UNIVERSITY of VIRGINIA HEALTH SYSTEM

Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0218

A. SUBJECT: Definition, Characteristics, Authentication and Maintenance of the Medical Record and Designated Record Set

B. EFFECTIVE DATE: July 1, 2012 (R)

C. POLICY:

The University of Virginia Medical Center maintains the medical record electronically, on paper and on microfilm. Staff can determine record locations and can assemble all relevant information from components of a patient's record when the patient is admitted or is seen for ambulatory or emergency care through use of the patient index in the electronic record of episode and reference to the Health System Record Location Matrix. A unified record is maintained, as all components are available to authorized users. Implementation of standard policies and procedures in the management of health information is required to achieve the following goals:

- Availability of all patient health information to authorized providers at the time of the patient encounter;
- Standardization of documentation formats in order to enhance content access, legibility, compliance adherence, and on-line reporting;
- Availability of all supporting documentation at the time of coding the patient encounter;
- Safeguarding health information confidentiality and release of information;
- In addition, federal regulations specify that patients have the right to access and request amendments to their protected health information that is maintained in a designated record set (DRS). While the DRS includes much of what is defined as the medical record, there are other documents to be considered for inclusion or exclusion in the definition of the DRS.
- Medical record entries are to be made in a timely manner and the record is complete when the content reflects the patient's condition on arrival, diagnosis, test results, therapy, condition changes and in-hospital progress and condition on discharge. The contents are assembled and scanned into the imaging system. The final diagnoses and complications are recorded and the record is authenticated, as required.

Implementation of access and security requirements for electronic signatures is used to authenticate documentation within the electronic medical record and serves as an equivalent to handwritten signatures.

D. DEFINITION OF THE INPATIENT AND OUTPATIENT MEDICAL RECORD:

The medical record is defined as the patient's primary health information record and is comprised of paper and microfiche documentation housed in the Health Information Services (HIS) Department

and documentation that is housed in paper and electronic formats. See Attachment: "*Definition of the Inpatient and Outpatient Medical Record"*

E. DEFINITION OF THE DESIGNATED RECORD SET (DRS):

The DRS is a group of records maintained by UVA Medical Center that includes the billing records in addition to the medical records of individuals.

Excluded Items	**Included Items**	**Media or Access Point Provided to Patient**	**Source for Included Items**
Psychotherapy notes; source data, including photographs, films, monitoring strips, videotapes, slides, CD/DVD's, and worksheets that may not be incorporated into the medical record.	The medical record, as defined above. Also includes photographs, strips and other source data that are incorporated into the main body of the medical record.	Copy of the paper record, CD, DVD, access to a secure internet connection, MyChart or printout. View of computer screen or original record with health professional in attendance.	HIS Department; Physician or Nurse for view with health professional in attendance.
Administrative data: e.g. audit trails, appointment schedules, practice guidelines that are separate from patient data, Quality Reports, risk management, quality, and peer review records; research documentation; information subject to and exempt from CLIA, at 42 USC 263a and 42 CFR 493.(a)(2).	Patient bill; financial assistance application; correspondence with patient or 3rd party payor; formal payment arrangements; warrants; liens; judgments.	Copy of paper document or printout.	Patient Financial Services.
Copies of records from other providers or requests to amend.	Consent and authorization forms.	Copy of paper document.	HIS Department.

F. USE OF ELECTRONIC SIGNATURES TO AUTHENTICATE THE MEDICAL RECORD:

All electronic signature software applications to be used to authenticate electronic medical record entries shall be approved by the Health Information Management (HIM) Subcommittee. The HIM Subcommittee Chair, or designee, shall present recommendations to the Quality Committee for approval, in conjunction with Health System Technology Services, prior to implementation. Electronic signature software applications shall include the following features:

- Required review of the entry and document prior to signature
- Authentication of the signature by the user's entry of a unique user ID and password
- Binding of the signature to the document

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- Non-alterability after the signature has been affixed to the document
- Password expirations
- Inactivity timeouts

Additional standards for implementation of electronic signature software applications are linked to Medical Center Policy No. 0227, "Protection of Electronic Information and Information Systems." In order to use an electronic signature to authenticate medical record entries, prospective users shall request access by completing and electronically signing a Health System Technology Services (HS/TS) Access Request Agreement Form.

