Managing Outside Information:
Creating an Internal Plan for Externally Generated Information
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Most HIM departments have yet to master the management of patient health information exchanged across healthcare organizations. Typically the well-established processes and standards for managing internally generated information do not address health information that is generated outside the organization.

Despite an avalanche of published articles and dialogue on how to exchange health information across organizations, little has been said or written about how to manage this information once it is received.

Healthcare still requires best practices or guidelines for managing externally generated patient information. In this absence, organizations are developing their own individual policies and procedures. These internal plans must be based on sound HIM principles.

The Issues with Outside Information

Although an increasing number of clinicians are requesting information be sent to their office-based and hospital EHR systems, most hospitals and clinicians today still send and receive analog-based (including faxed) information.

Often the information does not reach the intended recipient or reaches the recipient at the wrong time, causing numerous requests for additional copies. This kind of communication is chaotic to manage and requires hours of staff work.

Externally generated information that is incorrectly sent or inaccessible when received presents a significant risk to patient care and compliance with pertinent regulations. Receipt of this information also does not always meet an organization's standards for data confidentiality and security.

Too often organizations receive redundant or irrelevant information, and caregivers and management staff typically make decisions with little guidance on how to appropriately store, retain, or destroy electronic PHI.

File Formats and Management

Most externally generated patient health information is delivered by the patient (or a representative), courier (including mail), or fax on analog storage media, whether paper, photographic film, glass slide, video cassette tape, CD, or DVD.

If digital, often the information is received via unsecured e-mail messages or in a variety of unreadable data file formats—in proprietary data file formats or in de facto or de jure standard data file formats, but often without the required viewers. Too often, the information is not indexed or labeled (e.g., no patient name).

All this complicates the disposition of the information, with some of the information needing to be destroyed immediately, stored as part of the organization's legal and permanent health record, retained as "external" information, or organized so that it can

be used appropriately for patient care or legal, business purposes.

Typically in acute care organizations, relevant, nonredundant externally generated information is retained by filing or scanning the information into the relevant department's manual or automated system or it is returned to the patient, representative, or the external provider, with the exception of paper.

Interestingly, laboratory, radiology, and cardiology tests typically are repeated even when the clinician does receive relevant, nonredundant test results.

The following strategic process and technology recommendations can help practitioners create an internal HIM plan for externally generated patient health information. The recommendations mix process and technology recommendations, which is consistent with healthcare informatics literature that advocates reworking and successfully managing manual business processes prior to introducing technology solutions. Consequently, these recommendations also might be considered starters for developing best practices to help healthcare organizations seek excellence.

Establish an externally generated patient health information initiative and tie it to the organization's legal health record initiative. The literature on defining the legal health record is in agreement that each organization must determine the contents of its own legal health record, including externally generated information (a process that should include several organizational disciplines).

Consider all relevant, nonredundant externally generated information part of the legal health record. Currently, legal analysts and experts insist that if external information is used to provide patient care services, make clinical decisions, review patient data, or document observations, actions, or instructions, the external information must be considered part of the legal health record. If it is omitted, the record does not tell the whole story of care and can be a challenge with Present-on-Admission indicators and medical necessity denials of reimbursement.

On the other hand, unless a care provider specifically documents such use in a note or report, there is no way to determine if the information was used to provide patient care or make clinical decisions. Therefore, until there is a suitable, technical means to determine if externally generated information is or was used without having to burden clinicians with more documentation requirements, it is recommended that all externally generated patient health information be included in the legal health record.

Create an analog or digital section, folder, or tab for all health records called "Externally Generated Patient Health Information" or "Other Provider Records," separating outside information from internally generated patient health information.

Organizations should then establish enterprise-wide rules and an appropriate policy for the redisclosure of externally generated patient health information. This health record section then can be used to direct the user to either the redisclosure or nondisclosure of the information upon receiving authorized requests.

Currently, legal analysts and experts believe that healthcare organizations should redisclose externally generated patient health information. There is no law or regulation

that prohibits the redisclosure of information received from another organization other than mental health, HIV/AIDS, drug or alcohol abuse testing and treatment records, and some state Medicaid statutes. For example, physician offices routinely include test result reports performed by external sources in their records, and they routinely release these records.

Most important is the general principle used to respond to HIPAA Title II Administrative Simplification's Confidentiality and Privacy Standards Regarding the Designated Record Set. The principle is that a covered entity is required to provide access to PHI in accordance with the rule, regardless of whether or not the entity created the information (though there are exceptions, such as psychotherapy notes and information compiled for civil, criminal, or administrative action).

Tie the externally generated information initiative to the ongoing implementation of HIPAA Title IIAdministrative Simplification Confidentiality and Privacy Standards and Security Standards directed by the healthcare organization's privacy and security officials. This will allow the organization to apply its existing HIPAA standards to the intake and use of information received.

Accept externally generated patient health information stored only on, for example, analog paper, photographic film, glass slides, video cassette tapes, or digital CDs. Unfortunately, most healthcare organizations cannot receive, read, or appropriately retain other storage media, such as USB flash drives, projector slides, cine spools, and unsecured e-mail attachments. Therefore, organizations require an appropriate policy to either return to the source or shred or destroy the other storage media on which the information was received.

Invest in an enterprise content management system as a proposed technology solution. An enterprise content management system consists of tools, technologies, systems, and methods to manage organizational content wherever it exists—from traditional content (office documents, diagnostic images, graphics, print streams) to electronic objects (Web pages, e-mail, video files)—throughout the content's life cycle. Using an enterprise content management system will help healthcare organizations eventually capture, manage, store, preserve, and deliver *all* digital externally generated patient health information, including all types of externally generated patient information-based documents (e.g., video, audio, and diagnostic image files, if readable; e-mail messages; and Web pages).

As such, the system would be able to effectively manage the potential discovery of an organization's digital assets, such as e-mail messages that contain PHI, under the Federal Rules of Civil Procedure Governing Electronic Discovery.

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