

HB

214

Alaska State Legislature

Interim:
P.O. Box 1287
Soldotna, AK 99669
(907) 262-8114

Session:
State Capitol
Juneau, AK 99801
(907) 465-2693

Representative Gary L. Davis

MEMORANDUM

April 12, 1995

TO: Senator Lyda Green, Chair
Senate HESS Committee

FROM: Representative Gary Davis *Davis*

RE: House Bill 214, "An Act relating to the maintenance by health care providers of medical records in an electronic format."

Please schedule House Bill 214 for a hearing in the HESS Committee at your earliest convenience. Attached are the bill, fiscal note, sponsor statement, sectional analysis, the current statute, three letters of support, and a legal memorandum relating to the issue.

Thank you for considering this legislation.

attachment

APR 13 1995

Passed House -

40-0

ZERO
fiscal note

9-LS0313C

HOUSE BILL NO. 214 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE G.DAVIS

Amended: 4/10/95

Introduced: 3/1/95

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the maintenance by health care providers of medical records
2 in an electronic format."

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

4 • Section 1. AS 18.20.085 is amended by adding a new subsection to read:

5 (e) This section is subject to AS 18.95.010.

6 • Sec. 2. AS 18 is amended by adding a new chapter to read:

7 CHAPTER 95. MISCELLANEOUS PROVISIONS.

8 Sec. 18.95.010. USE OF ELECTRONIC MEDICAL RECORDS. A health
9 care provider may maintain and preserve its medical records in an electronic format
10 that protects the physical security of the records and protects the records from access
11 by unauthorized persons. A health care provider who maintains and preserves the
12 records in an electronic format that provides these protections is not required to
13 maintain a separate paper copy. The Department of Health and Social Services may
14 adopt regulations under AS 44.62 (Administrative Procedure Act) to regulate the

1

implementation of this section.

STATE OF ALASKA
1995 LEGISLATIVE SESSION

BILL NO. HB 214

Revision Date: _____
 Title: Relating to Maintenance of Medical Records
in Electronic Format
 Sponsor: G. Davis
 Requestor: H. WESS

Dept. Affected: Health and Social Services
 BRU: Administrative Services
 Component: Administrative Services Support
 COMPONENT SERIAL NO. 320
 See also (SN#): _____

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY96	FY97	FY98	FY99	FY00	FY01
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES

CHANGES IN REVENUES

FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MMTIA						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY95) cost: 0.0

ANALYSIS: Attach a separate page if necessary!

There is no fiscal impact on the Department of Health and Social Services.

Prepared by: Janel Clarke, Director
 Division: Administrative Services

Phone: 465-3082
 Date: 03/09/95

Approved by Commissioner: Karen Perdue, Commissioner
 Agency: Department of Health & Social Services

Date: 3/15/95

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(b) The department may by regulation require that a licensee or applicant desiring to make a specified type of alteration or addition to its facilities or to construct new facilities shall, before commencing the alteration, addition, or new construction, submit plans and specifications to the department for preliminary inspection and approval or recommendations with respect to compliance with its regulations and standards. (§ 40-6-9 ACLA 1949; am § 5 ch 112 SLA 1957; am § 1 ch 40 SLA 1986)

Cross references. — For requirement for certificate of need to alter a health care facility, see AS 18.07.

Sec. 18.20.085. Hospital records retention. (a) Unless specified otherwise by the department a hospital shall retain and preserve records that relate directly to the care and treatment of a patient for a period of seven years following the discharge of the patient. However, the records of a patient under 19 years of age shall be kept until at least two years after the patient has reached the age of 19 years or until seven years following the discharge of the patient, whichever is longer. Records consisting of X-ray film are required to be retained for five years.

(b) The department shall by regulation define the types of records and the information required to be included in the records retained and preserved under (a) of this section. The department may by regulation specify records and information to be retained for longer periods than those set out in (a) of this section.

(c) If a hospital ceases operation, it shall make immediate arrangements, as approved by the department, for the preservation of its records.

(d) In this section, "hospital" includes those facilities defined as hospitals under AS 18.20.130 and 18.20.210. (§ 1 ch 41 SLA 1970)

Collateral references. — Admissibility on issue of sanity of expert opinion based partly on medical, psychological or hospital reports. 55 ALR3d 561.

Admissibility under business entry statutes of hospital records in criminal cases. 69 ALR3d 22.

Admissibility under Uniform Business Records as Evidence Act or similar statute of medical report made by consulting phy-

sician to treating physician. 69 ALR3d 104.

Admissibility under state law of hospital record relating to intoxication or sobriety of patient. 80 ALR3d 456.

Discovery of hospital's internal records or communications as to qualifications or evaluations of individual physician. 81 ALR3d 944.

