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Title: <b>AVATAR Document Management for Clinical Records</b>	Functional Area: <b>Administration</b>					
Approved By: (Signature on File) <b>Signed Version available upon request</b>						
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## I. PURPOSE:

The purpose of this policy is to provide direction to service providers regarding the management of clinical documentation in the AVATAR Clinician Work Station (CWS). AVATAR is a web-based information management system used by Sacramento County, Division of Behavioral Health (DBHS). Avatar includes practice and claims management, state reporting and clinical documentation for clients receiving behavioral health services. Areas addressed in this policy include transition from paper documentation to electronic records, management of clinical information for existing and new clients in CWS and the scanning and retention timeframes for records and documents.

## II. DEFINITIONS:

**Behavioral Health Record or Behavioral Health Chart:** Any item, grouping or collection of client specific information that is maintained, collected, used or disseminated by or for Sacramento County Behavioral Health contracted or county operated provider. A single behavioral health record for an individual consists of all materials that are part of the designated record set, even when these elements are physically separated from other chart components.

**Covered Entity:** (1) A health plan, (2) A health care clearinghouse, (3) A health care provider who transmits any health information in electronic form.

**Custodian of Record:** The individual or organization responsible for monitoring and maintaining both the integrity and confidentiality of medical records, as well as the retention guidelines for a provider or program.

**Designated Record Set:** A subset of “record” (definition below). Includes enrollment, payment, claims, adjudication and case or medical management information maintained by or for a health care provider concerning a client. All information within the designated record set is protected health information.

**Hybrid Chart:** A combination of a paper chart and electronic health record. Involves charts where clients were receiving care when AVATAR CWS was implemented OR other types of records that require paper retention. Includes the designated record set.

**HIPAA:** Health Insurance Portability and Accountability Act of 1996 requires all covered entities to prevent unauthorized access to Protected Health Information or PHI.

**Protected Health Information:** This term refers to a subset of confidential health information, including demographic information, collected from an individual. PHI is created or received by a

health care provider, health plan, employer, or health care clearinghouse; and relates to the (i) Past, present, or future physical or mental health or condition of an individual; or, (ii) The provision of health care to an individual; or, (iii) The past, present, or future payment for the provision of health care to an individual; and (iv) Either: Identifies the individual; or the confidential information creates a reasonable basis to believe it can be used to identify the person. PHI is transmitted by electronic media; or maintained in electronic media; or transmitted or maintained in any other form or medium. PHI does not include employment records or education records or records covered under the Family Educational and Right to Privacy Act.

**Record:** Any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

### **III. DETAILS:**

It is the policy of the Division that complete clinical records be available for all clients. Record storage will be phased over time to an Electronic Health Record (EHR) in AVATAR CWS. Information will be documented directly in CWS or will be scanned into a specific provider episode in the system. No documents will be scanned into a non-episodic category without prior approval by Quality Management. Clinical records along with administrative, enrollment, payment and billing records will be maintained in AVATAR and are designated Protected Health Information (PHI). PHI must be safeguarded in accordance with all applicable State and Federal laws and regulations.

### **IV. OVERARCHING PRINCIPLES FOR DOCUMENT MANAGEMENT:**

The following principles apply to clinical document management for AVATAR CWS.

1. Service provider users of Avatar CWS will maintain, and have the ability to produce, a complete behavioral health chart at any time during the transition from paper chart to electronic health record. The bridge between, or combination of, paper and electronic charts will be referred to as the "hybrid" chart, which includes all clinical information pertaining to care provided to any client receiving services.
2. Record retention of the combined paper and electronic system will meet State and Federal requirements for client record retention. All adult records will be maintained for 20 (twenty) years after the date of discharge. Records of minors will be maintained at least one year after the minor has reached the age of eighteen. For psychologists, client records are to be maintained for 20 (twenty) years from the patient's discharge date, or in the case of a minor, 20 (twenty) years after the minor reaches 18 years of age. Sacramento County MHP will retain records for a period of 20 (twenty) years from date of discharge.
3. During the transition, paper portions of charts that are not scanned into the electronic record and are part of the "hybrid" record must be maintained for one year at the site and then be available for reference as necessary (see Section VI).
4. Scanning of records must follow the designated categories and conventions for sections established in AVATAR CWS. These are standard categories that provide a common location for scanned documents in AVATAR. Any new categories must be approved by the AVATAR Steering Committee. New categories will be incorporated for use only at established planned release cycles.
5. After paper records are scanned into the designated categories, a verification process will be completed (see Section VII). Following verification, the paper documents may be destroyed (provided it is not in current or noticed litigation) meeting established HIPAA policies and procedures concerning protection, and shredding to protect client privacy (see Section VIII).

