.gov/. This is an internal VA Web site that is not available to the public. 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.*

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

d. **Permanent Transfer.** For patients receiving the majority of their care at a VA medical facility different from where their paper health records are being kept or stored, those health records must be transferred to the current treating facility. Paper health records that are transferred to another facility are not to be refused by the receiving facility.

18. LOANING HEALTH RECORDS: Health records may be copied, loaned, or transferred to other VA medical 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. Utilizing available electronic means for viewing or copying for record transfer is encouraged.* If it is necessary to loan or mail original health records, VA Directives 6609, Mailing of Sensitive Personal Information, and VA Directive 7179, Mandatory Use of the Federal Strategic Sourcing Initiative for Domestic Delivery Services for Express and Ground Small Package Shipments and Express Heavyweight Shipments, must be followed sending the records by a secure delivery service that tracks mail from pick-up to delivery. Under no circumstances are health records to be mailed with a weekend delivery date.

19. 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, including images,

need to be retained and limit this to pertinent, present, 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 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 health 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 (38 U.S.C. Chapter 57). 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 to the original source.

c. If an external image is to be included in the electronic health record, the image must be scanned and imported into VistA Imaging with an origin of "NON-VA", type of image, procedure or event of "Photograph", and "Patient Provided" entered in the short description field and attached to the progress note for the visit or the appropriate non-VA titled note.

d. Electronic images must be screened through the Information Technology (IT) Office to determine if the media can be read or printed and to ensure security guidance is met before importing into VistA Imaging. If the image cannot be imported or printed out for scanning, the practitioner must document in the progress note and the patient notified.

20. MASTER VETERAN INDEX (MVI):

a. The role of the Master Veteran Index (MVI) is to assign and maintain a unique identifier for patients. This unique identifier (Integration Control Number or ICN) is used across the system to link patient data and facilitate the longitudinal health record.

b. Active patients are enumerated at the MVI nationally as identity information is entered into VistA at local sites. Accuracy of patient identity data is essential. Patient's full name, SSN, DOB, and gender are key elements used to uniquely identify patients. Additional traits that can be used to identify patients include, but are not limited to: mother's maiden name; place of birth city and state; and some address information. Inaccurate entry can mean that a new ICN is generated, when, in reality, the patient already has an existing ICN. This prevents the linking of all records for that patient and limits the ability to view the complete VA health record.

21. ADVERSE AND SENTINEL EVENTS AND CLOSE CALL REPORTING:

a. Adverse and sentinel events and close call reporting is the reporting, review, or analysis of incidents that cause harm or have the potential for causing harm to the patient. The reporting of such events is stated in VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook.

b. 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 health record.

c. 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.

d. Disclosure of adverse events to patients refers to the forthright and empathetic discussion of clinically significant facts between providers or other VHA personnel and patients or their personal representatives about the occurrence of a harmful adverse event, or an adverse event that could result in harm to the patient in the foreseeable future. Requirements for documentation of clinical, institutional, and large-scale disclosure of adverse events to patients can be found in VHA Handbook 1004.08, Disclosure of Adverse Events to Patients.

22. NON-VA MEDICAL CARE:

a. The requesting practitioner must document in the VA health record a justification for using non-VA medical care in lieu of VA medical care. Decisions to continue the use of non-VA medical care must be documented in the VA health record by the reviewing practitioner, including justification for extending short-term, non-VA services. Copies of clinical documentation submitted by non-VA medical care providers and other reports (such as dental records, laboratory records, and radiology records) should be available in the VA health record (i.e., captured in VistA Imaging).

b. Clinical documentation for denied VA non-medical care claims, such as ambulance records and the associated documentation must be scanned to an administrative document class until such a time that there is an administrative tab in CPRS. To capture in VistA Imaging:

(1) Attach to the Patient Only (Administrative).

(2) ORIGIN: FEE.

(3) DOCUMENT IMAGE DATE: Date of service.

(4) DOCUMENT IMAGE TYPE: DENIAL LETTER.

(5) IMAGE DESCRIPTION: Type in the facility's name that performed the service.

23. 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 or individually-identifiable health information (IIHI). In addition, certain research activities may require the creation of health records. ***NOTE:*** *VHA Handbook 1605.1, Privacy and Release of Information, VHA Directive 1200, Veterans Health Administration Research and Development Program, and the VHA 1200 series Handbooks contain additional VHA polices relating to research.*

a. VA health records must be accessible for VA investigators for preparing and conducting research protocols and pilot studies once all privacy and research requirements have been met. In compliance with VHA series 1200 Handbooks, VA investigators must:

(1) Obtain Institutional Review Board (IRB) and R&D Committee approvals as required by VHA Handbooks 1200.01, Research and Development (R&D) Committee, and 1200.05, Requirements for the Protection of Human subjects in Research.

(2) Meet all other requirements of VHA Handbooks 1200.01, 1200.05, and 1200.12, Use of Data and Data Repositories in VHA Research.

(3) Meet the same approval requirements for access to health records required as is required for access to records for non-research purposes.

(4) Either obtain a written HIPAA authorization signed by the individual prior to accessing the individual's health record, or obtaining a waiver of HIPAA authorization from the IRB or Privacy Board. ***NOTE:*** *Guidance on access and other privacy laws affecting research can be found in VHA Handbook 1605.1, Privacy and Release of Information.*

(5) Either obtain informed consent for research from each individual whose health records are accessed, or obtain a waiver of informed consent from the IRB (see VHA Handbook 1200.05, Requirements for the Protection of Human Subjects in Research).

b. VA investigators and VA research staff may only access those records necessary to prepare a research protocol or conduct the approved research.

c. If access to health records is needed preparatory to research, it must be in compliance with all applicable privacy regulations and policies; however, access to health records 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 Handbooks 1605.1, 1200.05, and 1200.12 for further information on polices related to preparatory to research.*

d. Once access has been approved, the investigator must retain the IRB approval number with the list of health records accessed for the study. The list of required health records, along with who is authorized to review them, and the IRB approval forms (including approval of waiver of recruitment, 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 (such as the Privacy Officer) who are required to audit or review such information. These files must receive the same level of security as the other research records.

e. VA 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.

f. If access to health records or databases containing health information located at remote VA medical or administrative facilities is needed, the investigator must follow all applicable research policies found in VHA Handbook series 1200. Permission to access records from other sites must follow all procedures as defined by the Office of Informatics and Analytics, National Data Systems and the offices having responsibility for the health records creation and use.

g. A VA health record must be created or updated for all research subjects when required by VHA research policy as found in VHA Handbook 1200.05.

h. A method to identify clinic visits solely for research must be used to differentiate those visits from any other clinic visits. Clinic visits and inpatient care for research purposes must be coded as non-billing events.

i. Except as listed in the preceding, the investigator's research records (Investigators Case History) must 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.

j. 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 professional and, if applicable, the ISO.

24. DISASTER RECOVERY PLAN:

a. An adequate disaster recovery and contingency plan for VA health records must be established at each VA medical facility according to VA Directive 6500, Managing Information Security Risk: VA Information Security Program, and Handbook 6500, Managing Information Security Risk: VA Information Security Program, and VA Handbook 6500, Risk Management Framework for VA Information Systems - Tier 3: VA Information Security Program Appendix D, Department of Veterans Affairs National Rules of Behavior Introduction. 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:

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

(2) 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;

(3) Contingency methods to provide access to records, which may require coordination with national MVI, in electronically stored or paper form;

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

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

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

(7) 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.

b. 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.

c. Staff must be oriented to the location of disaster manual materials.

d. Routine disaster drills must be conducted.

e. 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.

f. The disaster recovery plan needs to be reviewed at least annually.