Sec. 18.20.090. Information confidential. The department may not publicly disclose information received by it in a manner identifying an individual or hospital except in a proceeding involving the question of licensing. (§ 40-6-11 ACLA 1949)

AMENDMENT # 1

OFFERED IN THE HOUSE

BY REPRESENTATIVE BROWN

TO: HB 214

G. DAVIS

Physical

1 Page 1, line 9, following "format":
2 Insert " that protects the security of the records and protects the records from access
3 by unauthorized persons. A health care provider who maintains and preserves the records in
4 an electronic format that provides these protections is not required to"

5 Page 1, line 10:

- 6 Delete "without maintaining"
- 7 Insert "maintain"
- 8 Following "separate"
- 9 Insert "paper"
- 10 Delete "in a handwritten or other tangible format"

*amended on the
House floor
passed
unan.*

Approved

*Privacy protection
for patient's records*

*passed House
unanimous
consent*

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

Senator Lyda Green, Chair
Senate HESS Committee
Room 423 State Capitol
Juneau, AK 99801-1182

April 28, 1995

Dear Senator Green:

Yesterday I had some questions about the process for authentication of appropriate signatures when health care facilities maintain electronic medical records.

HB 214 requires the Department of Health and Social Services to adopt regulations to implement the provisions allowing electronic records to be maintained without paper backup. The Department has drafted the regulations and the Alaska Health Information Management Association has formally supported them. A copy of the regulations is accompanies this letter for your review.

On page 4 of the draft regulations, the issue of signatures is addressed as follows:

(3) written signatures or initials and electronic signatures or computer-generated signature codes are acceptable as authentication. All signatures or initials, whether written, electronic, or computer-generated, shall include the initials of the signers credentials.

(4) In order for a facility to employ electronic signatures or computer-generated signatures codes for authentication purposes, the facilities Governing Body and Medical Staff, if appropriate, must adopt a policy that permits authentication by electronic or computer-generated signature. The policy shall identify those categories of the medical staff, allied health staff or other personnel within the facility who are authorized to authenticate patient records using electronic or computer-generated signatures.

On page 7 of the draft regulations, the qualifications of Records Administrators are set out:

(i) Each facility subject to the provisions of this section, with the exception of ambulatory surgical facilities, must employ the services of a records administrator who is registered by the American Medical Record Association or a record technician who is accredited by the American Medical Record Association to supervise the medical record service.

Please let me know if you have additional questions. We hope HB 214 will be back on the Senate Calender soon for final passage.

Sincerely,

A handwritten signature in cursive script, appearing to read "Garrey M. Peska".

Garrey M. Peska, C.P.A.
Financial Consultant

cc: Harlan Knudson
Representative Gary Davis
Portia Babcock

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7 AAC 12.770. is proposed to be repealed and readopted to read:

7 AAC 12.770. MEDICAL RECORD SERVICE. (a) Each facility, with the exception of home health agencies, intermediate care facilities for the mentally retarded and birth centers, must have a medical record service which complies with the provisions of this section.

(b) A facility must keep records on all patients admitted or accepted for treatment. Originals or accurate reproductions of the contents of the originals of all records, including x-rays, must be maintained in a form which is legible and readily available upon the request of the attending physician, medical staff, representative of the department, or, upon the patient's written request, to other practitioners.

(c) Each in-patient medical record must include, as appropriate:

(1) an identification sheet which includes the:

- (A) patient's name;
- (B) medical record number;
- (C) patient's address on admission;
- (D) patient's date of birth;
- (E) patient's sex;
- (F) patient's marital status;
- (G) patient's religious preference;
- (H) date of admission;
- (I) name, address and telephone number of a contact person;
- (J) name of the patient's attending physician;
- (K) initial diagnostic impression;
- (L) date of discharge and final diagnosis; and
- (M) source of payment including Social Security, Medicare and Medicaid identification number (if applicable).

(2) a physical examination statement which includes all positive and negative findings resulting from an inventory of systems;

(3) a medical and, if applicable, a psychiatric history record, to include at a minimum, a history of the patient as to chief complaint, present illness, pertinent past history, family history, and social history;

(4) sufficient information to justify the diagnosis and warrant the treatment and end results;

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- (5) consultation reports containing written opinions signed by the consultants, dental records, and reports of any special studies;
- (6) an order sheet which includes medication, treatment, and diet orders signed by a physician;
- (7) progress notes for each service or treatment received which give a chronological picture of the patient's progress and which are sufficient to delineate the course and results of treatment;
- (8) nurses' notes, which must include but not be limited to the following:
 - (A) concise and accurate record of nursing care administered;
 - (B) a record of pertinent observations and response to treatment, including psychosocial and physical manifestations, incidents and unusual occurrences, relevant nursing interpretation of such observations, and vital sign charting made by nursing personnel;
 - (C) an assessment at the time of admission;
 - (D) a discharge plan;
 - (E) the name, dosage, and time of administration of a medication or treatment, the route of administration and site of injection, if other than by oral administration, of a medication, the patient's response, and the signature of the person who administered the medication or treatment; and
 - (F) a record of any restraint used, except soft tie restraints used for support and protection of the patient, showing the time of application and removal;
- (9) court orders relevant to involuntary treatment;
- (10) Laboratory reports;
- (11) x-ray reports;

