Kansas
Department of Corrections

INTERNAL MANAGEMENT POLICY & PROCEDURE

Applicability: ☐ Adult Operation Only ☐ JUVENILE Operations Only ☒ DEPARTMENT-WIDE

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HEALTH CARE SERVICES: Health Record

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Approved By:  , **Secretary** **Next Scheduled Review:** 06/2025

POLICY

A confidential health record separate from the confinement record is to be created and maintained in a standardized format that contains accurate, cumulative documentation of all health care services and encounters provided throughout the period of incarceration. The contracted healthcare services provider is to provide guidelines in the implementation of and compliance with HIPAA Privacy Rule Requirements.

DEFINITIONS

Active Health Record: Medical, dental, and behavioral health records of all residents housed within any KDOC facility.

Behavioral Health File: Raw Psychological Testing Data File which reflects all behavioral health and psychiatric testing material.

Comprehensive Health Summary: Documents containing relevant health information including medical, dental, and behavioral health diagnoses, medications, significant chronic conditions, allergies, and pending health referrals.

Health Services Administrator H.S.A.: The individual responsible for ensuring the organization and delivery of all levels of quality accessible health services in the facility. The H.S.A. works under the direction of the Regional Medical Director clinically and the Regional Vice President or designee administratively.

Health Record: Medical dental, and behavioral health information maintained and secured by the health care provider and contained in the form of electronic or paper media.

HIPAA: Health Insurance Portability and Accountability Act. Privacy Rule from the US Department of Health and Human Services that includes criteria for a medical provider, organization, business, agency, or part thereof to be considered a “covered entity” subject to compliance with the Rule.

Inactive Health Record: Medical, dental, and behavioral health records of all residents discharged from sentence or released to post-incarceration supervision.

Inactive Offender Records Repository: A centralized records section for the Kansas Department of Corrections, located at the Lansing Correctional Facility Warehouse. Inactive and active older healthcare records or extra volumes that have continued documentation or documentation that coincides with the E.H.R. that has not been scanned into the electronic record or Docuware.

KDOC Records Custodian: The individual responsible for keeping records in the ordinary course of business. Processes include shared Subpoena or Release of Information. The records custodian pulls the relevant records, verifies accuracy, and certifies them with affidavit or a declaration of business records. These documents can be used in lieu of asking the records custodian to appear in court, as it indicates the records are true and correct

to the best of the custodian's knowledge. The KDOC Records Custodian works under the direction of the Technology Support Consultant.

Regional Medical Director: The physician Medical Director of the contracted agency or organization responsible for the provision of health care services for the KDOC resident population. This position has full clinical autonomy and responsibility for the provision of clinical services within the KDOC.

Regional Medical Records Supervisor: This individual is responsible for directing, planning, and working in coordination with the KDOC Records Custodian and the KDOC legal department, to process all requests for healthcare records for all of the KDOC correctional facilities utilizing the secure electronic healthcare record release process. These processes are completed in accordance with KDOC confidentiality policies and HIPAA. The Regional Medical Records Supervisor works under the direction of the Regional Vice President of Operations of the current, contracted healthcare provider.

PROCEDURES

I. Establishment of the Health Record

A. The Regional Medical Director and KDOC Director of Healthcare Compliance are to approve the contents and format of the health care record.

B. The Kansas Department of Corrections has a unified electronic health care record utilizing Nextgen Software. Procedures that address integration of health information in electronic and paper documents are to be outlined by the contracted health services provider.

C. Health records are to be initiated upon entry into the system, at the time of the intake screening.

D. The Regional Medical Director is to ensure that the health record contains sufficient information to identify the resident, support diagnoses or assessment, justify the treatment or care, and accurately document the results.

E. The contracted health services provider is to develop policy and procedure for staff orientation training in confidentiality and handling of protected health information, access to health records, transfer of health records or summaries, records reactivation, records retention, and release of records.

F. The contracted health services provider is expected to meet legal requirements for retention and release of records.

G. The Health Services Administrator (HSA) or designee at the Topeka Correctional Facility - Reception and Diagnostic Unit (TCF-RDU) and EDCF- RDU shall be responsible for initiating a health record at the time of the resident's reception into KDOC custody.

H. The health record is to be available to health care staff and all health care encounters are to be documented.

II. Contents of the Health Record

A. The health record shall be established and maintained in the electronic format which includes medical, behavioral health and dental information, but at a minimum shall include:

1. Identifying information (e.g., patient name, identification number, date of birth, sex.)

2. A defined database including past health care history, initial receiving screening and health assessment, problem list containing medical, dental, and behavioral health diagnoses and treatments as well as known allergies.

3. Progress notes or flow sheets of all significant findings, diagnoses, treatments, dispositions, and special needs treatment plans. (Documentation of all occasions of health care provided both on-site and off-site)

4. Prescriber orders for medications, current medication list, and medication administration records.

5. Reports of laboratory, X-ray, EKG's, and other diagnostic studies.

6. Optometry exams, corrective eyewear prescriptions, and treatments.

7. Consent and refusal forms.

8. Release of information forms.

9. Results of specialty consultations and off-site referrals.

10. Discharge summaries of infirmary stays, hospitalizations and other inpatient stays.

11. Special needs treatment plans.

12. Immunization records.

13. Location, date, and time of each clinical encounter.

14. A legible signature (includes electronic), name, and title of each person documenting.

15. Templates in the NextGen system used to build health care encounters must be finalized into legal documents by the health care personnel documenting the encounter.

