

 <p>State of Indiana Indiana Department of Correction Division of Youth Services</p>	Effective Date  4/1/2022	Page 1 of  7	Number  1.14Y
<p><b>HEALTH CARE SERVICES DIRECTIVE-YOUTH SERVICES Manual of Policies and Procedures</b></p>			

<p>Title <b>HEALTH RECORDS</b></p>
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the Department's health record system and creates a consistent standard for content, maintenance, and confidentiality of patient health records, in accordance with State and federal rules and regulations and applicable correctional standards.

II. DEFINITIONS:

**ELECTRONIC MEDICAL RECORD (EMR):** A longitudinal electronic record of patient health information generated by Health Services staff, using a designated application, established templates and free text to document the delivery of health care and patient encounters.

III. GUIDELINES:

A. The Health Record

The patient health record is a combination of paper chart and electronic documentation. It is the legal record of the care provided to patients by Health Services staff. Documentation in the EMR includes, but is not limited to patient demographics, allergies, progress notes, chronic problem list, past medical history, drug orders, vital signs, intake and transfer screens, immunizations, and laboratory data.

Access to the health record, including the EMR, shall be limited to those Health Services staff having a need to use the health record in the performance of their duties. Paper health records shall be stored in a secure location under the authority of the Health Services Administrator (HSA).

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Youth shall not be used in the processing, storing, or destroying of medical record information under any circumstances.

Chronology is essential to the maintenance of the health record. All documentation in the health record must include the patient's name and IDOC number.

The paper health record must be stored in a jacket separately from the facility packet, although information which is necessary for the classification, security, and control of youth must be shared with the appropriate Correctional personnel.

Access to the EMR shall be granted in accordance with the facility access procedures and IDOC User Agreements. Staff who access the EMR must have a unique user ID and password.

Computer passwords for the EMR are confidential and shall not be shared with or used by any other person. Health Services employees must use their individually assigned logon information to access and document in the EMR.

**At no time may an employee use another person's logon identity to access the electronic health record.**

Health Services staff must properly secure the workstation for the EMR from unauthorized access.

Health Services staff documenting in the EMR must adhere to verification requirements to ensure information is entered in the correct encounter record for the correct patient.

Electronic dental records are maintained separately from the physical, behavioral, and transitional health records. The HSA shall establish a process which ensures that pertinent information is shared between all providers and clinicians.

All health record documentation must be made as soon as possible after the patient is assessed or care is provided.

Each facility shall develop and implement procedures to preserve health record information and ensure the proper documentation of care during those times when the EMR is unavailable. Documentation during this time shall be scanned into the EMR as soon as possible upon the EMR's availability.

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The paper chart must contain original reports when used, if possible.

Releases of the health record shall be managed in accordance with signed authorization of the patient in accordance with applicable Indiana laws and federal rules and regulations. Health records must be released, without the patient written authorization, in response to a subpoena or court order. Health records of a deceased youth may be released to the coroner upon request.

**B. Content of the Health Record; Paper and Electronic**

All clinical contacts between providers and patient, and decisions and correspondence affecting or relating to the health care delivered to a patient (even if no direct contact occurred) shall be documented in the health record. The health record must contain the following:

- Patient identification on each form or printed sheet
- A problem list of medical and mental health diagnoses
- Known allergies
- Completed receiving screening and health appraisal data forms
- Health care request forms
- Progress notes/reports of all findings, diagnoses, treatments, and dispositions
- A record of immunizations
- Tuberculosis screening
- Provider orders for prescribed medication and medication administration records
- Individualized treatment plan, when applicable
- Reports of laboratory, x-ray and diagnostic studies
- Flow Sheets
- Health service reports (e.g., emergency department, dental, behavioral health, telemedicine, or other consultations)
- Flow sheets
- Consent and refusal forms
- Release of information forms
- Results of specialty consultation and off-site referrals
- Discharge summaries of hospitalizations, inpatient stays, and other Health Services termination summaries
- Place, date and time of each clinical encounter
- Legible signature (electronic or written) and title of each provider (may use ink, type, or stamp under the signature)

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C. Confidentiality of the Health Record

1. Health records shall be maintained securely, and in a confidential manner at all times. Extreme care shall be exercised to ensure that the health record remains secure and intact. All active paper health records are maintained securely in file cabinets or open shelf files in the Health Services Unit unless there is no Health Services Unit in the facility. When not under direct supervision, health records shall be locked securely in cabinets and/or rooms.
2. Designated workstations for the EMR must be appropriately secured to prevent unauthorized access and loss of data.
3. At the inception of mental health treatment, patients shall be fully informed regarding the limits of confidentiality, including information that may be necessary in order to protect the health, safety, and welfare of others.
4. The Electronic Dental Record's (EDR) confidentiality and security shall be maintained in the same manner and importance as the EMR.
5. Sex Offender Management and Monitoring Program (SOMM) documentation is not a part of the health record. As a condition of participation each participant agrees that information generated in the program may be shared as necessary, without written authorization or consent, under the provision of continuity of care. This does not, however, authorize release of this information for general review by the public.