6. Each program will have a designated Custodian of Records to facilitate monitoring, management and retrieval of hard copy charts that are part of the hybrid chart. Such charts shall be available for all auditing, monitoring, record requests and utilization review purposes.

## V. IMPLEMENTATION OF AVATAR ELECTRONIC HEALTH RECORD (EHR):

Effective September 1, 2012, the Division of Behavioral Health Services (DBHS) initiated “GO-LIVE” -- the plan to implement AVATAR CWS system-wide. Prior to this date, selected pilot sites were using the CWS modules. For pilot sites, the date of pilot implementation is the GO-LIVE date. The training calendar established by the County establishes the rolling GO-LIVE date by program and provider for all other providers.

For clients admitted to a program after the GO-LIVE date the electronic system for all established clinical documentation will be used.

Each client active at the time of GO-LIVE may have three types of records: (1) a paper chart containing services and clinical information; (2) electronic documentation in CWS; and (3) key historical records from other information collected as part of ongoing care (eg. letters, hospital information etc.).

### **Existing Clients: Transition from Paper Records**

1. **Active Client Treatment/Service Plan:** This document is the reference and anchor document for all services delivered. At time of renewal, electronic documentation will be completed. The current active client treatment/service plan should be scanned into the “Client Plans – Non Avatar Generated” section of the chart. The description field will clearly identify the type of plan (e.g. *TBS plan, Annual Client Plan*). Following verification (see Section VII), the original document may be destroyed (provided it is not in current or noticed litigation) meeting established HIPAA policies and procedures concerning protection, and shredding to protect client privacy (see Section VIII).
2. **Active Safety Plans:** This includes any safety plans or other emergency contact documents to facilitate continuity of care. Safety plans should be scanned into the “Client Plans – Non Avatar Generated” section of the chart. The description field will clearly label this document as a “*Safety Plan*”. Following verification (see Section VII), the original document may be destroyed (provided it is not in current or noticed litigation) meeting established HIPAA policies and procedures concerning protection, and shredding to protect client privacy (see Section VIII).
3. **Inpatient Discharge Documentation:** This includes any and all documentation specific to an inpatient psychiatric episode to facilitate inpatient/outpatient communication. This should be scanned into the “Hospital Discharge” section of the chart. The description field will clearly label these documents (e.g. *Discharge summary, special medication orders*, etc) Following verification (see Section VII), the original document may be destroyed (provided it is not in current or noticed litigation) meeting established HIPAA policies and procedures concerning protection, and shredding to protect client privacy (see Section VIII).

### **New and Existing Clients: Collateral Information to Scan Into the Electronic Record**

Upon transition to CWS, the following documents should be scanned into the appropriate episode of the electronic chart. Following verification (see Section VII), the original documents may be destroyed (provided they are not in current or noticed litigation) meeting established HIPAA policies and procedures concerning protection, and shredding to protect client privacy (see Section VIII).

Documents should be scanned into designated categories so that scanned records have a common convention and method to ensure that retrieval and record retention is not compromised. Examples of categories include, but are not limited to: Access Forms; Assessments; Client

Correspondence; Court/Legal; Labs; Medication Consents; Labs; Hospital Discharge. A comprehensive list of categories is available in Avatar CWS and is available to all users.

There will remain collateral documents or documents without electronic versions in CWS that must become a part of the electronic record. These documents should be scanned into the relevant sections of the electronic health record following the established sections (e.g. "Assessments – Non Avatar Generated") and using the description field to clearly identify the types of documents (e.g. Out of County Assessment, MHSA – Key Event Tracking (KET), etc.). Please use the date field to indicate the date of the document (e.g. the date the assessment was completed). Following verification (see Section VII) , the original document may be destroyed (provided it is not in current or noticed litigation) meeting established HIPAA policies and procedures concerning protection, and shredding to protect client privacy (see Section VIII).