B. Behavioral Health data is to include:

1. Reception and Diagnostic Unit evaluations;

2. Psychological testing results;

3. Clinical Service Reports;

4. Psychiatric evaluation summaries;

5. Behavioral Health treatment plans;

6. Chronological notes from counseling sessions;

7. Activity Therapy; and

8. Documentation of treatment in a behavioral health treatment facility.

C. Dental Health data is to include:

1. Dental screenings, examinations, and all treatment provided;

2. Oral hygiene, oral disease education and self-care instruction; and

3. Dental tooth and hygiene charting system that identifies the oral health condition and specifies priorities for treatment by category.

D. Health care personnel shall have input, when appropriate, into the health record. This is to include: Physicians, Registered Nurses, Licensed Practical Nurses, Dentists, Psychiatrists, Physician Assistants, and treatment specialists.

E. Each document contained within the health record is to be dated, titled, and signed.

F. When initials are used on flowsheets or Medication Administration Records (MARS), a corresponding signature must be placed on them to authenticate and identify the initials.

G. Abbreviations used for documentation in the health record are to be clear and consistent. Healthcare staff are to avoid using abbreviations that are easily misinterpreted. The Joint Commission "Do Not Use List" should be used for guidance in use of abbreviations.

H. When it is necessary to make an entry that is not in chronological order, a late entry is to be made as soon as possible. A late entry is made in the health record by labeling the entry as a "late entry." Record the date and time that the entry is made as well as the date and time when the entry should have been made.

I. The contracted health services provider is to provide workflows to all health care units for the creation of documents in the electronic health record.

J. Criminal justice information that is pertinent to clinical decisions is to be available to qualified health care professionals.

III. Health Record Maintenance and Review

A. The Health Services Administrator of the facility in which the resident is housed shall ensure that each health record is maintained in a manner consistent with statutory requirements and accepted standards of care and security for the following purposes:

1. To serve as a basis for planning individual care;

2. To facilitate and document continuity of evaluation, treatment, care, and any changes in the resident's condition;

3. To facilitate evaluation of quality of care;

4. To protect the legal interests of the KDOC, facility, resident, and the health-care providers;

5. To serve as a basis for statistical analysis and clinical data for use in program planning, education and approved research; and,

6. To document communication between the responsible physician and other health-care providers contributing to the resident's total health care system.

B The Regional Medical Director and Director of Healthcare Compliance shall approve the methods of recording entries in the health records, the form and format of the health records, and the procedures for their maintenance and safekeeping.

1. KDOC health records are primarily in the electronic format. However, in a limited number of circumstances a hard copy document must be generated. Any health record document created in hard copy format must be scanned upon completion and placed into the appropriate folder/category within the electronic health record.

C. The Health Information Technology Administrator, employed by the contracted health services provider, shall conduct an annual audit of health records at each facility.

1. This audit shall be for the purpose of ensuring accuracy and completeness of information, organizational conformity, and secure handling of protected health information.

D. The Health Services Administrator and designee shall conduct random spot audits of health care records in conjunction with onsite visits and shall conduct audits of particular records whenever questions or problems dictate.

E. The contracted health services vendor's policy and procedures for electronic health records are to address:

1. How the system should protect access and provide security of the record;

2. Procedures for downtime;

3. Ability to retrieve data by diagnosis, medication, and special needs;

4. Documentation of disaster recovery once per year and verification of regular back ups;

5. Role based access;

6. An audit log function; and

7. Encryption software for electronic distribution of patient health records.

IV. Transfer of Health Records

A. Health records shall be brought up to date prior to a resident's transfer to another KDOC facility.

1. Facility personnel responsible for resident transfers shall notify health care personnel at least 24 hours prior to a routine transfer, whenever feasible, to ensure that health record review and updates are completed as well as review of appropriateness of the patient for transfer to the intended facility with consideration for pending diagnostic tests, off-site referrals, and appointments.

2. A copy of the resident's health summary shall be transferred with the resident in accordance with IMPP 16-114D Medical Transfer Screening.

3. Protected health information in hard copy format is to be sealed when transported by non-health care staff.

B. When transferring a resident to offsite emergency care, requested copies of pertinent information from the resident's health record shall be transmitted by electronic/ encrypted email, or fax by health care staff, or delivered by KDOC personnel, to the emergency provider.

C. The transfer and sharing of health care records shall comply with state and federal law.

V. Storage of Health Records

A. The health record is in electronic format. However, any hard copy document that contains protected healthcare information is to be maintained in a secure area and accessible only to authorized personnel. Hard copy documents are scanned into the record, then destroyed. There are no hard copy record volumes stored at the individual facilities. Old hard copy volumes of all KDOC patient records are stored in a warehouse at Lansing Correctional Facility (LCF).