D. Health Record Storage

All inactive health records are retained in the appropriate storage location for a period of not less than ten (10) years following discharge of the youth. Paper health records shall be placed with the youth's facility record and stored in accordance with Policy and Administrative Procedure 01-04-104, "Offender Records." Paper records shall be maintained in a designated Department records storage facility where they shall be held until eligible for destruction

All loose filing relating to a released patient shall be filed in the paper health record as soon as possible after the youth's release so the complete record may be transferred to the Department's Records Warehouse.

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In the event of a return to incarceration, the health record shall be forwarded to the appropriate facility for reactivation.

E. Access to Health Records

The HSA controls access to the health records. Health information which is necessary to address the special medical needs of a patient regarding housing, program placement, security, and transportation shall be provided to the appropriate Department staff.

All employees who have a need, in the course of their assigned duties, to use information found in a patient's health record (including physical, behavioral, and transitional health entries) shall have access to them. Special consideration shall also be given to information related to mental health, HIV infection, substance abuse, and all employees using health records must be aware of specific prohibitions under State and federal statutes and regulations regarding release of such information.

Youth shall be allowed to access and review their health records. If copies are requested, the facility shall charge the youth the current Indiana Department of Administration (IDOA) copy rate, regardless of the indigent/non-indigent status. There shall be no unreasonable delays in providing these copies. The youth shall be required to sign a release indicating that they understand that the Department accepts no responsibility for the documents once the youth obtains them.

F. Information Release

Copies of health records shall be processed via the appropriate channels and under all State and federal law. No patient's health record shall be removed from Department premises unless there is a court order.

Health record information may be shared with other health care agencies such as the Indiana Department of Health, Family of Social Services Administration or the Occupational Health and Safety Administration, as authorized by statute. However, no photocopying of health records by these agencies may be performed. Access to the EMR by staff from a non-Department of Correction agency shall be provided, with the Department's Legal Division's approval, through a unique logon when necessary or the requested material shall be exported or scanned and e-mailed with notification that the material is confidential and protected. The material provided to outside agencies shall be the minimum necessary to meet the request.

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Health Services providers also have an obligation to divulge information under certain circumstances. These include:

1. Information relating to the neglect or abuse of a child or endangered adult;
2. Information which describes or clearly suggests the presence of a future threat to the welfare of a person.

#### G. Clinical Critical Incident Reviews

Clinical Critical Incident Reviews (CCI) are performed after every identified CCI event. However, the CCI review records are strictly confidential and maintained only by the designated Continuous Quality Improvement (CQI) staff. Copies shall not be stored in the health records and may not be released to any party.

#### H. Availability and Use of Health Records

A patient's health record shall be available for documentation and reference during each health care encounter. "Shadow" health records (secondary files containing partial documentation for the convenience of a provider or type of provider) shall not be established. If identified, shadow health records shall be destroyed.

Except in emergency circumstances, a patient's health record must be made available to those delivering on-site clinical services to them. Documentation shall be accurate, legible, complete, and timely.

#### I. Transfer of Health Records

To enhance continuity of care, it is imperative that a patient's paper health record accompany them upon transfer to another facility (intrasystem). When a youth is transferred from one facility to another, the paper health record shall be securely and confidentially packaged and transported at the same time as the youth. Loose filing shall be incorporated into the patient's health record prior to the youth's transfer. If loose filing or other reports relating to a transferred youth are found, these shall be forwarded to the youth's current facility as soon as possible.

Health Services staff at receiving facilities must review all incoming youth with their health records within the parameters established in HCSD 2.07, "Transfer Screening."

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Health records may not be transferred to non-Department facilities, although full copies may be transferred when appropriate in order to ensure continuity of care. For purposes of this HCSD, contract facilities which receive youth, manage them, and return them to Department control are considered Department facilities.

If a youth is transported to an off-site health care consultant or clinical setting for care, the original health record may not be sent along. However, a written form including pertinent information must be sent to the off -site providers so that care may be provided in a continuous fashion. The forms used must make it simple for the off-site provider to return pertinent information, so that care may be provided in a continuous fashion.

### III. APPLICABILITY:

This HCSD is applicable to all facilities housing youths.

signature on file

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Kristen Dauss, MD  
Chief Medical Officer

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Date