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(12) consent forms, when applicable;

(13) operative report on in-patient and out-patient surgery including pre-operative and post-operative diagnosis, description of findings, techniques used, and tissue removed or altered, if appropriate;

(14) anesthesia records including pre-operative diagnosis and post-anesthesia follow-up;

(15) a pathology report, if tissue or body fluid is removed;

(16) recovery room records;

(17) labor record;

(18) delivery record;

(19) record of a neonatal physical examination and condition on discharge;

(20) a discharge summary, prepared and signed by the attending physician, which briefly recapitulates the significant findings and events of the patient's stay in the facility, conclusions as to the primary and any associated diagnoses, disposition at discharge to include instructions and/or medications, and recommendations and arrangements for future care; and

(21) any autopsy findings on a hospital death.

(d) A facility must maintain procedures to protect the information in medical records from loss, defacement, tampering or access by unauthorized persons. The medical record, including X-ray films, is the property of the facility and is maintained for the benefit of the patient, the medical staff and the facility.

(e) A record must be completed within 15 days of discharge and authenticated or signed by the attending physician or dentist.

(f) Medical record entries must be authenticated as follows:

(1) All entries into the medical record shall be authenticated by the individual who made or authorized the entry. "Authentication," for the purposes of this section, means identification of the author of a medical

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record entry by that author, and confirmation that the contents are what the author intended.

(2) Medical record entries shall include all notes, orders or observations made by direct patient care providers and any other individuals required to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or electrocardiographic reports, operative reports, reports of pathologic examination of tissue and other similar reports.

(3) written signatures or initials and electronic signatures or computer-generated signature codes are acceptable as authentication. All signatures or initials, whether written, electronic, or computer-generated, shall include the initials of the signer's credentials.

(4) In order for a facility to employ electronic signatures or computer-generated signature codes for authentication purposes, the facilities Governing Body and Medical Staff, if appropriate, must adopt a policy that permits authentication by electronic or computer-generated signature. The policy shall identify those categories of the medical staff, allied health staff or other personnel within the facility who are authorized to authenticate patient records using electronic or computer-generated signatures.

(5) As a minimum, the policy shall include adequate safeguards to ensure confidentiality, including, but not limited to, the following:

(A) Each user must be assigned a unique identifier that is generated through a confidential access code.

(B) The facility must certify in writing that each identifier is kept strictly confidential. This certification must include a commitment to terminate a user's use of a particular identifier if it is found that the identifier has been misused. "Misused" shall mean that the user has allowed another person or persons to use his or her personally assigned identifier, or that the identifier has otherwise been inappropriately used.

(C) The user must certify in writing that he or she is the only person with access to the identifier and the only person authorized to use the signature code.

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(D) The facility must monitor the use of identifiers periodically and take corrective action as needed. The process by which the facility will conduct the monitoring shall be described in the policy.

(6) A system employing the use of electronic signatures or computer-generated signature codes for authentication shall include a verification process to ensure that the content of authenticated entries is accurate. The verification process shall include, at a minimum, the following provisions:

(A) The system shall require completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps or obvious contradictory statements appearing within those designated fields. The system shall also require that correction or supplementation of previously authenticated entries shall be made by additional entries, separately authenticated and made subsequent in time to the original entry.

(B) The system must make an opportunity available to the user to verify that the document is accurate and that the signature has been properly recorded.

(C) The facility must, as part of its quality assurance activities, periodically sample records generated by the system to verify the accuracy and integrity of the system.

(7) A user may terminate authorization for use of an electronic or computer-generated signature upon written notice to the Director of Medical Records or other person designated by the facility's policy.

(8) Each report, record or entry generated by a user must be separately authenticated and dated.

(9) Any use of electronic recordkeeping to store patient records shall ensure the safety and integrity of those records at least to the extent of hard copy records.

(A) All providers shall ensure the safety and integrity of all electronic media used to store patient records by employing an offsite backup storage system, an image mechanism that is able to

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copy signature documents, and a mechanism to ensure that once a record is input, it is unalterable.