25. ELECTRONIC HEALTH RECORD:

a. **Computerized Patient Record System (CPRS).** Computerized Patient Record System (CPRS), VA's electronic health record, contains Electronic Protected Health Information (EPHI). As such, CPRS is subject to the HIPAA Security Rule, which requires that covered entities guarantee the confidentiality, integrity, and availability to EPHI that they create, receive, maintain, or transmit.

(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. 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 VA.

(3) In CPRS, the following terms apply:

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

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

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

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

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

b. **Standards of Electronic Notes.**

(1) Electronically stored 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.

(a) As nomenclature evolves, note titles must be standardized as proliferation of note titles makes retrieval difficult and cumbersome.

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

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

(8) 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 VA medical 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.

(9) 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.

(10) Electronic health record 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, 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. ***NOTE:*** *Multidisciplinary referrals such as VHA organ transplant referral are not subject to this*

limitation as they are created for the sole purpose of expeditious clinical review, not to document clinical progress.

(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 health 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. ***NOTE:*** *The exception to this is VHA organ transplant referral documentation that is compiled to present a standard data set captured at a particular moment in time to facilitate review by the clinical review board.*

(3) A policy that ensures the elimination 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 or Copying Text.

1. Never copy the signature block of a completed note into a new 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 health record verbatim into progress notes, consults or discharge summaries 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. ***NOTE:*** *See paragraphs 26 and 27 of this Handbook for guidance on alterations or modifications to the health record. For guidance on correcting non-TIU documents, see "Erroneous Document Corrections" at http://vaww.vhahim.va.gov/index.php?option=com_edocman&task=document.download&id=119&Itemid=713. This is an internal VA Web site that is not available to the public.*

(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 the 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. 552a(e)(5)); or

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

3. Disciplinary actions may be taken if violations of these standards are validated according to VA Directive 5021, Employee/Management Relations. 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. Crisis notes, clinical warnings, and Advance Directives are entered with an appropriately titled progress note and may be rescinded by changing the note title (for example, "Rescinded Advance Directive"). Allergies are entered from the cover sheet by going to the allergies or adverse reaction box and adding a new allergy. They can be removed by marking the allergy as entered in error. ***NOTE:*** *Future developments may allow the capability to inactivate a posting without changing the title of the note. For information on Patient Record Flags, go to:*http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=2341. *This is an internal VA web site and is not available to the public.*

e. **Clinical Reminder.**

(1) A clinical reminder is an electronic decision support tool to remind clinicians of an action or to display a patient's state in order to facilitate actions when appropriate, or to make the clinician aware of a patient's state. Reminders are support tools to assist health care staff. They are not a part of the health 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, and the clinical information that may not be available in a computed format for a reminder to evaluate.

(2) Clinical reminders are dynamic; i.e., they are a function of CPRS, not stored data elements. A clinical reminder is run each time the patient record is opened and is based on data capable of being evaluated at that moment in time. Clinical reminder behavior changes with time. Some reminders apply only to certain age ranges, vital sign values, medication orders, diagnoses, or laboratory results, which all change frequently over time. Therefore, a reminder may have a state on one day, but a different state when viewed at a different point in time.

(3) A clinical reminder dialog is the documentation tool that acts as a template for documenting appropriate actions taken related to a given clinical reminder. The documentation of responses to a reminder, including progress note text, entry of orders, entry of vital signs, or entry of other data elements is part of the patient health record.

(4) Clinicians must evaluate clinical documentation resulting from the reminder for accuracy. Correction of any incorrect data is made based on facility policy.

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 legally accountable for the sole use of his or her own access and verifies codes. The person whose signature the electronic code represents must sign a yearly "Rules of Behavior" statement that this individual is the code's only user. This agreement includes the agreement for nondisclosure of codes to others.

(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 separate purposes depending on the role of the signer. For example: author, 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-laws or policies. A co-signer may edit and authenticate a document if the author has not already signed the document.

(c) "Additional signer" is 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.

g. **Document Scanning.** Document scanning, or document imaging, is a process by which a paper document is converted to an electronic file.

(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 must be scanned. CPRS documents from VA medical facilities must not be printed and scanned into

VistA Imaging as the documents can be viewed in VistA Web and Remote Data View. Scanned images, digital X-rays, and other digital images from other facilities can be viewed in Remote Image View. Development of document scanning policies is a shared responsibility among HIM and other appropriate services.

(3) The NARA disposition authority for electronic health records allows VA to destroy source documents after scanning, but only if health record retention and retrieval requirements can be met, and quality control processes are in place. In accordance with the NARA disposition authority, document imaged records must be retained to satisfy the "75-year after the last episode of care" retention requirement.

(4) Original source documents may be destroyed after scanning as long as the person doing the scanning performs a 100 percent review of each scanned document during the scanning process for quality control purposes to ensure it is readable and retrievable for health record retention.

(5) Source documents may be retained if there is a compelling business reason to do so.

(6) Quality assurance reviews must be conducted by a third party (i.e., supervisor, quality coordinator) on a sample of the scanned documents.

(7) VHA-originated scanned images of paper documents must include the patient identifier of full name, last four digits of the SSN, and DOB.

(a) Digital image captures must meet the same criteria of patient identifier as scanned documents. However, some paper and digital images received from sources outside VA, such as private hospitals or physician offices; do not contain all of the identifying data required of VHA-originated documents. In the case of electronically received images, the cover page must include, at a minimum, the patient's name and last four digits of their SSN before importing into VistA Imaging. Each subsequent page needs to contain, at a minimum, enough identifying traits to clearly identify the patient. In the case of a large quantity of paper documents (determined by local policy, such as over 100 pages) received, the full name, last four digits of the SSN, and DOB can be written on the first and last page of the documents in lieu of adding the last four digits of the SSN and DOB to the patient name on every page when scanning as a complete packet.

(b) Photographs also need to include the patient identifier, but may not be able to accommodate the identifier when taking a close up photograph, such as a wound. Therefore, when photographs cannot capture the patient identifier, take a picture with the patient identification (name, last four numbers of the SSN, DOB), such as on an index card with the information to be used as the first image in the study. Then take the close up picture(s) of the body part or area. Finally take another identification picture at the end. The identification pictures must be the first and last picture in the series with the non-identified close-up pictures in the middle. ***NOTE:*** *It may be beneficial to take a wide angle picture(s) before the close-up pictures when possible.*

(8) Local policy on scanning documents 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 a 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 the scanning takes place (centralized versus decentralized scanning).

(d) The handling of external source documents (see paragraph 19).

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

26. HEALTH RECORD ALTERATIONS AND MODIFICATION:

a. 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 (see paragraph 29).

b. There are four types of health record changes:

(1) **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 individual, are generally considered to be administrative in nature and may be initiated by the Veteran.

(2) **Administrative Correction.**

(a) 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.

(b) Examples of items that can be handled in this manner include, but are not limited to: incorrect date, association or linking data to wrong patient, association or linking data to wrong

clinician or facility, and other designated clinical data items impacting the integrity of a patient's record.

(c) 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.

(3) **Addendum.**

(a) 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, to document supervision, and to indicate concurrence with the decisions of a trainee or resident.

1. Addenda are linked to originally created documents.

2. Addenda must be authenticated in an approved manner.

3. 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.

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

(4) **Amendment.**

(a) 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 VA health records must be submitted in writing to the facility Privacy Officer, or designee, by the patient or Veteran stating explicitly what information is in contention and why, i.e., inaccurate or erroneous, irrelevant, untimely, or incomplete. ***NOTE:*** *If a patient requests in writing (versus a practitioner request) that external source documents be made a part of the patient's record, it is considered a request for amendment to the patient's VA health record.*

(b) When a request to amend a health record is approved, the disputed information must be corrected or deleted using the TIU AMEND action by the Chief HIM. 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.

(c) 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:

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

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

(d) 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 must not be made within the body of the electronic document, they are included automatically when the document is printed or displayed.

