ICE HEALTH SERVICE CORPS **OPERATIONS MEMORANDUM**

OM 16-022
Effective Date: 21 Mar 2016

By Order of the Acting Assistant Director
Stewart D. Smith, DHSc/s/

TO: IHSC Public Health Service (PHS) Commissioned Corps Officers, Civilian Federal Employees and Contract Personnel

SUBJECT: IHSC Health Records Management

1. **PURPOSE:** The purpose of this Operations Memorandum (OM) is to set forth guidance for creating and maintaining detainee health records for ICE Health Service Corps (IHSC). Health records are legal documents and must be designed, used, and stored to facilitate IHSC operations while protecting the information contained within them. The health record is a key tool used in planning, coordinating, and evaluating patient care. In addition, the content and documentation contained in the health record is essential for education, research, administrative planning and accreditation.

2. **APPLICABILITY:** This OM applies to all IHSC personnel, including but not limited to, Public Health Service (PHS) officers and civil service employees supporting health care operations in ICE-owned or contracted detention facilities and to IHSC Headquarters (HQ) staff. This OM applies to contract personnel when supporting IHSC in detention facilities and at HQ.

3. **AUTHORITIES AND REFERENCES:**

   (1) Information Quality Act, Public Law 106-554 (2001).

   (2) Privacy Act of 1974, 5 U.S.C. §552a, as amended.

   (3) Homeland Security Act of 2002, Public Law 107-296, 6 U.S.C. Chapter 1.

   (4) The Information Technology Management Reform Act of 1996 (ITMRA) 3.4.1. (Clinger-Cohen Act), 40 U.S.C. Subtitle III.

   (5) The Government Paperwork Elimination Act of 1998, 44 U.S.C. §3504

   (6) The Rehabilitation Act of 1973, 29 U.S.C. §794(d), as amended (Section 508).

4. **GUIDANCE:** IHSC staff creates and maintains health records as necessary to comply with changes to law, regulation, policy, or procedure consistent with Department of Homeland Security (DHS), ICE Enforcement and Removal Operations (ERO) and IHSC requirements.

4-1. GOAL. The primary goal of Health Record Management is to maintain and manage a health record system which enables all health care team members to document and review all health care encounters and events. Office files are not considered part of the official health record and are to be maintained separately by Administrative staff. All documents pertinent to the treatment and ongoing care of a patient are to be forwarded to Health Record Services for inclusion in the health record.

4-2. Ownership of the Health Record. Original health records may only be removed from the medical facility jurisdiction and safekeeping in accordance with a court order or direction received from ICE OPLA or IHSC Assistant Director. All health records are the property of the ICE.

4-3. Health Information Practitioners. Credentialed health record practitioners are accredited by the American Health Information Management Association (AHIMA) and are qualified to manage and supervise the Health Information Service.

(1) Registered Health Information Administrator (RHIA): Has a Bachelor's Degree in Health information Administration and has successfully passed the AHIMA's registration examination.

(2) Registered Health Information Technician (RHIT): Has an Associate Degree in Health Information Technology and has passed the AHIMA's accreditation examination.

(3) IHSC National Health Information Consultant: IHSC medical facilities will have the IHSC National Health Information Management Consultant evaluate the efficiency and management of detainee health records and the facility's health record system. She will make recommendations regarding the implementation of health information policies and procedures and conduct health information related training, as required. The IHSC Health Information Consultant will conduct onsite reviews as directed by HQ or indirect reviews through the receipt of facility reports as deemed necessary or via remote access to the electronic health record. The IHSC Health Information Management Consultant will submit a written consultant's report as a result of each on-site review.

4-4. Health Record Content. The health record primarily serves the patient; however, it has many additional values to the health care team. The most

obvious use of the health record is to document and record patient care encounters, treatments, and outcomes. Patient care providers rely on the health record as the principal means of communication and information exchange regarding patients under their care.

4-5. Health Record Function. Each HSA will designate an individual from the Health Record Service (Medical Record Technician) to manage the health record responsibilities. The responsibilities include, but are not limited to, the following:

(1) Managing the compilation of health records

(2) Maintaining the confidentiality, security, and integrity of the health record

(3) Ensuring that medical staff have prompt accessibility to the health record

(4) Participating in performance improvement activities and functions

(5) Ensuring accurate filing, safe and secure storage and prompt retrieval of health information and loose documents for patient care, research, release of information, legal, and performance improvement.

(6) Ensuring timely, accurate entry of scheduled appointments and close out of all health care data encounters.

4-6. Accreditation. Health records for each detainee are maintained in accordance with applicable laws and with applicable National Commission on Correctional Health Care, American Correctional Association, and ICE Detention Management Standards.