(B) At a minimum, reasonable security shall be maintained for any computer on which any primary patient record or primary patient record entry is created, entered, or retrieved. Reasonable security shall be maintained in the connection of such computer to any computer or communications system or network. The reasonableness of the security of a computer or a connection shall be determined taking into consideration at least the following:

(1) the state of commercially available computer technology;

(2) the affordability of security technology, procedures and techniques;

(3) the likelihood of failure of security and the risk that such a failure could be caused intentionally;

(4) the magnitude of harm that could result if security fails, is inadequate or is breached;

(5) known and reasonably anticipated threats to security; and

(6) standards promulgated by nationally recognized standard setting organizations and professional associations in the fields of health information, healthcare informatics, and computer security.

(C) The security system of any computer on which a primary patient record or primary patient record entry is created, entered, or retrieved, including any connections to such computer, shall be designed, utilized, maintained and administered to prevent unauthorized access to primary patient records and to data contained in such records, and to prevent unauthorized input to, or modification or deletion of, such records and data.

(10) Original hard copies of patient records may be destroyed once the record has been electronically stored.

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(11) The printout of the computerized version shall be considered the original for the purpose of providing copies to patients.

(12) Access to electronically stored patient records shall be made available to the Section of Health Facilities Licensing and Certification staff promptly, upon request.

(13) Any provider subject to this section, choosing to utilize an electronic recordkeeping system, shall develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored patient health records, authentication by electronic signature keys, and systems maintenance.

(14) Nothing contained in this chapter shall affect the existing regulatory requirements for the access, use, disclosure, confidentiality, retention of record contents, and maintenance of health information in patient records by health care providers.

(a) Records must be indexed in accordance with standard medical record nomenclature to insure the prompt location of a patient's medical record. A unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(b) A transfer summary, signed by the physician, must accompany the patient if the patient is transferred to another facility or if transferred to a nursing or intermediate care service unit within the same facility. The transfer summary must include essential information relative to the patient's diagnosis, condition, medications, treatments, dietary requirements, known allergies, and treatment plan.

(i) Each facility subject to the provisions of this section, with the exception of ambulatory surgical facilities, must employ the services of a records administrator who is registered by the American Medical Record Association or a record technician who is accredited by the American Medical Record Association to supervise the medical record service, and if the administrator or technician is a consultant only, to make visits to the facility not less than twice per year to organize and evaluate the operation of the service and to provide written reports to the medical record service and the administration of the facility. The administrator of the medical record department shall participate in educational programs relative to medical record activities, in on-the-job training and orientation of other medical record personnel, and in-service medical record educational programs. Professional consultation services should be provided for the medical record

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practitioner. The administrator or accredited record technician shall be assisted by such qualified personnel as are necessary for the conduct of the service.

(j) Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least until two years after such minor has reached the age of 19 years and in any case not less than seven years.

(k) The facility shall maintain a medical record service which shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing and filing of all medical records. Medical records shall be filed in an easily accessible manner in the facility or in an approved medical record storage agency off the facility premises.

(l) Provision shall be made for the safe storage of medical records. This shall be deemed to mean that medical records are handled in such manner as to ensure safety from water seepage or fire damage and are safeguarded from unauthorized use. Medical records generally must not be removed from the facility environment except upon subpoena.

(m) If a facility ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required. The facility shall have a policy for the preservation of patient medical records in the event of the closure of the facility.

(n) If ownership of a licensed facility changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patient records, as above required, and that the records are available to both the new and former licensees and other authorized persons.

(o) A committee of the organized medical staff shall be responsible for reviewing medical records to ensure adequate documentation, completeness, promptness, and clinical pertinence.

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(p) Any person who is or has been a patient of a physician, hospital, or other medical facility shall be entitled to obtain access to the information contained in all his/her medical records upon request. This request for medical information will include minors when such request is made by the parent or legal guardian. Copies of all medical records shall be furnished pertaining to his or her case upon the tender of the expenses of such copy or copies.

(q) Out-patient medical records will be maintained and correlated with other facility medical records.

(1) The out-patient medical records will be filed in a location which ensures ready accessibility to the physicians, nurses, and other personnel of the department.

(2) The out-patient medical record will be integrated with the patient's over-all medical record.

(3) Information contained in the medical record must be complete and sufficiently detailed--relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis, and treatment--to facilitate continuity of care.

(r) Current records and those on discharged patients must be completed promptly.

(1) current records will be completed within 24 to 48 hours following admission

(2) If a patient is readmitted within 30 days for the same condition, reference to the previous history and physical examination with an interval note will suffice.

(s) Health facilities generating medical records may microfilm the medical records and destroy the original record in order to conserve space.

(t) Laboratory reports and test results shall be filed in the patient's medical record and duplication copies maintained by the laboratory.

(1) The laboratory supervisor shall be responsible for the laboratory report.

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(2) The governing body shall establish a procedure to assure that all tests are appropriately ordered.

(3) Signed reports of tissue examinations shall be filed in the patient's medical record and duplication copies kept in the laboratory.

(4) All reports of macro- and microscopic examinations performed shall be signed by the pathologist performing the examination.