(e) 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.

c. The following electronic options for correcting data are currently available:

(1) **Deletion.**

(a) 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.

(b) 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 where the use of the TIU DELETE action causes a retraction of the original document include:

1. 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.

2. A TIU document may be automatically generated by other packages, such as Medicine or Clinical Procedures. If the document must be removed, the best solution is to regenerate the document correctly (by retransmitting the procedure from vendor device to VistA by Health Level Seven (HL7)) and delete the incorrect document. If an audit trail of the deletion does not exist, paper copies of the original documents must be saved, as with other manual correction processes.

(2) **Reassign.**

(a) 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, i.e., 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:

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

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

3. Full progress note title of the erroneously-entered note;

4. Date and time of the erroneously-entered note; and

5. Reason the note is to be reassigned.

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

(c) When the reassignment action is complete, the user is prompted to clean up the encounter data from the original visit. When the author authenticates the unsigned copy in CPRS, they are prompted for encounter information if site specific parameters are set up to trigger this action.

(d) Reassignment of documents must not be done on notes that automatically pulled in patient specific information by use of data objects when the note was initially entered. ***NOTE:*** *The data is erroneous information for the correct patient documentation.*

(3) **Reassignment of Addenda (Promote).**

(a) 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, i.e., by sending an electronic mail message to the designated VistA mail group. Addendum reassignment takes place when any of the following four scenarios occur:

1. An addendum must be moved to a different document;

2. An addendum must be moved forward as a document for another visit;

3. A parent document is to be replaced with an addendum; or

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

(b) The TIU software behaves consistently regardless of the action selected. The TIU software 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.

(4) **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:

(a) 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.

(b) 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.

(5) **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 found at:* http://www.va.gov/vdl/application.asp?appid=65 . Only the Privacy Officer, or designee, or the Chief, HIM, or designee, is authorized to make amendments. ***NOTE*:** *For changes or corrections to non-TIU documents, i.e., radiology or pathology reports, see the Erroneous Document Corrections Practice Brief posted on the VHA HIM Web site at:* http://vaww.vhahim.va.gov/index.php?option=com_edocman&task=document.download&id=119&Itemid=713 . *This is an internal VA Web site and is not available to the public.*

27. 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 health records.
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 patient.	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, irrelevant, untimely, or incomplete.
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 patient.	Addresses a dispute a patient has about information in their permanent health record.
<u>Examples</u>: a. Solicitations from	<u>Examples</u>: a. Progress note entered	<u>Examples</u>: a. A supervising	<u>Example.</u> Signed (legally binding) subjective comments

UPDATE	ADMINISTRATIVE CORRECTION	ADDENDUM	AMENDMENT
Health Eligibility Center (HEC) mail outs, means test requirements, registration activities, etc. b. An address change.	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 health record. d. Transcription typing the wrong word or diagnosis.	practitioner adds information on the physical exam omitted by the resident. b. A nurse indicates education was provided, omitted from the original document.	or interpretations found in: a. Progress Note; b. Discharge Summary; c. (H&P); d. Autopsy; e. Consult Note; and f. Comments.

28. 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:

(1) 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;

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

(3) Accurate and timely claims review and payment;

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

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

(6) Accurate coding of diagnosis and procedures performed.

b. **Documentation Principles.**

(1) **Standards.**

(a) The Joint Commission 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 VA 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, 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 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 accurate and clinically-relevant statements; derogatory or critical comments are prohibited. 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 or reason for visit and, as appropriate:

1. Relevant history, examination findings, and prior diagnostic test results;

2. Assessment, clinical impression, or diagnosis plan for care;

3. Date and legible identity of the health care professional; and

4. Identification of appropriate risk factors.

(d) The scope of documentation must be comprehensive enough to:

1. Provide continuity of care;

2. Be concise and complete;

3. Reflect any treatment for service-connected condition(s), including Agent Orange, ionizing radiation, military sexual trauma (MST), or external contaminants;

4. Support reported workload; and,

5. Bill for services.

(3) **Timeframes.**

(a) Each entry in the health 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. Notation as to the reason for the delay must also be made. In CPRS, the date of entry identifies when the documentation actually occurred.

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

(4) **Resident Supervision.** The patient health record must document adequate supervision of residents and other health professions trainees in the care of patients according to the most current VA policy (see VHA Handbook 1400.01, Resident Supervision, for additional information pertaining to the supervision of physician, dental, optometry, and podiatry residents, and VHA Handbook 1400.04, Supervision of Associated Health Trainees, for the supervision of all other health professions trainees).

c. **Medical Alert.** Medical alert refers to allergy or adverse reaction information that must be entered in CPRS through the order tab. It must be available for review in CPRS in the top right corner of every tab in the patient posting box and on the cover sheet in the postings box. Allergy information is also available on the cover sheet under the "Allergies/Adverse Reactions" box.

d. **Evaluation and Management Services.** For evaluation and management (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:

1. History;

2. Examination; and

3. 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 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. When not possible for patient to give history, the reason for this must be 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 tests, consults, or changes in medication.

(h) Care received prior to arrival.

(i) Condition at discharge. For Dead on Arrival (DOA) cases or deaths in the Emergency Department, the time and date when the patient expired and the events leading to the death must be recorded by the physician.

(j) Discharge instructions.

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

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

(b) When emergency care is provided, a copy of the health 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 includes:

(a) Reason for transfer;

(b) Stability of patient;

(c) Acceptance by the receiving organization;

(d) Responsibility during transfer; and

(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 or Ambulatory Care.**

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

(2) By the third visit, a summary or problem list must be initiated and maintained by the health care practitioner and must include:

1. Known significant diagnoses;

2. Conditions;

3. Pertinent past procedures;

4. Allergies to foods or drugs;

5. Current medications; and

6. 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 the practitioner has determined that care is no longer required. The termination of care summary note must include:

1. The condition on discharge;

2. Any patient instructions; and

3. 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 The Joint Commission requirements or specific VHA program regulations.

(2) An initial screening 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 Community Living Center (CLC). CLC care requires the Minimum Data Set (MDS) 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 The Joint Commission 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 history and physical (H&P) examination, including updates, must be available within 24 hours of admission but prior to surgery or a procedure requiring anesthesia. The medical staff member's or supervising practitioner's note or addendum may be entered within one calendar day of admission. In a CLC, an H&P must be available within 72 hours of admission, including any co-signature that may be required. In a Mental Health (MH) Residential Rehabilitative Treatment Program (RRTP), an H&P must be completed no more than seven days after 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 recording the history, opinions of the interviewer ordinarily are not to be recorded in the body of the history.

(4) All 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 examination performed within 30 days prior to admission may be used in the patient's health 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 examination 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. An appropriate assessment was completed prior to surgery confirming that the necessity for the procedure is still present.

3. The patient's condition has not changed since the H&P was originally completed, or any other 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 examination must be completed for inpatients and those in CLC care when the patient's length of stay exceeds 365 days.

(e) Ambulatory Care H&P.

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

2. If a patient is on ambulatory or outpatient care status for a year, at the time of the next visit, the patient must be given an annual physical. The mental status of patients receiving mental health services 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 1400.01, Resident Supervision, for documentation requirements).*

(f) Dental Surgery. Qualified oral surgeons must 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 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 VHA Handbooks 1301.01, Ionizing Radiation Registry (IRR) Program Procedures, 1302.01, Agent Orange Health Registry (AOR) Program Procedures to Include All Veterans Exposed to Agent Orange and Special Health Care Benefits for Vietnam Veterans' Children, 1303.1, Evaluation Protocol for Gulf War and Iraqi Freedom Veterans with Potential Exposure to Depleted Uranium (DU), and 1601A.02, Eligibility Determination, must be followed for certain patients, such as former prisoners of war (POWs) and those who have alleged exposure to:

a. Ionizing radiation;

b. Agent Orange;

c. Depleted Uranium; or

d. 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 health record must be created.

j. **Re-assessments.** Re-assessments are completed at regularly specified intervals as outlined in national guidance or when the patient's status significantly changes. All Resident Assessment Instrument (RAI) Minimum Data Set (MDS) assessments are transmitted to the Austin Corporate Data Center Operations (CDCO) where they are kept indefinitely.

k. **Treatment Plan.**

(1) 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.