4-7. Equipment and Work Areas. Each facility will have adequate office space for administrative functions, files, and sufficient work desks for staff. Each facility will establish, maintain and support the Health Record functions with the following equipment, at a minimum:

(1) Photocopier/Printer

(2) Fax Machine

(3) Personal Computer

(4) Scanner

(5) Telephone

4-8. Security of Health Records. As of August 2013, all IHSC staff facilities began transitioning to the electronic health record, eClinicalWorks. Access is limited to staff members with appropriate system logon credentials. All health records are maintained in a secured area separate from custody records. Access is restricted to authorized personnel only and information is controlled by the responsible health authority. All personnel having authorized access are required to have received orientation and training in basic health record procedures, privacy and confidentiality. Each site with designated storage areas for storage of active and inactive health records should have a sign visibly posted outside the entrance of the area indicating "Access Limited to Authorized Personnel Only." Records transported by non-health services staff are placed in sealed envelopes.

4-9. Electronic Health Record. IHSC began using eClinicalWorks (eCW) as the official electronic health record for IHSC staffed facilities beginning in August 2013. All health care is documented in this system. All paper documents received are reviewed by a clinical staff member, signed, dated and scanned into the electronic record.

4-10. Health Record Practice during EHR system outage. In the event, eCW is non-operational due to computer equipment or system communication issues, all documentation of services and health care provided to detainees will be \ documented on paper. These documents/forms will be scanned into the EHR once operational and appropriate electronic entries made into the EHR system as defined by eCW User Guides.

4-11. Standard Health Record Documentation Practice. Manual documentation during system outage is performed using the Problem Oriented "SOAPE" (Subjective, Objective, Assessment, Plan, Education) format.

4-12. Health Record Identification. All health record documents and forms will be identified with at minimum the detainee name and Alien number which can be hand printed or a computer generated label. The label is placed in the upper right-hand corner of the document if no standardized location is provided on the form. The label will include the detainee's first name, last name, date of birth, alien number, country of origin, facility name, and date of camp arrival.

4-13. Health Record Folder. If the electronic health record system is not available for a significant amount of time, a health record folder may be created to file all patient health information. The folder will be identified with a label include the detainee's first name, last name, date of birth, alien number, country of origin, facility name, and date of camp arrival. The front of the folder must contain the facility name and address.

4-14. Format for Manually Recording Entries. The Standard Form (SF)-600 and IHSC forms are used to reflect the chronological order of patient care received from all providers, and services received from administrative personnel during an EHR outage. All entries on the SF-600 will be expressed in the SOAPE format as follows:

- Subjective: the patient's description of the problem; symptoms in the patient's own words
- Objective: the information/data received from observations, diagnostic evaluations and tests, etc.
- Assessment: the provider's interpretation of the subjective and objective data, evaluation of the patient's current health status and identification of problem
- Plan: specific course of action to include: 1) diagnosis or plan for further investigation to establish a diagnosis, 2) treatment or plans for patient care and problem management and 3) follow-up or schedule of return visits and/or referral(s)
- Education: all education provided the detainee regarding the condition, laboratory, imaging, medications, treatment, future care, etc.

Each problem on the Problem List will be assigned a number, which will be reflected on the Problem List and all other corresponding and related entries, tests and documents. The Problem List contains medical and mental health diagnoses, as well as known allergies.

4-15. Health Care Provider Entries. All entries will be identified and authenticated with the signature of the staff member and use of the block stamp. All entries are to be legible and in black or blue ink only. Highlighter pens may to be used in the health record when doing so enhances the meaning of the documentation. Blank spaces are not to be left in the body of the entries, between entries or at the top and bottom of pages. Corrections of recorded data in the health record must be made properly. <u>At no time should incorrect information be obliterated from the record so that the information cannot be read</u>. Obliteration of an entry would suggest tampering with the record.

For manually created documents, a neat line should be drawn through the incorrect information with an explanatory note (i.e. error, wrong chart) and the date of correction and initials added to the correct entry.

In the electronic health record, a correction to the record can be made by documenting an addendum to the original encounter note or by adding "notes" in appropriate fields within the system.

4-16. Late Entries. A late entry is a notation which was not made at the time that the service was provided or when the patient was seen. Late entries are to be documented as follows:

- "Late entry for (date and time).... The date and time of the entry should be the date and time that the note is actually made. In the case of the electronic health record, the date and time of the note is electronically documented.

4-17. Abbreviations. IHSC Senior Leadership annually reviews and approves the standard IHSC abbreviation list to be used by all medical facilities. The use of medical abbreviations is limited and only abbreviations from the approved IHSC abbreviation list will be used. All facilities maintain a list of abbreviations that are not to be used.

