Purpose:
The intent of this policy is to define the legal/hybrid medical record and to define for staff where the components of the hybrid medical (health) record reside so they can access, use, quickly assemble and disclose the information as necessary, regardless of the information’s location or the media on which it is maintained.

Policy:

1. LSUSHC will maintain a hybrid medical record as the legal medical record. This record will include both paper and electronic documents for all patients who receive health care at the facility either as an inpatient or through hospital-based outpatient services. The electronic and the paper record, combined are the official legal source of medical record content.

2. The legal medical record is the repository for information about the patient’s health history, past and present illness and documented care and treatments provided.

3. Electronic healthcare information systems that are included as a part of the transition to a complete electronic record are:
   - EPIC (Electronic Medical Record)/PELICAN (Patient Electronic and Care Network)
   - GE PACS (GE Picture Archiving Communication System)
   - Siemens Lifetime Clinical Record (temporary historical repository)
   - CLIQ (Clinical Inquiry) permanent historical data repository

4. Documents defined as electronic are viewable by all those in the organization who have the need and authority to access the electronic health information system. These documents must also be able to be printed as a legal document by the Health Information Management staff authorized to provide release of information.

5. The electronic health record includes the following EPIC applications:
   - ASAP – Emergency Department Documentation
   - ClinDoc – Inpatient Clinical Documentation
   - Ambulatory – Outpatient Clinical Documentation
   - CPOE – Physician’s Orders
   - Beacon/Research – Oncology and Research clinical Documentation
   - Willow – Pharmacy and Medication Records
   - OpTime – Operative and Anesthesia Documentation
   - ADT – Patient Registration Information
   - Cadence – Patient Scheduling Information
   - HIM – Legal Medical Record (POI, Deficiency Tracking, Coding)
   - Hospital Billing
6. Information not documented, interfaced or scanned into EPIC must be maintained in the paper "lite record". During the transition to the electronic medical record, part of the record is complied on paper and part is created using the electronic system, but all content will be eventually converted to electronic form thru scanning.

7. The following medical records reports were retained both electronically and on paper prior to the implementation of the EPIC electronic health record in November 2011, with the exception of clinical laboratory, radiology reports, Neurosurgery and Family Medicine outpatient reports:

<table>
<thead>
<tr>
<th>Admission History &amp; Physical</th>
<th>Inpatient Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Orders</td>
<td>Discharge Summary</td>
</tr>
<tr>
<td>Medication Records</td>
<td>Clinical Consults</td>
</tr>
<tr>
<td>Operative Reports</td>
<td>Pathology Reports</td>
</tr>
<tr>
<td>Organ/Tissue Donations</td>
<td>Patient Problem Lists (Summary Sheets)</td>
</tr>
<tr>
<td>Emergency Records</td>
<td>Consent Forms</td>
</tr>
<tr>
<td>Advance Directive</td>
<td>Nurses’ Notes</td>
</tr>
<tr>
<td>Nurses’ Notes</td>
<td>Flow Sheets</td>
</tr>
<tr>
<td>Feist-Weiller Cancer Center O/P Clinic Notes</td>
<td></td>
</tr>
</tbody>
</table>

Access to the clinical laboratory, radiology reports, Neurosurgery and Family Medicine outpatient reports was online only effective October 2005/2006. These reports are temporarily stored in Siemens’ pending transfer to CLIQ for permanent storage.

8. Ten years of demographic data and historical patient information from Siemens Lifetime Clinical Record November 2009-2011 was uploaded into EPIC’s electronic health record.

Approved by Clinical Board: 2/20/07, 1/19/10, 11/20/12
Written: 12/06
Revised: 11/09, 11/12
Reviewed: 11/09, 11/12