(5) Provision shall be made for the prompt filing of examination results in the patient's medical record and notification of the physician requesting the examination.

(6) Duplicate copies of the examination reports shall be filed in the laboratory in a manner which permits ready identification and accessibility.

(u) Radiology department reports must be signed and shall be filed with the patient's record with duplicate copies kept in the department.

(1) Requests by the attending physician for X-ray examination shall contain a concise statement of reason for the examination.

(2) Reports of interpretations shall be written for dictated and signed by the radiologist.

(3) X-ray reports and roentgenographs shall be preserved or microfilmed in accordance with the statute of limitations.

(v) Social work shall provide adequate documentation of social work services provided which shall be part of the patient's medical record and shall include:

(1) Observation and social assessment of the patient.

(2) Plan of treatment and social work services provided.

(3) Social work summary, including any recommendation for follow-up.

Alaska State Legislature

Interim:
P.O. Box 1287
Soldotna, AK 99669
(907) 262-8114



Session:
State Capitol
Juneau, AK 99801
(907) 465-2693

Representative Gary L. Davis

SPONSOR STATEMENT

HOUSE BILL 214

"An Act relating to the maintenance by health care providers of medical records in an electronic format"

House Bill 214 is fairly basic legislation. HB 214 will clarify that electronically stored medical records on computer terminals are legally acceptable in lieu of records on paper.

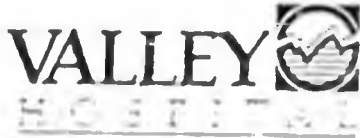
Hospitals and Nursing Homes are moving toward "paperless offices" in an effort to promote efficiency. However, some providers are hesitant to implement the electronic retention and maintenance of medical records without a hard-copy back-up due to the lack of explicit legal authority.

The current statute relating to medical records neither prohibits or permits them to be kept electronically. A legal memorandum from Legislative Legal Services is indicative of health care providers' concerns that the ability to maintain medical records is not clearly defined in statute or regulation. House Bill 214 will lend some clarity to the medical records statute.

* The amendment approved on the House floor adopted language to better ensure the privacy of the patients' records.

Passed 40-0

Representing House District 8 - Soldotna to Seeward



March 10, 1995

Representative Gary Davis
420 State Capital
Juneau, AK 99801-1182

Dear Representative Davis:

We truly appreciate the work that you have done to bring about HB214. We believe it is an important step in helping control costs of health care. The space we have allocated to paper files is large and growing every day. To be able to store on disk will save time, space, and effort.

Sincerely,

A handwritten signature in dark ink, appearing to read "Tom Davis", written over a light-colored background.

Tom Davis
Acting Executive Director

cc: Representative Scott Ogan
Representative Beverly Masek

TD/vlr

TOM\TOM.155

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

Senator Lyda Green, Chair
Senate HESS Committee
Room 423 State Capitol
Juneau, AK 99801-1182

April 13, 1995

Dear Senator Green:

The members of the Alaska State Hospital and Nursing Home Association support House Bill 214 am, "An Act relating to the maintenance by health care providers of medical records in an electronic format."


As health care providers move toward "paperless offices", it is important that Alaska law keep pace with those changes. HB 214 will clarify that electronically stored medical records are legally acceptable in lieu of records on paper.

House Bill 214 am requires that medical records stored electronically be protected from unauthorized access and for physical security.

Thank you for scheduling the bill for a hearing in the Senate Health Education and Social Services Committee on April 19, 1995. We would appreciate your yes vote on HB 214.

If you have any questions or comments please contact me at 364-2244 or Harlan Knudson at 586-1790.

Sincerely,



Garrey M. Peska, C.P.A.
Financial Consultant

cc: Harlan Knudson
Representative Gary Davis

APR 17 1995

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

Representative Gary Davis
Room 420 State Capitol
Juneau, AK 99801-1182

March 2, 1995

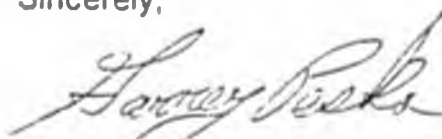
Dear Gary:

The members of the Alaska State Hospital and Nursing Home Association support House Bill 214, "An Act relating to the maintenance by health care providers of medical records in an electronic format."

As health care providers move toward "paperless offices", it is important that Alaska law keep pace with those changes. HB 214 will clarify that electronically stored medical records are legally acceptable in lieu of records on paper.

Thank you for sponsoring HB 214. We look forward to working with you to support passage of the bill during this legislative session.

Sincerely,



Garrey M. Peska, C.P.A.
Financial Consultant

cc: Mr. Ian Knudson



HC01, Box 6201-AB
Palmer, AK 99645
907/762-0273
Fax 907/762-0280

March 12, 1995

Representative Gary Davis
State Capital Room 420
Juneau, AK 99801

Dear Representative Davis,

I am writing in support of House Bill No. 214, an Act relating to the maintenance by health care providers of medical records in an electronic format.

