

Legal Health Record Webinar February 23rd at 12pm CT

About a decade ago, the Legal Health Record (LHR) was the focus of frequent discussions, initiatives and publications. Since then, however, attention to this topic has dwindled. Like bringing back an old, favorite television series, we are returning to the LHR plot with a refreshed look and new ideas. With continually advancing technology, it is more important today to have clear policies, decisions and leadership support for what documentation will (and will not be) produced when the “entire” medical record is requested from the organization. The “Custodian of Medical Records” must be confident when providing testimony or signing an attestation to certify that the records produced from the Electronic Health Record (EHR) are complete. Items such as photographs, electronic alerts and reminders, graphs, outside records and patient generated information should be considered at the organization level before including them in the LHR definition. This webinar will also review options for developing a multi-disciplinary program to oversee the development of a comprehensive LHR.

Objectives:

- *Define what the Legal Health Record is today*
- *Identify common components that make up the legal health record*
- *Discuss inclusions and exclusions based on industry standards /best practice*
- *Review scenarios and common responses to litigation requests*
- *Suggest methods and approaches to defining a comprehensive LHR*

Presenter: Debbie Boos-Neff, Senior Consultant, RHIA, CPHIMS



Debbie joined the Haugen Consulting Group with over 20 years of health information operations management experience. Debbie has been involved with all aspects of HIM, including departmental reorganization, workflow optimization, EHR implementation and decommissioning, document imaging management, coding and clinical documentation improvement assessments, data integrity and release of information.

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