If a prospective user is an employee of the Medical Center, the University or the University of Virginia Physicians Group, the original completed and signed Electronic Access Agreement Form must be sent to and maintained by the employee's Human Resources Department. If a prospective user is an affiliated student of the University of Virginia (e.g., Schools of Medicine or Nursing), the original completed and signed Electronic Access Agreement Form must be sent to and maintained by the student's manager or sponsor approving the access request. If the user is neither an employee nor affiliated student, (i e, a Medical Center vendor), the Electronic Access Agreement must be maintained by the manager/sponsor approving the access request. User access approvals shall be reviewed annually by each department supervisor/manager and the user access is to be removed when no longer needed.

G. RESPONSIBILITY TO ESTABLISH AND MAINTAIN:

The HIS Department is responsible for establishing policy and procedures for documentation management and retention of the patient's primary health information. Records are retained according to the Federal Privacy Rule under the Health Insurance Portability and Accountability Act and Virginia statutes for record retention. HIS has significant responsibility for the approval, management, and maintenance of all documentation required for storage in the medical record.

SIGNATURE:

Robert S. Gibson, M.D., President Clinical Staff

R. Edward Howell, CEO, UVA Medical Center

DATE: 6/27/12

Medical Center Policy No. 0218 (R)
Approved October 3, 2000
Revised November 2002, December 2003, September 2005, December 2006, June 2008, February 2011, June 2012
Approved by Quality Committee and Health Information Management Subcommittee

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Approved by Clinical Staff Executive Committee

***Attachment**: "Definition of the Inpatient and Outpatient Medical Record"*

Attachment: Medical Center Policy No. 0218

Definition of the Inpatient and Outpatient Medical Record

The medical record is defined as the patient's primary health information record and is comprised of paper and microfiche documentation housed in the HIS Department and documentation that is housed in paper, computer and electronic formats. The sources of the electronic record are listed below.

Components/Media	The Content	The Responsible Party	EMR Source
EpicCare (EMR)	Order Entry, Allergies, Problems, Medications, Clinical Documentation (Repository & Charting), Result Retrieval, Image Retrieval, etc.	HS/TS	N/A
The paper/microfilm record	Inpatient and outpatient documentation prior to August 18, 2003	HIS	No
Clinician Working File	Duplicate copies of pertinent records as well as ancillary documentation such as sensitive notes, photographs, or laboratory data used by specific providers	Ambulatory Areas/Clinics, Clinician offices, etc.	No
Sunquest	Laboratory results	Medical Labs	Yes
Co-path	Anatomic Pathology, Cytology, Autopsy, etc. results	Medical Labs	Yes
Encompass and Encompass Web - Heart PACS	DICOM-compliant digital imaging and procedure reporting system for cardiovascular medicine. Web-enabled interface for clinical review	Heart and Vascular Center	Yes
Tracemaster Vue	ECG management system; waveform and procedure reporting	Heart and Vascular Center	Yes

Components/Media	The Content	The Responsible Party	EMR Source
Calysto/Series IV	Patient physiomonitoring system, cardiac catheterization and electrophysiology laboratories	Heart and Vascular Center	Yes
PedCath7	Pediatric cardiac catheterization and intervention reporting	Heart and Vascular Center	Yes
Paceart/TeleTrace	Implantable device management system	Heart and Vascular Center	Yes
DataCheck	Vascular laboratory procedures reporting	Heart and Vascular Center	Yes
ImageReview	Nuclear cardiology imaging and procedure reporting	Heart and Vascular Center	No
HeartStart	Pre-hospital ECG management system	Emergency Heart and Vascular Center	No
LifeNet	Pre-hospital ECG management system	Emergency Heart and Vascular Center	No
HAL and STRANDS	Organ transplant information systems	Transplant Center	No
Zymed Holter	Holter monitor system	Heart and Vascular Center	No
Siemens Invision	Resource Scheduling (A2K3), Patient Demographics, Patient Accounting	HS/TS	Yes
Outpat	Patient Demographics	Psychiatric Medicine	No
PACS –Imaging	Web enabled, advanced solutions for medical imaging. Includes teleradiology, image management and distribution, archiving, 2D and 3D image processing	Health System Technology Services and Radiology	No
Centricity Perioperative Manager System	Peri-Operative Record	Surgical Services	No
AMI Dialysis System	Dialysis record	Dialysis Center	No
Streamline Health (document imaging system)	Scanned images from August 18, 2003 forward	HS/TS	Yes
MOSAIQ	Radiation Oncology record/treatment plan	Radiation Oncology	No
Impac	Radiation Oncology plans and treatment documentation	Radiation Oncology	No