Computer based patient records are important tools for supporting the clinical decision making process and improving the quality of patient care. Computer based patient records assist health care providers to promptly locate and retrieve patient information, which can increase the quality and efficiency of health care. Current paper based medical records can lead to delays in diagnosis and treatment due to time required to retrieve the medical record and route it to the treatment area. Electronic patient records can save essential time in treatment of patients during emergencies.

Computer programs can be utilized to alert health care providers to patients clinical parameters requiring immediate attention. These programs will improve the quality of care provided to patients. Computer based medical records can quickly alert providers to patient's medical diagnoses and allergies, which are essential to emergency treatment.

As proponents of health care reform frequently note, it is imperative that health care costs be reduced. The use of computers to document patient care can assist in reducing costs. It is essential that health care professionals be allowed to utilize computers to their fullest extent by maintaining and preserving patient medical information in an electronic format, without being required to also maintain a paper copy of the patient record. Currently health care providers are required to print the patient reports from the computer for maintenance in a paper based medical record. These reports must be signed by the health care professionals. This is a very expensive and time consuming process, which does not add to the quality of patient care or documentation.

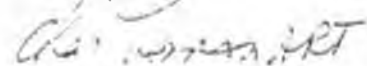
Electronic patient records will also facilitate treatment of patients at different locations within a health care system. Electronic based patient records can assist health care providers to provide integrated health care services across multiple settings and providers of care, and can support efforts to simplify the administration of health care and reduce health care costs.

AKHIMA has been working with DHSS Health Facilities Licensing and Certification Division to develop regulations for electronic medical records. It is necessary to allow patient information to be maintained in electronic format, with adequate security and backup processes to assure proper retention of the medical record data, and with provisions to safeguard the confidentiality of the patient information. We have developed draft regulations which address the essential issues relating to electronic patient information, including authentication, confidentiality, access, and retention and security.

The Alaska Health Information Management Association (AKHIMA) is Alaska's professional organization of credentialed specialists in medical records and health information management. Health information management professionals are responsible for patient health information, including patients medical record, both computer based and paper.

AKHIMA supports HB214 and urges the Legislature of the State of Alaska to enact this proposed Bill.

Sincerely,



Char Thompson, ART
President

cc: Darin Morgan ✓



HC01, Box 6201-AB
Palmer, AK 99645
907/762-0273 (work)
907/373-6347 (home)
Fax 907/762-0280

April 15, 1995

Senator Lyda Green
State Capital Room 423
Juneau, AK 99801-1182
Fax 465-3805

Dear Senator Green,

I am writing in support of House Bill No. 214, an Act relating to the maintenance by health care providers of medical records in an electronic format, which is scheduled for hearing by the Senate HESS Committee on April 19 at 9:00 am. I wish to testify via teleconference in support of this bill on behalf of the Alaska Health Information Management Association.

Computer based patient records are important tools for supporting the clinical decision making process and improving the quality of patient care. Computer based patient records assist health care providers to promptly locate and retrieve patient information, which can increase the quality and efficiency of health care. Current paper based medical records can lead to delays in diagnosis and treatment due to time required to retrieve the medical record and route it to the treatment area. Electronic patient records can save essential time in treatment of patients during emergencies.

Computer programs can be utilized to alert health care providers to patients clinical parameters requiring immediate attention. These programs will improve the quality of care provided to patients. Computer based medical records can quickly alert providers to patient's medical diagnoses and allergies, which are essential to emergency treatment.

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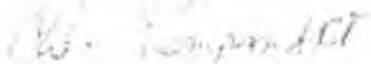
APR 18 1995

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AKHIMA supports HB214 and urges the Legislature of the State of Alaska to enact this proposed Bill.

Sincerely,



Char Thompson, ART
President

APR 18 1995

Who We Are

The Alaska Health Information Management Association, or AKHIMA, is Alaska's professional organization of credentialed specialists in health information management (HIM). AKHIMA is affiliated with the 35,000 member American Health Information Management Association (AHIMA).

AKHIMA's Professional Definition

HIM professionals are the experts who secure, analyze, integrate and manage information that steers the healthcare industry. At the heart of the profession's information responsibilities are records, both computer-based and paper, of patients' health care. The HIM professional orchestrates the collection of many kinds of data while advocating patient confidentiality and ensuring authorized access to the individual patient record.

The Mission of AKHIMA

The mission of AKHIMA is to promote the art and science of health information management by achieving and maintaining high standards of competency, developing educational programs and promoting professional growth. Along with physicians, nurses, administrators and other members of the health care team, we continually strive to improve the quality of health information for all Alaskans. We endeavor to meet the challenges of a changing health care delivery system by providing assistance and contribution within the scope of our profession.