(2) In the CLC, the initial treatment plan for short-stay and long-stay residents must be completed within 21 days of admission.

l. **Care Plan.**

(1) The care is planned and coordinated by an interdisciplinary team appropriate to a patient's needs. Members responsible for providing care are identified in the care plan.

(2) The care plan indicates the goals and frequency of interventions to achieve those goals.

(3) Care planning recognizes Advance Directives and evidence of resident and family participation in developing and reviewing the care plan.

(4) Documentation in the health record includes the resident's response to care.

(5) For short-stay admissions, the resident is reassessed every 14, 30, 60, and 90 days.

(6) For long-stay admissions, the resident is reassessed every 90 days or, when there is a significant change in condition.

m. **Laboratory and Imaging.**

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

(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:

(a) Patient identity;

(b) Date performed;

(c) Date interpreted;

(d) Type, route, and amount of contrast or radio-pharmaceutical agents used, if applicable;

(e) Specific preparation of the patient;

(f) Findings; and

(g) Name of interpreter.

n. **Progress Notes.**

(1) **General.** 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.

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

(b) 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 clinical warnings and directives.

(c) 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.

(d) Supervision for inpatients and outpatients must be documented by a supervising practitioner according to VHA Handbook 1400.01, Resident Supervision.

(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; a tentative or differential diagnosis, and evidence of medication reconciliation upon the admission. 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, and document in a progress note by the end of the calendar day following admission.

(c) Supervising practitioner admission progress notes may or may not refer to the patient's plan of care, but need to reflect the supervising practitioner's findings and recommendations regarding the patient 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.

(d) The progress note must be properly signed, dated, and timed.

(e) 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) **Community Living Center.** Progress notes must be documented at least every 30 days after admission for the first 90 days of admission and then every 60 days thereafter.

(4) **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.

(5) **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 mental health provider licensed and privileged to do so.

(6) **Electroconvulsive Therapy.** The indications or contraindications for electroconvulsive therapy (ECT) must be documented in a progress note.

o. **Commitment.** 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.

p. **Seclusion and Restraint.** The appropriate licensed health care professional must clearly document the necessity for each seclusion or restraint order in the progress notes.

(1) Seclusion and restraint are interventions of last resort only to be used when the behavior of a patient presents an imminent risk to self or others and other de-escalation interventions have not adequately mitigated the risk. Documentation must include the justification for using seclusion or restraint, a description of the patient's behavior just prior to the use of seclusion or restraint, a description of interventions utilized to de-escalate or reduce the imminent risk so as to avoid the use of seclusion or restraint, a description of the patient's behavior while in seclusion or restraint, and the length of time in seclusion or restraint. If the patient has been in seclusion or restraint in the past, a description of trends in behavior or precipitating events should be documented along with interventions to mitigate these factors. Seclusion or restraint should be terminated as soon as it is safe to do so. Documentation of termination of seclusion or restraint must include a description of the change in behavior that demonstrates that the imminent risk is no longer present, as well as clinical processing or debriefing of the seclusion or restraint with the patient.

(2) 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.

q. **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 and caregivers do not change, 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, including the indications for transfer, and the content 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 be used (see VHA Handbook 1400.01, Resident Supervision, for documentation requirements when residents are involved in the provision of patient care).*

r. **Inter-facility Transfer.** VA Form 10-2649A, Inter-Facility Transfer Form, and VA Form 10-2649B, Physician Certification and Patient Consent for Transfer, are used to record data for both clinical and monitoring purposes and are to be included in the health record. Completion of a templated note in the patient's CPRS with electronic signature is acceptable in place of VA Form 10-2649A. VA Form 10-2649B is available in the iMedConsent library.

s. **Clinician to Clinician Shift Handoff.**

(1) Standard data elements such as allergies, medications, problems, H&P, admitting diagnosis, laboratory results, and consults are routinely communicated from physician to

physician during a shift hand off or a transition in care. Transitions in care include changes in setting, service, practitioner, or level of care.

(2) The "Shift Handoff Tool" in CPRS is the tool by which information may be shared. Any text entered or modified in this tool is not retained permanently as part of the patient's health record. No information intended to be included in the permanent health record must be entered solely in this tool. Any information to be retained permanently must be entered in the appropriate location within the patient's health record.

t. **Discharge Progress Note and Discharge Instructions.**

(1) The physician must complete a discharge progress note or instruction sheet for each period of hospitalization. It must contain the date and the type of discharge, diagnoses, 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, patient education, and discharge medication information. The discharge medication information must contain or reference complete updated medication information, highlighting what's been changed, added, or discontinued (see VHA Directive 2011-012, Medication Reconciliation). The information contained in the Discharge Progress Note, Discharge Instructions, Discharge Summary and related documents must be consistent. The involvement of the supervising practitioner in discharge planning may be reflected by co-signature, or by independent note or addendum.

(2) The health record needs to indicate when instructions are given to the patient or designee. A formal narrative summary (discharge summary) is not a substitute for a discharge 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 AMA must have a final progress note written by a physician indicating any known reason for leaving and any special disposition arrangements.

u. **Consultations and Referrals.**

(1) **Consultation.** A consultation is a service performed for further evaluation or management of the patient (i.e., opinion or advice). 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.

(a) 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 that may affect the condition being evaluated; and

4. The electronic signature of the requestor.

(b) The consultant's 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 the treatment recommended.

(c) 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.

(d) The supervising practitioner is responsible for clinical consultations from each specialty service.

(e) When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents.

(f) Documentation of supervising practitioner involvement must be by independent note, addendum, or in the resident's note.

(g) Consultation notes by a resident must reference the supervising practitioner's name, the nature of the discussion, and concurrence with the management plan.

(h) The consultant's report of advice, opinion, and any services that were ordered or performed must be documented in CPRS to "complete" the consult. 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 as to whether or not the patient was examined, and, if so, if that examination occurred by telemedicine or in person. If the patient's record was reviewed to provide an electronic consult, and the patient was not examined in person or by telemedicine, the consult should be labeled as an Electronic Consult;

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

4. The date of the consult; and

5. The consultant's signature.

(i) 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 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.

(a) Referral for procedures, patient "walk-ins," and self-referrals are not considered a consultation.

(b) A practitioner cannot perform a consultation on the practitioner's own patient, unless it is for a pre-operative clearance.

v. **Informed Consent.**

(1) Practitioners must document the patient's informed consent and discussion in the health record in accordance with 38 CFR 17.32, VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, and VHA Handbook 1004.05, iMedConsent. Separate, specific consent for any aspect of the recommended treatment or procedure that involves research sponsored by VA, as well as any human subjects research conducted on VA premises, must meet requirements of 38 CFR part 16, Protection of Human Subjects, and must be obtained in accordance with VHA Handbook 1200.05, Requirements for the Protection of Human Subjects in Research, VHA Handbook 1058.03, Assurance of Protection for Human Subjects in Research, or superseding regulation and policy. Informed consent for the research aspects of a clinical treatment or procedure must be obtained in addition to informed consent for non-research aspects of that treatment or procedure. In addition, documentation in the health record must comply with The Joint Commission documentation standards.

(2) Written consent is not required to take a photograph or record video or voice for treatment purposes. Photographs, video, voice recordings, digital images, and other non-written media images when obtained for treatment purposes must be placed in the health record, and are subject to all of the same privacy regulations for use and disclosure as the entire content of the patient's health record.