B. Stored healthcare records at the LCF warehouse are to be maintained in a locked and secure area accessible only to authorized personnel.

C. The health authority, in consultation with the Warden, shall identify those persons authorized to access health records.

1. The health authority shall maintain a current list, by name, of all persons granted health record access.

D. The Department's Contracted Healthcare Provider shall establish a policy and procedure that ensures accountability of the health record.

VI. Retention of Health Records

A. When a resident is released from custody to post incarceration supervision or dies when incarcerated, any remaining hard copy health record documents are to be scanned into the electronic health record.

1. Health records upon the death of a resident are to be encrypted and sent electronically to the Enforcement Apprehensions and Investigations (EAI) department.

VII. Release of Health Records

A. Release of information requests must be forwarded to either the KDOC Central Office Records Custodian or the Regional Medical Records Supervisor employed by the contracted health services provider within one working day of receiving the request. Requests for healthcare records received by the KDOC Records Custodian must be forwarded to the Regional Medical Records Supervisor. Release of information requests must be reviewed by the KDOC Legal Department prior to release.

B. The Regional Medical Records Supervisor shall log and monitor the release of all requests for medical, dental, and behavioral health information as they occur and are processed throughout the department. The KDOC Records Custodian must log and monitor requests whereby additional "Docuware," healthcare records are placed on a disc and mailed to complete the request.

C. The KDOC Records Custodian will contact staff in the LCF records storage area when a records request is received that requires release of stored, hard copy records. The Records Custodian shall contact the KDOC Legal Department and LCF staff to determine what records may be copied. Once authorization is received, the Records Custodian will scan the records into Docuware and upload them to a disc to send to the requester by mail.

1. The transmittal of information is to occur within three (3) working days.

D. Requests for information of residents whose records are currently in the custody of the Contracted Healthcare Provider are to be forwarded to the Regional Medical Records Supervisor. The Medical Records staff at the individual facility will coordinate the exchange of information with the Regional Medical Records Supervisor.

VIII. Security and Privacy of Protected Health Information Safeguards

A. The "Authorization for Release of Information," shall be reviewed for Health Insurance Portability and Accountability Act (HIPAA) compliance.

B. The Contracted Healthcare Provider at the Kansas Regional Office combines the requested records into a PDF format followed by steps to electronically encrypt the requested healthcare records. Two levels of encryption are applied to the records.

C. A two-step password process containing more than one password is created and sent separately from the records to the recipient, for access to the requested healthcare records.

D. The contracted healthcare provider maintains a restricted document of all healthcare record requests processed electronically.

E. Electronic/encrypted healthcare records are sent to all requesters, when possible, when there is a verified email address of the recipient. This may include **s**ubpoenas, court orders, attorneys, EAI, Vocational Rehabilitation Services, other healthcare providers, resident's family members. Requests shall be forwarded to the "KDOC Chief Legal Counsel," for approval before processing the request.

F. If the requester does not have the capability of receiving electronic/encrypted records via email, pertinent information within the healthcare record is faxed.

1. FAX transmissions are to be accompanied by a cover sheet identifying the intended recipient and containing a confidentiality statement. Transmission is preceded by telephone notification and followed by confirmation of receipt.

a) *Confidential Information statement: This transmission and any files which may accompany the transmission contain information belonging to (Name of Contracted Healthcare Provider) which is confidential and/or legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited and illegal. If you have received this transmission in error, please immediately notify us by telephone at 785 - 227 - 9792 to arrange for the return of the transmission and any accompanying files.*

G. To decrease HIPAA risks, healthcare records are rarely sent out in the mail. HIPAA does allow for healthcare records to be sent by mail. However, this is only done when electronic/encrypted release or faxing is not an option. Exceptions include:

1. Social Security Administration/Disability Determination Services does not accept encrypted records. However, they provide a secure portal with which to upload the records.

2. Veterans Administration has a secure portal for uploading records and does not require encryption or passwords.

NOTE: The policy and procedures set forth herein are intended to establish directives and guidelines for staff, residents, and offenders and those entities that are contractually bound to adhere to them. They are not intended to establish State created liberty interests for employees, residents, or offenders, or an independent duty owed by the Department of Corrections to employees, residents, offenders, or third parties. Similarly, those references to the standards of various accrediting entities as may be contained within this document are included solely to manifest the commonality of purpose and direction as shared by the content of the document and the content of the referenced standards. Any such references within this document neither imply accredited status by a Departmental facility or organizational unit, nor indicate compliance with the standards so cited. The policy and procedures contained within this document are intended to be compliant with all applicable statutes and/or regulatory requirements of the Federal Government and the state of Kansas. This policy and procedure is not intended to establish or create new constitutional rights or to enlarge or expand upon existing constitutional rights or duties.

REPORTS

None.

REFERENCES

IMPP 05-103D, 16-105D, 16-114D
5-ACI-6D-05 (Ref. 4-4413)
5-ACI-6D-07 (Ref. 4-4415)
NCCHC P-A-08

HISTORY

12-22-22 Original

ATTACHMENTS

None.