#### **Post GO-LIVE for All Services**

1. PHI shall not be maintained in a paper chart or in portions of a paper chart (eg. working charts). Specific authorized exceptions to the CWS system must be approved by the MHP. Examples may include out of county services or subacute programs where provider information is not attached to Avatar CWS.
2. Clinical documents and forms shall not be maintained outside of the CWS. Information will be located in the episode's scanned portion of CWS.
3. Every effort shall be made to obtain client/guardian signatures on treatment plans utilizing an electronic signature pad. Should it be necessary to use a paper form to document client care, such form or document must be scanned into the appropriate episode in CWS and shredded after 90 days.
  - a. If notes or worksheets are used during completion of any clinical activity, this document shall be shredded after data entry into AVATAR is completed.

#### **VI. HARD COPY RECORD MAINTENANCE (SEE ATTACHED REFERENCE MATERIAL: "CONVERSION TO ELECTRONIC HEALTH RECORD AND RETENTION OF PAPER RECORDS"):**

##### **Maintenance of Hard Copy Records:**

1. Each program shall have a designated staff (Custodian of Records) to manage the organization, maintenance and tracking of hard copy charts. Open or closed charts will be stored within established safety practices for locked chart room security (see QM P&P site certification protocol) until such a time that no paper charts remain at provider sites.
2. Hard copy portion of the hybrid chart will remain on site for a **minimum of one year** from date of GO-Live for any program. After one year from go-live in Avatar CWS, closed charts and hybrid charts for open clients may be moved to an offsite secure storage location utilized by the county operated or service provider. Should hard copy charts be needed for clients who return into care or for other consultation, reviews, audits or administrative purposes, all programs must have a process to retrieve charts from storage.
3. All programs must maintain a record of their hard copy record maintenance practices. Quality Management will review the hard copy record maintenance practice at site certification visit.

#### **VII. QUALITY ASSURANCE FOR DOCUMENT MANAGEMENT:**

Every agency/provider will have a written policy and procedure that establishes quality assurance standards for document imaging. The following elements shall be present in all provider

procedures and adapted to internal business practice and management of scanning equipment to ensure PHI is duly protected from other administrative activities.

1. The staff member(s) performing the actual scan will:
  - a. Observe that all pages (front and back) successfully pass through scanner and that image displayed on the imaging software preview screen appear accurate.
  - b. Affix a sticker marked "Scanned" to the top page, write the current date on the sticker and place on top of a pile of scanned material. An alternative to a sticker is initial and date document is scanned on top right of each document.
  - c. Verify the documents to be scanned are scanned into the correct episode.
2. The staff member(s) responsible for these records will have immediate access to the images, from their desktops, using the imaging software. They will have 90 days to use and review the images. If any problem is detected, the paper will be retrieved and rescanned. After 90 days, the paper copies are subject to proper disposal. In lieu of storing the hard copy for 90 days, providers may choose to have the custodian of records verify each scanned document to ensure that the entire document has been successfully scanned into the correct episode and is an exact replica of the original document. After review and verification by the custodian of records the original may be destroyed meeting established HIPAA policies and procedures concerning protection, and shredding to protect client privacy.
3. Document management/scanning policy and procedure will be added to site certification and recertification checklist and quality assurance procedures will be tested at that time.

## **VIII. DESTRUCTION OF RECORDS:**

Once a paper record or component of a paper record are scanned into CWS, such documents may be confidentially destroyed (California Civil Code 56.101). Client records are to be maintained and destroyed to preserve and assure client confidentiality in compliance with HIPAA regulations.