(3) Photographs, digital images, or video or audio recordings that are not made for treatment purposes must comply with the requirements of VHA Directive 1078, Privacy of Persons Regarding Photographs, Digital Images, and Video or Audio Recordings.

(4) VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, is required if the picture, digital image, or video or audio recording contains individually identifiable patient information and is going to be disclosed, even if the picture or recording was taken for treatment purposes.

w. **Anesthesia.**

(1) **Pre-anesthesia Evaluation.** The pre-anesthesia evaluation must be documented by an 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 (i.e., laboratory, Electrocardiogram (EKG), X-ray);

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

(e) Formulation and discussion of an anesthesia plan with the patient 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 a 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:

1. The patient evaluation on admission and discharge from the PACU;

2. A time-based record of vital signs and level of consciousness (either paper or electronic);

3. All drugs administered and their doses, type, and amounts of intravenous fluids administered, including blood and blood products;

4. Any unusual events, including post-anesthesia or post-procedural complications; and

5. Post-anesthesia visits.

(b) This documentation generally is completed by the PACU nursing staff (i.e. RN, LPN or Nursing Assistant as appropriate for the type of documentation.)

(c) 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.

(d) 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.

(e) For outpatients, appropriate ambulatory surgery personnel (determined by local policy) must call the patient after surgery. Post-operative calls that require an assessment to determine possible post-operative or post-anesthesia complications must be conducted by an RN.

x. **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 or Pre-procedural Note.**

(a) In all cases of elective and scheduled major surgery and 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:

1. The findings of the evaluation;

2. Diagnosis (es);

3. Treatment plan, to include choice of specific procedure to be performed;

4. Discussion with the patient and family of risks, benefits, potential complications; and

5. Alternatives to planned surgery.

(b) When a resident completes the note, the supervising practitioner must write an addendum to the pre-operative note.

(c) Staff or supervising practitioners are responsible for authorizing 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, immediately following surgery and before the patient is transferred to the next level of care. An immediate post-operative note is not required if a signed operative report is available in the health record immediately following surgery.

(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, if any.

(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.**

(a) An operative report must be written or dictated and completed by the operating surgeon immediately following surgery. If a post-operative note is written immediately after the operation or procedure, the operative report may then be completed within the time frame as defined in facility policy. ***NOTE:*** *Immediately is defined 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. 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.*

(b) The body of the report must contain the following:

1. Indication for the procedure;

2. Operative findings;

3. Technical procedure used;

4. Specimens removed;

5. Post-operative diagnosis;

6. Names of the supervising practitioner, primary surgeon, and assistants; and

7. The presence 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 Operating Room (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:

(a) Vital signs and level of consciousness;

(b) Medications, blood, and blood components;

(c) Any unusual events or post-operative complications, including blood transfusion reactions; and

(d) The management of such events.

(6) **Diagnostic and Therapeutic Procedure Reports.** Detailed reports of diagnostic and therapeutic procedures performed in other than the OR must be documented in the progress notes by the practitioner performing the procedure, and must contain:

(a) The name of procedure;

(b) The name of the person performing procedure;

(c) Details of performance;

(d) Major findings and conclusions;

(e) Whether or not tissue was removed;

(f) Any complications; and

(g) 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 that 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 must 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.

y. **Orders.**

(1) **General.** All orders, including admission 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 clinical privileges or scope of practice as defined by the medical staff by-laws, to include:

(a) Applicable diagnostic information to justify the service ordered.

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

(2) **Medications.** Medication orders must be reviewed and rewritten when a patient is transferred between services, specialties, or is transferred to a critical care unit. Evidence of medication reconciliation must be documented upon any of the previously mentioned transfers. Refer to VHA Handbooks 1108.05, Outpatient Pharmacy Services, and 1108.06, Inpatient Pharmacy Services, for more information.

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

(4) **CLC Care.** The CLC Program orders must be reviewed 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 health care 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. Standing or Pro Re Nata (PRN) orders must never be given for the use of restraint and seclusion.

(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 accordance 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 designates a clinician responsible for the order. The entering person is 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 accordance 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 DNR is used in this Handbook.* Requirements for DNR orders and documentation are detailed in VHA Handbook 1004.3, Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA). Clarification of this policy can also be found in the EthicsRx: Clarification of VA Do Not Resuscitate (DNR) Policy-Orders Written by Residents, available online at http://vaww.ethics.va.gov/docs/rx/EthicsRx_20030501_DNR_Orders_Written_By_Residents.pdf ***Note:*** *This is an internal VA Web site that is not available to the public.*

z. **Advance Directive.**

(1) Requirements and procedures for documenting and managing Advance Directives in the health record are established in VHA Handbook 1004.02, Advance Care Planning and

Management of Advance Directives, including procedures for managing rescinded Advance Directives.

(2) For the rare circumstances where there is no electronic health record and the patient only has 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. Each facility must develop a mechanism to ensure that the Advance Directive is maintained in both the paper outpatient record and the paper inpatient record to accommodate patient movement from one setting to another or one facility to another.

aa. **State Authorized Portable Orders.** Documentation is required for implementing Veterans' state-authorized portable orders (SAPO), and for writing state-authorized portable orders for VHA patients as part of outpatient or home care, or at discharge, can be found in VHA Handbook 1004.04, State-Authorized Portable Orders (SAPO).

bb. **Discharge Summary.** The discharge summary must be prepared for all releases from VA medical care, including deaths. Transfers to other levels of care (i.e., VA MH RRTP, VA CLC, or other VA medical facilities), must be documented by a discharge summary.

(1) 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.

(2) The completed (signed) summary must be available for viewing in CPRS within 2 business days of discharge from inpatient settings and within 3 business days for CLC residents.

(a) If the discharge summary is completed more than 24 hours prior to discharge, local policy determines the timeframe when an addendum is required.

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

(3) 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 or abbreviations, and in accordance with the latest edition of International Classification of Disease (ICD) Clinical Modification.

(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 Multiaxial format.

(c) Operations and Surgical Procedures. Operations and surgical procedures must be stated in full, without symbols or abbreviations, and in accordance with the latest edition of Current Procedural Terminology (CPT) or ICD- Clinical Modification. 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.

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

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

2. 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).

3. Other diagnoses or conditions treated.

4. All operations and procedures performed and the treatment rendered during current admission, with dates.

5. Pertinent past medical history.

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

7. Pertinent findings of the laboratory and radiological data.

8. Pertinent findings of the physical examination, particularly abnormalities.

9. A brief course in hospital stay, to include treatment received and condition on discharge. The condition must be more specific than "improved" and needs to permit measurable comparison with condition on admission.

10. Condition of wound, if applicable.

11. Place of disposition, i.e., home, CLC, etc.

12. Discharge instructions to patient or responsible other, to include:

a. Information regarding condition or proper home care.

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

c. Medications on discharge, which includes the complete updated medication information, highlighting what's been changed, added or discontinued or references the document that contains this information. For transitions in care or when requested for continuity of care, the complete updated medication list must be included when the Discharge Summary does not contain the complete updated medication list.

d. Diet instructions.

e. Activity or limitations.

f. Specific date to return to work. State if a period of convalescence is required, if retired, or if the date to return to work or period of convalescence is to be determined at a later date.

13. If the patient's mental health condition, including, but not limited to, psychosis or cognitive disorder, may affect the patient's competence to handle VA funds, an evaluation must be done to ascertain competency status and the findings must be documented.

14. If the summary concerns a death case, there must be a statement that an autopsy was or was not performed.

cc. **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.

dd. **Mental Health Residential Rehabilitation Programs.** For documentation requirements for MH RRTP programs, see VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP).

29. HEALTH INFORMATION MANAGEMENT (HIM):

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

b. **Characteristics of a HIM Program.** Characteristics of an effective HIM Program include:

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

(2) A documented, implemented, total data quality management plan including validity and reliability checks for data accuracy, consistency, and uniformity. This plan 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 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 health records performed on a concurrent basis.

c. **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 health record based on organizational defined indicators that address presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity, accuracy, completeness, and authentication.