AKHIMA Serves...

Patients: by advocating confidentiality of their health information and promoting comprehensive documentation of the medical care they receive. In an increasingly mobile society, AKHIMA members are key players in the development of the computer-based medical record.

Physicians and other health professionals: by providing the latest developments in health information systems, documentation requirements, data and statistical trends and information for clinical decision-making and patient care planning.

Researchers, government agencies, insurance companies and employers: by providing authorized data and access to our expertise.



The HIM specialist may be employed in the management of data and information; supervision of clinical registries (cancer, trauma, diabetes, cardiac); utilization management; quality assessment; risk management; sales and marketing; education; medical research. These professionals are visible in settings such as:

Health Facilities

- acute care hospitals
- ambulatory surgery centers
- medical and dental practices
- health maintenance organizations
- long term care hospitals
- mental health facilities
- substance abuse programs
- rehabilitation centers
- home health agencies

Private Industry

- insurance companies
- consulting firms
- computer companies
- industrial health
- law firms
- pharmaceutical companies

Government/Regulatory Agencies

- federal and state health departments
- federal and state regulatory agencies
- education
- peer review organizations

Our Members

AKHIMA members are committed to excellence in health information. Through our national organization, HIM specialists are credentialed in one of the following career paths:

RRA

Registered Record Administrator

A Registered Record Administrator (RRA) is a manager as well as an information specialist. RRAs frequently interact with other members of medical, financial and administrative staffs to ensure that information systems are protected and driven by accurate, up-to-date information. RRAs also typically determine health information policies, budgets and resources.

You can become an RRA by earning a bachelor's degree from an accredited college program and then passing the national registration exam. By passing this exam, you earn the RRA credential.

ART

Accredited Record Technician

An Accredited Record Technician (ART) compiles, analyzes and evaluates health information. An ART's responsibilities also typically include: maintaining and using health data; controlling the use and release of health information; and supervising staff.

You can become an ART by earning an associate's degree through an accredited college program, such as the University of Alaska-Sitka distance learning program in health information management, or by completing AHIMA's Independent Study Program. You earn the ART credential after successfully passing the national accreditation exam.

CCS

Certified Coding Specialist

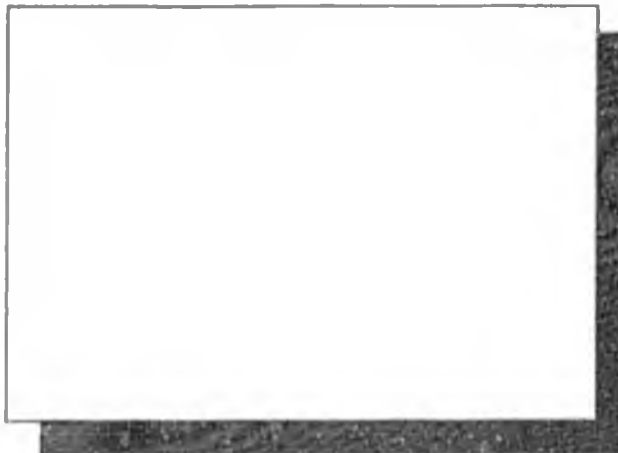
A Certified Coding Specialist (CCS) is the recognized expert in analyzing health records and assigning classifications to medical data. A CCS applies codes to report diagnoses and procedures for all payors including the federal government and private insurance companies. This information is also used in research, statistical reporting and planning.

To become a CCS, you must have a high school diploma or equivalent, on-the-job coding experience and a solid coding education. A coding education can be attained through workshops, seminars and coding tracts within HIM college programs. You may use the CCS credential after passing a certification exam.

Health Information Management is a Growing Profession

HIM career opportunities continue to grow. The Bureau of Labor Statistics estimates that more than 47,000 additional HIM professionals will be needed by the year 2005.

For more information about retaining the services of an HIM professional or to learn more about careers in HIM, write or call:



Alaska Health Information Management Association



*Steering your health information
into the next century –*

2000 and beyond.

DIVISION OF LEGAL SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

December 14, 1994

SUBJECT: Electronic medical records (Work Order No. 9-LS0313)

TO: Representative Gary Davis
Attn: Darin

FROM: *TB*
Theresa Bannister
Legislative Counsel

You have asked for an opinion relating to the use of electronic medical records. Essentially you are concerned with whether private health care facilities are legally able to keep all medical records electronically without maintaining a hard copy back-up. You have provided three situations for illustration and examination.