1. Every agency/provider will have a written policy and procedure that addresses the disposal of all PHI, including hard copy PHI, electronic PHI and/or the hardware or electronic media on which it is stored. The policy and procedure must also include procedures for removal of electronic PHI from electronic media before the media are made available for re-use. See 45 CFR 164.310(d)(2)(i) and (ii).
2. Agencies/providers must ensure that all staff involved in the disposal of PHI has been trained on the agency/provider policy and procedures. This includes staff that are responsible for the disposal of PHI as well as staff that supervise those responsible for the disposal of PHI (including volunteers).
3. Agencies/providers must determine the appropriate method for their agency to dispose of PHI while ensuring confidentiality of the PHI. Some possible ways to dispose of PHI include:
  - a. For PHI in paper records, shredding, burning, pulping, or pulverizing the records so that PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed.
  - b. For PHI on electronic media, clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing or exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains), or destroying the media (disintegration, pulverization, melting, incinerating, or shredding).

Agency/provider disposal of PHI policy and procedures will be reviewed and monitored during site certification visits.

**REFERENCE(S)/ATTACHMENTS:**

- 42 CFR 164.310
- Health Insurance Portability and Accountability Act of 1996
- California Civil Code 56.101
- Attachment A - [Conversion to Electronic Health Record and Retention of Paper Records](#)

**RELATED POLICIES:**

- 04-01 QM P&P Site Certification of Provider Physical Plant
- HIPAA Privacy Rule P&P <http://www.compliance.saccounty.net>

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# Conversion to Electronic Health Record and Retention of Paper Records

February 18, 2010 in [Electronic Health Records](#), [Health Information Technology](#), [HIPAA](#), [HITECH Law](#), [Privacy & Security](#) | Tags: [Converting from paper to EHR](#), [linkedin](#), [Paper Record Imaging](#), [Spoliation of evidence](#)

*Update: On August 8, 2010, Medicare issued [MLN Matters Article SE1022](#) on Medical Record Retention and Media Formats for Medical Records, which states that the Centers for Medicare and Medicaid Services (CMS) requires records of providers submitting cost reports (most hospitals) to be retained in their original or legally reproduced form (which may be electronic), for at least 5 years after closure of the cost report.*

Many hospitals have electronic health records (EHRs) that are hybrid digital records. While the hospital may be using electronic data entry in the ER, inpatient nursing care, pharmacy, lab, and pre-op anesthesia, oftentimes, these EHRs are not integrated and, thus, are not merged into a single EHR. The short-term solution may have been to scan printed records from some department, like lab or pharmacy, into the patient's on-line digital record. As a result, the hospital's "electronic health record" contains information that is not captured in a "coded format". For one, this will not meet the Stage One "meaningful use" criteria under the HITECH Act.

But let's assume that the hospital can overcome this hurdle by working with vendors to integrate these records in a way that will meet HITECH EHR certification standards. If the hospital has been maintaining certain portions of patient records in a paper format, what does it do with those paper records after converting to an EHR? If the hospital scans all the paper patient records into its EHR, how long should the hospital retain the paper record after it is scanned into their EHR?

Currently, there is very little specific guidance speaking to retention of paper records subsequent to EHR conversion. In other words, once paper records are scanned, they are, in fact, being retained on electronic storage media. However, if the paper record is being reentered into the EHR in the required "coded format," is that the same as the original record? Given that the broadening EHR world is in its infancy, retention of paper records for a sufficient period of time is likely the wisest course of action in either scenario.

**Liability Insurance Requirements.** As an initial matter, review your malpractice insurance and seek guidance as to the expectations of your insurer with regard to record retention. Some carriers have actually issued direct policy-requirement statements covering record retention in the context of EHR conversion. Your carrier may have a requirement or other guidance that would be useful in formulating or revising your record retention policy.

**Malpractice Claims.** Another important consideration is to determine the appropriate malpractice or negligence statute of limitations under applicable state law. For example, in Kentucky, under KRS 413.140(1)(e) "an action against a physician, surgeon, dentist, or hospital for negligence or malpractice" must be brought within one (1) year. Under KRS 413.140(2), the one-year clock starts when the injury is first discovered or when "in the exercise of reasonable care should have been discovered". Ultimately, an action must be commenced within five (5) years from the date on which the alleged negligence is said to have occurred. This five-year limitation places a cap on how long a

potential negligence/malpractice plaintiff has to bring suit against the health care provider and, therefore, how long such records are generally relevant in the malpractice context. However, the paper record may need to be kept longer in cases involving minors, an individual with a "disability", or in death cases where statutes of limitation may be extended to allow time to appoint a representative of the estate.