4-18. Consultant Entries. Findings and recommendations made by consultants are reviewed by Clinical Director or designated clinical staff prior to being entered into the health record. Approved recommendations will be documented and ordered as appropriated by an IHSC provider into an encounter note.

4-19. Use of Forms. When used, all forms in the health record will be properly identified with the detainee name, alien number, date of birth and facility name. Each component of the health record must be authenticated (signed or initialed and dated) by the provider. Health care providers must initial and date all documents (i.e. lab, x-ray, consults, operative reports) as proof that the documents were reviewed.

(1) Forms developed at the local level are NOT authorized for inclusion in the standard uniform IHSC health record unless prior approval has been received from IHSC Headquarters.

(2) Forms are located on the IHSC SharePoint site or IHSC HQ share drive.

4-20. Signature Block. Health care providers and administrative staff who review documents and/or make entries in the health record will be issued a rubber stamp to facilitate authentication and identification of documents signed in the health record. Signature stamps are not authorized for use in the health record.

(1) **Format for PHS Officers.** The following format will be used for Commissioned Officers of the United States Public Health Service:
- PHS Rank (properly abbreviated)
- First name or initial and middle initial
- Last name
- Professional discipline

Example: **(b)(6),(b)(7)(C)** RN

(2) **Format for Civilian providers**. The following format will be used for Civil Service staff, non-federal employees and/or contract staff:

- First name and middle initial
- Last name
- Professional discipline

Example: (b)(6),(b)(7)(C) RN or (b)(6),(b)(7)(C), RN

4-21. Review of multipage documents. Any documents received from outside sources must be reviewed by appropriate clinical staff. Staff members have the option to sign/initial and date every page. Or, the staff member may document on the first page of the document "I have reviewed the following X# pages" with signature and date. Each and every page must be numbered using the 1 of total#, 2 of total#, etc. format.

4-22. Transfer of Health Records. Utilizing the electronic health record, any transfer to another IHSC health services facility automatically provides the receiving site with the entire detainee health record.

Transfer of Detainee outside the IHSC System. A Transfer Summary will be completed which will assist the receiving health care facility in providing continued care for the detainee.

4-23. Filing of Records. While highly unlikely, if creation of health record folders becomes necessary, health records shall be filed in terminal digit order using the unit record system. The three part alien number is used to identify the patient. Records are grouped together first by using the last three digits of the alien number known as the Primary digits. Within each Primary section records are then filed numerically by middle (secondary) digits and last by first (tertiary) digits.

The following illustrates terminal digit filing:

14-652-202	19-605-264	27-798-307
14-752-202	19-905-265	27-898-307
15-852-202	20-605-266	28-898-307
15-952-202	20-906-267	29-898-307

4-24. Charge Out (Outguide) System. All paper health records removed from the Health record department must be replaced by an outguide containing the following information:

- Detainee Name
- Alien #
- Date record removed from file
- Name of person receiving the record

4-25. Color Coding. The last three digits are color coded and labeled on the side of the record. The bottom number should be positioned approximately two inches from the bottom edge of the folder.

4-26. Assembly of Record. All sections of a health record will be filed in the following format in reverse chronological order.

LEFT SIDE OF OPENED HEALTH RECORD

		Problem List	
IHSC		Detainee Medical Status	
IHSC		Chronic Disease Flow Sheet	(Diabetes)
IHSC		"	(Seizure Disorder)
IHSC		"	(Tuberculosis)
IHSC		"	(Hypertension)
IHSC		"	(Asthma)
IHSC	(b)(7)(E)	"	(HIV/AIDS)
IHSC		"	(Mental Health)
IHSC		"	(Generic)
IHSC		Health Care Program Medication Profile	
HRSA		Medication Administration Record	
IHSC		Medical/Psychiatric Alert	
IHSC		Suicide Observation Checklist	

Administrative Records:

IHSC	(b)(7)(E)	Medical Consent Form
SF		Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

All Other Consent Forms including **psychotropic drug consents IHSC 844s:**

IHSC	(b)(7)(E)	Refusal Form
G		Freedom of Information/Privacy Act Request
IHSC		Pre and Post HIV Test Counseling and Consent
		Inmate Transfer Summary Form

RIGHT SIDE OF RECORD

SF	(b)(7)(E)	Chronological Record of Medical Care
IHSC		Treatment, Authorization & Consultation Form (file in reverse chronological order behind the progress note)