(2) Results of health record reviews, findings from health 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 must 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, or action taken.

(3) 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 The Joint Commission standards and all VHA policy.

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

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

(a) Encounters without an associated progress note in VistA;

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

(c) Unsigned orders.

(6) Examining inappropriate documentation needs to be included in the review process and needs to encompass at a minimum the following areas:

(a) Copy and paste use within CPRS;

(b) Authenticity of user electronic signatures (see paragraph 25.f. of this Handbook);

(c) Unauthorized entries into the health record (see paragraph 14 of this Handbook); and

(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.*

d. **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 in order to serve as a subject-matter expert in planning and decision-making activities related to this area.

e. **Release of Information Unit.** Release of information is organized and managed as a comprehensive, centralized unit that:

(a) Meets the requirements of the Freedom of Information Act (FOIA), HIPAA, 38 U.S.C. 5701, 5705, 7332, and the Privacy Act, 5 U.S.C. 552a.

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

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

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

(e) Establishes a central liaison with Regional Counsel for coordination of Tort Claims, which may include health records located at multiple facilities.

(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.

(h) Reviews health records against established sensitive information criteria and coordinate the review and release of sensitive information to the Veteran upon his or her request.

f. **Coding.**

(1) **Closeout.**

(a) Monthly, semi-annual, and annual closeout of the patient data files (Patient Treatment File (PTF) and Patient Care Encounter (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 VHA Directive 2011-025, "Closeout of Veterans Health Administration Corporate Patient Data Files Including Quarterly Inpatient Census," for further information.*

(2) **Coding Systems.**

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

(b) The current edition of the International Classification of Diseases-Clinical Modification (ICD-CM) and the latest United States editions of the American Medical Association'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), American Medical Association, and APA guidelines. ***NOTE:*** *The VHA Coding Guidelines provides guidance on coding for VHA and can be located at: http://vaww.vhahim.va.gov/index.php?option=com_content&view=article&id=24&Itemid=694. 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-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.

(3) **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-CM and CPT codes.

(4) **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.

(5) **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 separately.

(a) Physician queries must be written clearly and concisely stated 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.*

(b) 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.

(c) Any response from the physician of a coding query that is to be used to support a code assignment must be documented by the physician in the health record.

g. **Management of the Paper Health Record.** See paragraph 31 for information on the management of paper health records.

30. THE HEALTH INFORMATION MANAGEMENT PROFESSIONAL:

a. HIM 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 health record entries, correction of documentation errors, documentation approaches, information system backup, medico-legal or tort claim issues and disaster recovery. Health information management 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.

b. **Attributes.** Professional education and experience prepare credentialed HIM professionals to direct health information programs, develop systems that document, manage, validate, and use medical information; and advise medical staff and management on medico-legal and compliance, research, quality assurance, and other related issues. ***NOTE:*** *The term management is synonymous with effectiveness.*

(1) 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.

(2) Ethics, including the AHIMA Code of Ethics (http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_024277.hcsp?dDocName=bok1_024277), as well as continuing education, guide the health information professional's actions.

(3) 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.

31. 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 health 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 health record file service. Because of the wide variation in physical locations, space allocations, and resources for patient health 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 health record documents.

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

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

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

b. **Centralization of Health Records.** Centralization of health records and 24-hour access for paper health records is encouraged. Where 24-hour coverage of an HIM professional is not available, a secure method for location of needed health records needs to be 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-hours 7-days a week availability of patient information.

c. **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. The administrative record must be maintained according to local policy (see paragraph 30.g of this Handbook).

(2) Following the release of the inpatient, the administrative records folder must be inserted in the most recent volume of the patient record folder, thus becoming the Consolidated Health Record (CHR). The health record must be filed in terminal digit filing sequence according to SSN (see paragraph 31.j. of this Handbook).

(3) Applications of individuals who are found not to be in need of care, along with a medical certificate and any accompanying health 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 care, outpatient care, MH RRTP, or CLC care).

(4) Records of subsequent periods of health 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.

d. **Health Record Charge-out System.**

(1) The principal rule for the file area is that no health 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 health record may be kept out of file. To the extent practicable, health 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) Health 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) Health record charge out or Record Tracking must be accomplished by the VistA Record Tracking Package. Local policies and procedures must be established and published for use of the system (see paragraph 11.a.(15). of this Handbook).

e. **File Area Rules And Procedures.**

(1) Patient health 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 last four number of the SSN. All documents must be incorporated into the health 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 health record availability for those patients who have multiple clinic appointments on the same day.

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

(7) Proper use of filing equipment must be emphasized. Files are not to be jammed so tightly, or health 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) Health records being processed must remain on desktops, or in specified marked files, so they can be available at any time to authorized personnel.

f. **Duplication, Transfer, and Loan of Records.** ***NOTE:*** *Utilizing available electronic means for viewing and copying for record transfer is encouraged.*

(1) Procedures relating to the duplication of medical, administrative, and perpetual medical records must be established and controlled by the HIM professional (see paragraph. 30.b. of this Handbook).

(2) Health records to be sent through the mail must be packaged carefully to guard against damage to the health record or improper routing and in accordance with VA Directive 6609, Mailing of Sensitive Personal Information.

(3) The patient health record may be temporarily transferred to the Veterans Benefits Administration (VBA) or the Board of Veterans Appeals (BVA); however, copies of the original health record must be maintained at the facility.

g. **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 must create a document class for administrative documents.

h. **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 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.

i. **CBOC Health Records.** Satellite CBOC health 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 health records.

j. **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 VA medical 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, DOB, etc.).

32. PAPER HEALTH RECORD MAINTANENCE:

a. **Labels.**

(1) When indicated, a VA Form 10-1079, Emergency Medical Identification Symbol and Labels, is used to identify multiple medical problems experienced by a patient or special medical program into which a patient has been entered. ***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) or program(s) on the newly-created labels of the patient records volumes. 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 must not obscure the printing on the form or other notations on the health record.

(5) When an individual is identified as a former prisoner of war (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. 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 Medical Care Cost Recovery (MCCR) and Visual Impairment Services Team (VIST), may also be used based on facility policy.

(8) A procedure must be established at each facility for annotating the outside of the most current volume of the patient health record folder with the label “Do Not Resuscitate” or “Advance Directive,” when appropriate. This notation must be removed when it no longer applies (see paragraph. 28.z. of this Handbook).

b. **Filing Sequence for Inpatient Records.**

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

(2) When possible, the patient health records of multiple admissions of an inpatient must be filed in one folder. Patient health 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 health 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. A patient health 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, CLC, MH RRTP) must be entered on the divider tab.

(4) Reports from non-VA health care facilities provided at VA expense, i.e., 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 or Outpatient Care Records.**

(1) Paper patient record forms pertaining to ambulatory or outpatient care must be filed on the left side of the patient health 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 last four numbers of the SSN; it is recommended that the DOB and the name of the VA medical facility be included.

(3) The patient Problem List for ambulatory 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 health record. The outpatient Medication Flow Sheet or Medication Profile must be filed as the second document in the outpatient care section of the health 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 health 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, Official Form (OF) 517, Medical Record - Anesthesia; Standard Form (SF) 516, Medical Record - Operation Report; and SF 515, Medical Record - Tissue Examination, must be filed together in sets.

(f) A completed copy of the C&P exam must be kept in the patient's health record and retained as part of the legal health record.

d. **Filing Sequence for CLC Records.**

(1) **Procedure.** The health records of nursing home or CLC 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 (CLC, Community Nursing Home (CNH), etc.), to separate each period of CLC care. Periods of inpatient hospitalization and CLC care must be filed separately.