State licensing authorities. Review the licensing and Medicaid regulations applicable to your organization. And, speak to your state licensing agency to get their take on how long to keep paper records that have been either scanned to PDF or entered into the EHR in a coded format. Individuals within the Kentucky OIG, for example, have indicated that as long as the records can be accessed and accurately produced, there is no requirement to retain the paper versions. It is essential to weigh the regulatory authority viewpoint against the risk of exposure to a spoliation claim.

Federal Law and Medicare. Consider the ramifications of defending a federal fraud and abuse action in the absence of the "original" paper record. The Civil False Claims Act, 31 U.S.C. § 3729, is most often cited when establishing the upper limits of federal fraud and abuse statutes of limitation. Section 3731(b)(2) provides that in no event may such an action be brought more than ten (10) years after the date on which the violation is committed. This may not mean that you keep all paper records for ten years, but this must weigh into the development of your retention policy.

Other federal law considerations include the Medicare conditions of participation for hospitals, which require that medical records "be retained in their original or legally reproduced form for a period of at least five (5) years". (42 C.F.R. 482.24(b)(1).) Though it would seem extremely unlikely that conversion of a record to an EHR would not be viewed as a "legally reproduced form," retaining the paper records of Medicare patients for five (5) years is a consideration. Also consider applicable FDA regulations if any research is conducted in your facilities, as well as any occupational health regulations related to retention of occupational health records.

Electronic record image must be identical to the paper. The Medicare General Information, Eligibility and Entitlement Manual, Pub. 100-01, Ch. 7, § 30.30.1.4 (the "General Manual") contains a section addressing "Disposition For Medicare Records that are Imaged/Scanned." The General Manual provides that imaging can be used to replace paper documents "only when the image will be identical to the paper" (emphasis in original). The General Manual goes on to state that a contractor "must retain the paper records until their certification/quality assurance process has been completed and the imaged information is verified as an identical replication of the paper document. Only then can the paper records be destroyed." The General Manual also sets forth a "sample quality assurance procedure," which illustrates the emphasis CMS places on quality control when scanning records into an EHR.

Accordingly, quality control becomes extremely important when scanning paper documents onto electronic storage media. Your policy should include a method to verify that the image maintained on electronic media is identical in every way to its paper source – this includes all writing and text in margins, footnotes, etc. Quality control in record conversion and retention is crucial to ensuring that text that runs to the edge of a page does not get cut off or become illegible after the document is scanned. If you are considering converting paper records to a "coded format," the resulting record would not seem to meet the "identical" image requirement, especially if you are unable to retain the *context* in which notes on the original record were made.

Destruction of Evidence. Destroying records in compliance with an established, written internal policy is extremely important. In U.S. and Aflatouni v. Kitsap Physicians Service, et al., 314 F.3d 995 (9th Cir., 2002), the Court found that the defendant, a pathology group, did not engage in spoliation of

evidence in a *qui tam* action when it destroyed relevant billing records after six years pursuant to a retention policy implemented in accordance with state and federal regulations, in the normal course of business, and more than two years before the relator initiated the action. However, the Court noted that the defendant would have engaged in spoliation of evidence *as a matter of law* if it had notice that the documents were potentially relevant to the litigation prior to destruction.

Summary. There is no single answer for how long to keep the original paper patient records. The CMS view seems to be that once records are converted to electronic storage media, and the converted image is identical to the original, the paper versions may not actually need to be retained at all. However, if you have notice of possible litigation or a fraud enforcement action, it would be prudent to retain the paper versions. Even in the absence of litigation or an impending federal enforcement action, you may decide to retain the paper records for the minimum of the applicable limitation period for a malpractice action, the five-year period indicated by Medicare, or as long as the ten-year False Claims Act statute of limitations. At a minimum, have a written retention policy that contains quality control procedures and that ensures paper records are not destroyed before their scheduled backup to an identical image.

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