Database

IHSC	(b)(7)(E)	In-Processing Screening Form

IHSC (b)(7)(E) History & Physical Examination
IHSC Immunization Record
IHSC Prenatal Care History & Physical Exam
IHSC Body Diagram
IHSC Detainee Special Needs

Laboratory

SF (b)(7)(E) Laboratory Report Display (when needed)
Reports from outside labs
Reports from onsite lab work

Radiology

SF (b)(7)(E) Radiographic Reports Backing Sheet
Reports from outside provider(s)
EKG and related (X-Ray & EKG)

Consultations/Other Reports

SF (b)(7)(E) Dental Record
SF Dental Record Continuation
IHSC Mental Health Screening (English/Spanish/Creole)
IHSC Hunger Strike Monitoring
IHSC Medical Observation of Detainee in Restraints
IHSC Post Restraints Observation Report
Short Stay Unit Record

- IHSC (b)(7)(E) SSU Discharge Summary
- IHSC SSU Admission and Discharge Form
- SF Chronological Record of Medical Care
- SF Nursing Notes
- SF Vital Signs Record
- IHSC Input/Output Flow Sheet
- Patient Care Plans

Summaries/Old Records
Offsite hospitalizations
Records transferred from other facilities

4-27. Labels. The only labels, if applicable, that require placement on the front of the health record include the following:

1. "Allergic to:_____" (centered beneath IHSC heading)
2. "Advance Directive on File" (centered below IHSC heading and allergy label, if applicable).

4-28. Health Record Completion. The timely completion of the health record is of critical importance. Documentation into the health record must be made within one hour of each encounter. The Medical Record Technician and his/her designees assure that each record is complete at time of release or transfer. In the event a record is incomplete due to the death, resignation, termination,

or incapacitation of the provider, appropriate review of the documentation will occur by the Clinical Director or HSA. The HSA or CD will close out the entry using guidance provided by the eCW User Guide.

4-29. Health Record Analysis. Health record analysis is to ensure the health record is complete and accurately reflects patient care, protects legal interests, meets standards, and is for accurate data and statistical analysis. Analysis for record completion is performed using various electronic reports generated by eCW and by review of the fluctuating eCW data. Data in eCW updates in real-time as clinicians review documents, labs, diagnostic imaging which can create fluctuating information.

Staff Responsibility. Each staff member is to monitor their own workload and assignments using the various report mechanisms in eCW such as the dashboard. Medical Record Technicians also review each record for completion. This includes for example insuring staff have completed and locked encounters, addressed referrals, addressed telephone encounters, cancelled future encounters, etc.

4-30. Confidentiality

(1) **Statements of Confidentiality**. Signed affirmations to protect and maintain the confidentiality and privacy of patient care information is required from all new employees who are employed in the medical facility and signed annual reaffirmation statements are required from each employee thereafter. This affirmation may be in the format of completing Information Assurance and Awareness Training (IAAT) provided by ICE.

(2) **The Privacy and Freedom of Information Acts**. It has been determined by that the guidelines and requirements as outlined in these two Acts will be applied to individuals in the custody of the ICE. Under the provisions of the Privacy Act regulations (45 CFR, Part 5b), detainees may access their health records and, upon written request, receive a copy of any or all portions of their health record, except information which might reasonably be expected to cause harm to the requestor or to another person while that detainee is in custody at the facility.

(3) **Privacy Act/FOIA Training**. All new employees will receive training on the Privacy and Freedom of Information Acts within thirty days of reporting and all current employees will receive annual refresher training. The training modules are available as hardcopy handouts or can be accessed through the IHSC SharePoint.

4-31. Release of Information. The Health Information Service reviews and coordinates requests for accurate and timely release of information to assure

continuity of patient care. The Health Information Service personnel are responsible for the preparation of subpoenaed health records for submission to courts of law. Under the provisions of the Privacy Act (45 CFR, Part 5b) detainees may access their health records. Additional questions or a request for additional clarification concerning the interpretation of this Act is to be directed to the IHSC National Health Information Consultant.

4-32. Release of Health Information. The Health Information Service reviews and coordinates requests for accurate and timely release of information to assure the continuity of patient care. The Health Information Service personnel are also responsible for the preparation of subpoenaed health records for submission to Courts of Law. Subpoenas may not be accepted by an IHSC staff member nor via fax. Subpoenas are to be served to ICE OPLA or the local Chief Counsel at the facility. Upon receipt of a subpoena or a request for documents from a court or attorney, notification must be given to the HSA and National Health Information Consultant. Guidance will be given from Headquarters on how to proceed with the subpoena.