(2) **Absent Sick in Hospital (ASIH).** For nursing or home care purposes, a resident whose period of CLC care is punctuated by periods where the patient is ASIH (30 consecutive 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 consecutive calendar days or more must be considered as having a new period of nursing or home care. ***NOTE:*** *All VA forms referenced by number within paragraph 33 can be found at http://vaww4.va.gov/vaforms/. This is an internal VA Web site and is not available to the public. All Optional and Standard forms can be located at http://www.gsa.gov/portal/forms/type/TOP.*

33. REFERENCES:

a. NIST Special Publication 800-53, Security and Privacy Controls for Federal Information Systems and Organizations.

b. NIST Special Publication 800-66, HIPAA Security Rule.

c. NIST Special Publication 800-88, Guidelines for Media Sanitization.

d. 5 U.S.C. 552a, The Privacy Act of 1974.

e. 44 U.S.C. chapter 33, Disposal of Records.

f. 5 CFR part 2635, Standards of Ethical Conduct for Employees of the Executive Branch.

g. 21 CFR part 1311, Subpart B, Obtaining and Using Digital Certificates for Electronic Orders.

h. The HIPAA Privacy and Security Rules, 45 CFR parts 160 and 164.

i. VA Directive and Handbook 5021, Employee/Management Relations.

j. VA Directive 6609, Mailing of Sensitive Personal Information.

k. Assistant Secretary for Information and Technology Memo, May 4, 2004, "Limits on the Use of Certain E-mail Features and Configurations."

l. Records Control Schedule (RCS) 10-1.

m. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

n. VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives.

o. VHA Handbook 1004.04, State-Authorized Portable Orders (SAPO).

p. VHA Handbook 1004.05, iMedConsent.

q. VHA Handbook 1108.04, Investigational Drugs and Supplies.

r. VHA Handbook 1200.05, Requirements for the Protection of Human Subjects in Research.

s. VHA Handbook 1605.1, Privacy and Release of Information.

DEFINITIONS

1. Active Health Record. An active health record is the health record of a patient who is currently receiving Department of Veterans Affairs (VA) authorized care.

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

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

4. Advance Directive. An Advance Directive is a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that the individual becomes unable to make those decisions. Although verbal statements may also be extremely useful in determining the prior preferences of a patient who subsequently loses decision-making capacity, statements that have been committed to writing in a formal Advance Directive document are accorded special authority, as described in Veterans Health Administration (VHA) Handbook 1004.02.

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

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

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

a. To authorize or validate an entry in a health record by a unique identifier that allows identification of the responsible individual.

b. To corroborate that the source or sender of the data received is as claimed.

c. To provide assurance of the claimed identity of the entity or receiver.

8. Authorization Subscription Utility.

a. Authorized subscription utility (ASU) is a software application consisting of electronic rules and user authorizations to execute facility policy for electronic documentation.

b. Strict maintenance of ASU software applications at facilities is required to ensure security and integrity of health record documentation.

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

10. Business Rules. Business rules authorize specific users, or groups of users, to perform specified actions on documents in particular statuses (i.e., 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.*

11. Clinical Applications Coordinator. The Clinical Applications Coordinator (CAC) is an employee at a health care facility assigned to coordinate the use of the Computerized Patient Record System (CPRS) and other Veterans Integrated and Systems Technology Architecture (VistA) software programs for end users.

12. Clinical Reminder. A clinical reminder is a software decision support tool that defines evaluation and resolution logic for a given clinical activity. The evaluation logic defines conditions in the database including the presence, or absence, of specified criteria, such as diagnoses, procedures, health factors, medications, or demographic variables (e.g., age, gender). A reminder may or may not require provider resolution, depending on its purpose and design, through a user interface, also known as a reminder dialog. Also, in accordance with the underlying logic, reminders may be used to collect specified patient information that may or may not be related to the dialog.

13. Community Living Center Care. The VA Community Living Center (CLC) is a component of the spectrum of long-term care that provides a skilled nursing environment and houses a variety of specialty programs for persons needing short- and long-stay services. VA CLCs are typically located on, or near a VA medical facility and are VA-owned and operated, but may be free-standing in the community. Provision of services is consistent with the long-term care standards set forth by The Joint Commission. For legal purposes, CLCs are subject to the laws and policies governing nursing home care in VA nursing homes (see 38 United States Code (U.S.C.) 101(28), 1710, 1710A and 1710B).

14. Community-Based Outpatient Clinic. A Community-Based Outpatient Clinic (CBOC) is a 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.

15. Compliance. Compliance is an oversight process, supported by appropriate organizational conditions (i.e., 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 ensure that appropriate corrective actions are taken.

16. Computerized Patient Record System. 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. VHA uses CPRS as its electronic health record system.

17. 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.

18. Consolidated Health Record. A consolidated health record (CHR) includes the electronic medical record and the paper record, combined, and is also known as the legal health record.

19. Consult. A consult is a specific document, most often electronic, which facilitates and communicates consultative and non-consultative service requests and subsequent activities.

20. Consultation. A clinical consultation is provided by a physician or other health care provider in response to a request seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem (e.g., a consult to dermatology for a rash). A clinical consultation request is initiated by a physician, or appropriate source, with the clear expectation that a reply will be provided in a timely fashion.

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

22. Crisis Notes, Warnings, Adverse Reactions, Allergies, 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 paragraph 58).

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

24. 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.

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

26. 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.

27. Encounter. An encounter is a professional contact between a patient and a practitioner who is vested with the responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting.

a. Contact can include face-to-face interactions or those accomplished by telecommunications technology.

b. The use of e-mail is limited and does not constitute an encounter.

c. Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself

and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc.

d. A telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter, namely history and clinical decision-making.

28. Erroneous Entry. An erroneous entry is incorrect data within the content of a note or is information entered on a wrong patient document.

29. Facility. Facility includes a hospital, medical center, CLC, Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP), outpatient clinic, or CBOC (satellite clinic), unless otherwise specified.

30. 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. They have primary responsibility for the management of the health record and health information program, computer-based or otherwise. ***NOTE:*** *The Health Information Manager is referred to as "HIM professional" throughout this Handbook.*

31. Health Professions Trainee, "Trainee (T38/Hybrid T38)" or "Clinical Trainee" (T38/Hybrid T38). Health professions trainee describes undergraduate, graduate, and continuing education students, interns, residents, fellows, and pre- and post-doctoral fellows who have clinical training experiences at VA facilities. Health professions trainees are appointed under 38 U.S.C. 7405 and 7406. Health professions trainees function under supervision at all times regardless of licensure status.

32. 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 following:

a. **Clinical Health Record.** The clinical health record is the documentation of all types of health care services provided to an individual, in any aspect of health care delivery. A clinical health record includes: individually identifiable data, in any medium, collected and directly used in 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 clinical health record includes all handwritten and computerized components of the documentation.

b. **Administrative Health Record.** The administrative health record 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.

33. Health Record Review. A health record review is the process of measuring, assessing and improving the quality of health record documentation. Health record review evaluates 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.

34. Health Summary. A health summary is the compilation of components of patient information extracted from other VistA applications.

35. Inactive Health Record. An inactive health record is the health record of a patient who has not received VA authorized health care in a 3-year period.

36. Incomplete Health Record. An incomplete health record is a patient health record missing content, reports, or authentications, as defined by medical staff by-laws or facility policy.

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

a. **Integrity.** Integrity means guarding against improper information modification or destruction, and includes ensuring information non-repudiation and authenticity;

b. **Confidentiality.** Confidentiality means preserving authorized restrictions on access and disclosure, including means for protecting personal privacy and propriety information; and

c. **Availability.** Availability means ensuring timely and reliable access to, and use of, information.

38. Inpatient. An inpatient is a recipient of medical services who is admitted to a VA medical 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.*

39. Inter-facility Transfer. An inter-facility transfer is the transfer of a patient between VA medical facilities or VA and non-VA medical facilities.