1. Introduction of electronic information. You have raised the potential problem of introducing a hard-copy of electronic information as evidence in court. Aside from other evidentiary rules that have to be satisfied for the introduction of any piece of evidence, it appears that the fact that you are working from an electronic source would not by itself prevent the introduction of the hard copy. Alaska Rule of Evidence 1002 appears to allow the introduction. That rule requires that the "original writing, recording, or photograph" is required, except as otherwise provided by state statute or other state court rule. Although this wording does not look promising, the definition of "original" includes the following language: "If data are stored in a computer or similar device, any printout or other output readable by sight, shown to reflect that data accurately, is an original." However, it is possible that an electronic reproduction of another document (e.g. a signed consent form) may not be considered to be "data" for the purposes of that definition. In that case, Alaska Rule of Evidence 1003 would seem to provide for the introduction, since it authorizes the admission of a duplicate unless a genuine question is raised as to authenticity or it would be unfair to admit the duplicate in lieu of the original. Therefore, it appears that the Alaska Rules of Evidence provide for the introduction of electronic information by hard copy. However, the rules may not be express enough for your purposes.

2. Requirement of "legibility" Does the regulatory requirement (7 AAC 12.770(b)) that medical records be maintained in a "legible" form mean only a "written" format, or does it include an electronic format as well? The term, "legible," is not defined for the regulation. Webster's Ninth New Collegiate Dictionary (1991) defines the term as "capable of being read or deciphered." Under that definition, "legible" would include electronic records since they

can be "read." The apparent purpose of the regulation would be served by this interpretation. That subsection reads as follows:

(b) A facility must keep records on all patients admitted or accepted for treatment. Originals or accurate reproductions of the contents of the originals of all records, including x-rays, must be maintained in a form which is legible and readily available upon the request of the attending physician, medical staff, representative of the department, or, upon the patient's written request, to other practitioners.

Aside from making the information available for regulatory purposes, it appears that the purpose of the legibility requirement is to expedite and facilitate the treatment of patients. Therefore, if one can obtain and read the information, whether written or not, it should be adequate. This requirement, therefore, does not prohibit the use of electronic medical records without hard copies.

Some of the other terminology and requirements in 7 AAC 12.770(c) suggest that some written documents have to be held and that "legible" might be interpreted to require a hard-copy back-up: the reference to "identification sheet," in 7 AAC 12.770(c)(1) and "order sheet" in 7 AAC 12.770(c)(4); the inclusion of court orders and consent forms (which involve patient signatures; and the signature of a person who administers medication or treatment in 7 AAC 12.770(c)(6)(E)). However, the regulation allows the facility to maintain "accurate reproductions" of the records (7 AAC 12.770(b)), and this would accommodate electronic filing without hard-copy back-up.


Assuming that no hard copy is required, the electronic system must still meet the requirements of the regulation: legibility and availability. In other words, the system must be designed to have these attributes. For example, since computers are notorious for "going down," it would seem that the electronic system must do whatever is necessary to insure that the records are legible and available at all times, e.g. back-up systems, other computer access, etc.

3. Use of fingerprint-based security system. The regulatory record security requirement does not either prohibit or allow the use of a fingerprint-based security system. 7 AAC 12-770(d) merely requires a facility to maintain procedures to protect the information in medical records from loss, defacement, tampering, or access by unauthorized persons. Even assuming a hard-copy back-up is required, a fingerprint security system could be used if it met the requirements of the regulation.


4. Authentication by computer key. You have suggested that the existence of a regulation 7 AAC 12.770(e) authorizing authentication by computer key may indicate that clarification is necessary to confirm the ability to keep medical records by electronic means. This provision is necessary only because the regulation itself requires generally that the attending physician or dentist authenticate or sign the record. This provision tends to reinforce the ability to keep

Representative Gary Davis
December 14, 1994
Page 3

medical records electronically without hard copies, because it establishes an alternative to making a signed hard copy.



5. General question. I have not found any statute or regulation that expressly allows or prohibits the keeping of medical records electronically without a hard-copy back-up, except that AS 18.20.085(a) does specifically address the retention of x-ray film. However, the court rule appears to be compatible with this proposed approach. The regulation appears also to be compatible with this approach, although it is not a clear conclusion, and I cannot say with any finality that a health care provider may maintain only electronic records without a hard-copy back-up.



6. Need for legislation or regulation and court rule change. In light of the conflicting signals provided by the regulation, it would seem advisable to obtain express permission for keeping electronic medical records without hard-copy back-up, and for any other connected potential problem areas. You may be able to approach this through regulation, since the Department of Health and Social Services appears to have quite a bit of authority to adopt regulations in this area (see AS 18.20.060 and 18.20.085). With regard to the admission of records in court, amendments can be handled either by amendment of the court rules by the Alaska Supreme Court, which periodically amends the court rules to accommodate changing needs, or by statutory change. The Alaska Supreme Court has standing committees that advise it on changes necessary for the court rules.

This analysis has been done very quickly to enable you to have some guidance before I leave the office for a few days. Therefore, if you need further research done, or if I can help with another aspect of this matter, please advise.

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