(1) Detainees can obtain copies of their health records by submitting a G-639, Freedom of Information, Privacy Act Request form, or any other means of written request to any staff member. All requests are to be forwarded to Health Record Services for processing. The request will be documented and routed to the HSA or Clinical Director for review and approval prior to release to the detainee. If the HSA or Clinical Director determines that the health record contains no information which may cause harm to the detainee, then Health Information Service may prepare the copies for the detainee. If it is determined that all or portions of the record should not be released to the detainee, then the detainee should be informed by the HSA, Clinical Director or designee of this determination and be provided the following options:

- The G-639 will be submitted to the ICE FOIA Office for a determination *OR*
- Complete another authorization for release of records authorizing the medical facility to send the requested information to an outside third party

When receiving requests from attorneys, the media and Orders from the Court, you will also contact IHSC HQ Clinical Operations Branch *prior* to responding to the request.

(2) **Documenting the Disclosure**. An entry will be made by Health Record Service in the detainee's health record stating that the disclosure was made, date of the disclosure, number of pages copied, inclusive dates and the nature of the information released. This entry will also have documentation of Clinical Director or HSA or designee concurrence with the release. A notation will also be made by the provider when

information requested is not released due to contraindication. If made, referral of request to ICE FOIA will also be documented.

(3) **Filing the authorization to release information.** Any form used by the detainee to request and authorize release of information will be placed in the detainee health record.

4-33. FOIA Log. The bound FOIA logbook provides an accounting of each disclosure made based on requests received from detainees. The log may be in an electronic or paper format and will contain the following information:

- Detainee Name
- Alien Number
- Date Request Received
- Date of Disclosure to Detainee
- Number of pages copied
- Nature of the information released
- Initials of Health Information employee disclosing the information

4-34. Disclosure without consent. Pursuant to the Privacy Act, provisions used as policy, certain disclosures may be made without the written or verbal consent of the detainee. The Alien System of Record Notice provides detailed information regarding routine uses of detainee health information which may be allowed without detainee consent. Release of information based on the Alien SORN should be routed through the IHSC National Health Information Consultant for verification.

4-35. Sharing of information. This will exist between HHS, IHSC and ICE when it is deemed relevant for the health and treatment of the patient.

The following are examples of information disclosure that does not require consent by the detainee:

To an outside provider when a detainee is referred and/or transferred to another health care provider or facility, i.e. Transfer Summary submitted upon the transfer of the detainee to a jail.

To an officer and/or employee of HHS, PHS or ICE when the health care provider believes such information may be relevant to the detainee's health and course of treatment.

The medical director or his/her designee shall have access to information contained in the detainee's confinement record when they believe that such information will be relevant to the detainee's health and course of treatment.

ICE staff may need to be advised of a detainee's health status in order to preserve the health and safety of the detainee, other detainees or staff.

4-36. Third Party Releases without detainee authorization. Requests from individuals outside the facility, such as attorneys, insurance companies, and disability claims processors, are considered third party requests. Third party requests not accompanied with a written consent are to be returned to the sender by the Health Information Service with a G-639 and state the reason(s) why the request cannot be honored.

4-37. IHSC Office of Communications. IHSC Office of Communications will be contacted when requests for any information are received from the media.

4-38. Retention of Records. Paper health records will be retained on file at the Health Services Unit until processed for sending to the Federal Records Center for storage. Electronic health records are retained electronically for the appropriate retention period. Records of adults are retained for 10 years after their last healthcare encounter and release from an IHSC staffed facility. Records of minors are maintained until the child reaches the age of 27 years.

4-39. Filing of Inactive Records. When paper records are transferred from active to inactive status a **month and year** label reflecting the inactive date is attached to the upper section of the folder's back edge. Inactive records should be filed in a secure designated area separate from active records.

5. PROCEDURES: No additional procedures.

6. HISTORICAL NOTES: This OM replaces Chapter 14. Health Records dated September 2007.

7. DEFINITIONS: See definitions for this OM at the IHSC Glossary located on SharePoint.

8. APPLICABLE STANDARDS:

(1) **Performance Based National Detention Standards (PBNDS):**

1.1.1. PBNDS 2011 Medical Care Y. Medical Records
1.1.2. PBNDS 2008 Medical Care; U. Medical Records
1.1.3. Family Residential Standards 4.3 Medical Care 21. Medical Records

(2) **American Correctional Association (ACA):**

1.2.1. 1-HC-4A-06 *Health Records*
1.2.2. 4-ALDF-4D-26 *Health Records*
1.2.3. 4-4413 *Health Records*

(3) **National Commission on Correctional Health Care (NCCHC):**

1.3.1. J-H-01Health Record Format and Contents
1.3.2. J-H-02 confidentiality of Health Records