40. Inter-service or Inter-ward Transfer. 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 supervising practitioner to another (see current VHA policy, VHA Directive 2007-015, Inter-Facility Transfer Policy regarding inter-facility transfer for more information).

41. 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 or for documenting health care or health status.

42. Master Veteran Index. VA's Master Veteran Index (MVI) began as the VHA enterprise-wide system that uniquely identifies all active patients who have been admitted, treated, or registered in any VA medical facility, and is expanding to incorporate populations from other VA lines of business. The MVI assigns a unique identifier (the Integration Control Number or ICN) to each person. The database contains person-identifying information and correlates a

person's identity across the enterprise, including all VistA systems and external systems, such as the Federal Health Information Exchange (FHIE) since 1996.

43. 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).

44. Mental Health (MH) Residential Rehabilitative Treatment Program (RRTP). MH RRTP is the umbrella term for programs that provide residential rehabilitative and clinical care to Veterans who have a wide range of problems, illnesses, or rehabilitative care needs (i.e., mental health, substance use disorder, co-occurring medical diagnosis, homelessness, vocational, educational, or social).

45. 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.

46. Non-VA Medical Care Health Record. A non-VA medical care health record is a record of treatment by non-VA health care providers authorized and paid for by VA.

47. 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.

48. Observation Patient or Status. 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 is defined in current VHA policy (VHA Directive 1036, Standards for Observation in VA Medical Facilities) and observation patients are not considered inpatients. Observation care may not be provided in CLCs. NOTE: Routine post-surgery recovery is not observation.

49. Outpatient. An outpatient is a recipient of health care services who is not admitted to a bed.

50. Patient. A patient is the recipient of VA-authorized health care. Veterans admitted to CLC care units and MH RRTP units may also be referred to as “residents.” For the purposes of this document, CLC and MH RRTP residents are included when referring to “patient.”

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

52. Patient Postings. Patient postings are a component of CPRS that includes messages about patients. ***NOTE:*** *This is an expanded version of CWAD (see paragraph 24).*

53. Patient Treatment File. Patient treatment file (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:

a. In VA hospitals, MH RRTPs, nursing care units, restoration centers; or

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

54. Perpetual Medical Record (PMR). The PMR is compiled of 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 10-10EZ, Application for Health 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.

55. Person Class File. The taxonomy for licensed health care providers who bill for health-related services rendered, and is inclusive for all those who appear on the Centers for Medicare and Medicaid (CMS) Provider Specialty listing. It reflects training, licensure, and scope of practice for that individual. Person Class associations are part of the minimum data set reported to the National Patient Care Database, which is VHA's principal national repository of patient care data.

56. Practitioner. VA utilizes the term practitioner when referring to one of the following types of individuals:

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

b. **Licensed Independent Practitioner.** A Licensed Independent Practitioner (LIP) 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.

c. **Non-licensed Practitioner.** A non-licensed practitioner is an individual without a public license or certification who is supervised by a licensed or certified individual in delivering care to patients.

d. **Supervising Practitioner.** Supervising practitioner refers to LIPs, regardless of the type of appointment, who have been credentialed and privileged at VA medical facilities in accordance with applicable requirements.

e. **VA Special Fellow.** A "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 Accreditation Council for Graduate Medical Education (ACGME) accredited core residency (i.e., medicine, surgery,

psychiatry, etc.) and may also have completed an accredited sub-specialty fellowship. VA Special Fellows are board-eligible or board-certified; consequently, they 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.

57. Provider. A provider is a person or organization that furnishes health care to a consumer and bills or is paid for the health care in the normal course of business. This includes a professionally-licensed practitioner who is authorized to operate in a health care delivery facility.

58. Query Form. A query form is a written communication tool sent by clinical coding personnel to a provider when health record documentation is unclear or conflicting.

59. Referral. A referral is a request to evaluate and assume the responsibility for care.

60. Resident. The term resident refers to an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, psychologists, pharmacists, or podiatrists, 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. Regardless of licensure status, resident trainees function under supervision at all times in VA clinical settings.* Veterans admitted to CLC care units and MH RRTPs may also be referred to as "residents". The CLC 'residents' are patients; whereas, the term 'residents' referred to in this definition for the purpose of entries in health record are appointed as VA health professions trainees.

61. Resident Assessment Instrument (RAI) Minimum Data Set (MDS). RAI MDS is a standardized instrument specifically designed for nursing homes; currently RAI MDS is used in VHA's CLC, (formerly known as Nursing Home Care Units) and Spinal Cord Injury and Disorders (SCI&D) units that are surveyed under The Joint Commission's Long-term Care (LTC) Standards. All assessments are completed according to national guidelines and are used for treatment planning. Use of the electronic version of the RAI MDS by AccuCare software is required for all CLC admissions and for all admissions to SCI&D units surveyed under The Joint Commission LTC standards.

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

63. Retract. Retract is to withdraw, call back, or indicate an item when validity or integrity is no longer in place.

64. Scan or Scanning. Scan is to digitalize documents and data using imaging or pictorial technology.

65. Sensitive Information. See VA Handbook 6500, Risk Management Framework For VA Information Systems – Tier 3: VA Information Security Program. For purposes of privacy, see VHA Handbook 1605.1, Privacy and Release of Information.

66. Shadow Records. Shadow records are defined as duplicate health records that are kept for the convenience of a department or health care provider.

67. Templates. 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 and contain text, TIU objects, and Template Fields that you can place in a document. Templates can also include overprinted paper health record documents.

68. Terminal Digit (TD) Order. The TD order is the filing system for the health record system. In this filing method, 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.

69. Telehealth. Telehealth Services may be described as:

a. **General Telehealth.** General telehealth is the use of real-time interactive video conferencing technology, sometimes with supportive peripheral devices, to provide care and consultation between providers and patients at VA medical facilities, which include clinics and other remote sites such as Vet Centers.

b. **Home Telehealth Services.** Home Telehealth Services is the use of in-home telehealth technologies for monitoring of Veteran patients with chronic diseases, such as diabetes, heart failure, and chronic pulmonary disease. Non-video messaging and monitoring devices or video technology are examples of telehealth technologies.

c. **Store and Forward.** Store and Forward is the use of imaging technologies at the patient site to acquire and store clinical information (e.g., data, image, sound, video) that is then forwarded to (or retrieved by) another health care practitioner site for reading, review, and clinical evaluation. For VA purposes, a telehealth contact between a practitioner and a patient is considered to be an encounter if the specific conditions are met as outlined in Decision Support System (DSS) instructions for Telehealth. The provider's encounter does not always occur simultaneously with the patient's encounter. ***NOTE:*** *Refer to VHA Directive 1082, Patient Care Data Capture, at http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID= for more information. This is an internal VA Web site not available to the public.*

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

71. 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).

72. User Class. User Classes (i.e., attending physician, dentist, optometrist, podiatrist, chiropractor, 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 (i.e., accessing, entering, signing, co-signing, editing, deleting, etc.) are assigned through this file and used in conjunction with ASU business rules to determine allowable actions for clinical documents.

73. Veterans Health Information Systems and Technology Architecture (VistA). VistA is a rich, automated environment that supports day-to-day operations at local Department of Veterans Affairs (VA) medical facilities. It is built on a client-server architecture, which ties together workstations and personal computers with graphical user interfaces at Veterans Health Administration (VHA) facilities, as well as software developed by local medical facility staff. VISTA also includes the links that allow commercial off-the-shelf software and products to be used with existing and future technologies. It was previously known as the Decentralized Hospital Computer Program (DHCP).

74. Visit. The term "visit" is used for the purpose of reporting services provided to a Veteran and patient in a 24-hour period; for example, the visit of an outpatient to one or more clinics or units within 1 calendar day at the health care facility level, including CBOCs.