



Department of Defense **INSTRUCTION**

NUMBER 6040.45
November 16, 2015

USD(P&R)

SUBJECT: DoD Health Record Life Cycle Management

References: See Enclosure 1

1. **PURPOSE.** In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)), this instruction reissues and retitles DoD Instruction (DoDI) 6040.45 (Reference (b)) to establish policy, assign responsibilities, and prescribe procedures for DoD Health Record management.

2. **APPLICABILITY.** This instruction applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense (IG DoD), the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this instruction as the “DoD Components”).

3. **POLICY.** It is DoD policy that the DoD Health Record be created, used, maintained, shared, stored, and dispositioned to ensure the maintenance of a complete and accurate health record for beneficiaries in accordance with References (c) through (l).
 - a. The DoD Health Record is the property of the U.S. Government, not the beneficiary or the beneficiary’s guardian. In accordance with section 552a of Title 5, United States Code (U.S.C.), (also known and referred to in this instruction as “the Privacy Act of 1974” (Reference (m)) and Public Law 104-191 (also known and referred to in this instruction as the “Health Insurance Portability and Accountability Act (HIPAA)” (Reference (n))), the patient has the right to a copy of the information in the DoD Health Record, as established and implemented in accordance with References (h) through (k), unless specifically excepted by this instruction and supporting implementation and procedural guidance.

 - b. Documentation of care performed at military treatment facilities (MTFs) must be maintained in accordance with the National Archives and Records Administration (NARA) approved disposition schedules and chapter 12 of Title 36, Code of Federal Regulations (CFR)

(Reference (c)). NARA-approved record disposition schedules (References (o) through (q)) determine the duration of storage of the DoD Health Record and its component records.

c. The information stored in the DoD Health Record must be made available to authorized personnel of the Military Health System (MHS) to support the health care operations of the MHS. This information must support continuity of care, medical facility accreditation requirements, the Military Departments' readiness, the graduate medical education programs of the MHS, the Defense Health Agency (DHA) clinical coding and auditing actions, and other missions as directed by the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

d. Medical and dental records are established for every Service member. Such records are also established for every DoD civilian employee involved in any occupational health matter and for other health care beneficiaries as appropriate.

(1) Documentation of those records may be performed by licensed military, civilian, and contractor personnel authorized by DoD.

(2) Healthcare practitioners and authorized personnel providing medical, dental, and mental healthcare and services will ensure accurate and complete descriptions of all care and services rendered are entered into the appropriate DoD Health Record for every individual treated, using the designated primary electronic medical record (EMR) of the MHS whenever possible.

(3) All documentation and entries into DoD Health Records must comply with applicable standards established by accrediting organizations, such as The Joint Commission.

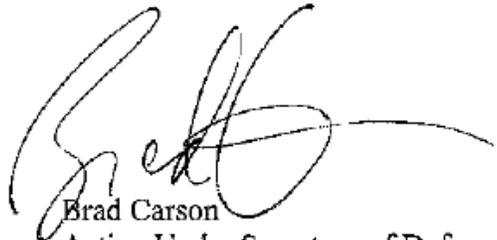
e. DoD Health Records are protected by the HIPAA Privacy, Breach Notification, and Enforcement Rules in accordance with Reference (m) and DoDI 6025.18 (Reference (r)). DoD Health Records maintained in digital form must be compliant with the HIPAA Security Rule in accordance with DoDI 8580.02 (Reference (s)). DoD Health Records are also protected by the Privacy Act (implemented at DoD through DoDD 5400.11 (Reference (h)) and DoD 6025.18-R (Reference (k))).

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. RELEASABILITY. **Cleared for public release.** This instruction is available on the Internet from the DoD Issuances Website at <http://www.dtic.mil/whs/directives>.

7. EFFECTIVE DATE. This instruction is effective November 16, 2015.



Brad Carson
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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
- (b) DoD Instruction 6040.45, "Service Treatment Record (STR) and Non-Service Treatment Record (NSTR) Life Cycle Management," October 28, 2010 (hereby cancelled)
- (c) Title 36, Code of Federal Regulations
- (d) Memorandum of Understanding Between Department of Defense (DoD) and Department of Veterans Affairs (VA), October 1995
- (e) Public Law 110-181, "The National Defense Authorization Act for Fiscal Year 2008," January 28, 2008
- (f) Public Law 113-66, "National Defense Authorization Act of 2014," December 26, 2013
- (g) DoD Instruction 5015.02, "DoD Records Management Program," February 24, 2015
- (h) DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014
- (i) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
- (j) DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014
- (k) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
- (l) DoD Directive 6040.41, "Medical Records Retention and Coding at Military Treatment Facilities," April 13, 2004
- (m) Section 552a of Title 5, United States Code (also known as "The Privacy Act of 1974")
- (n) Public Law 104-191, "Health Insurance Portability and Accountability Act (HIPAA)," August 21, 1996
- (o) National Archives and Record Administration Record Schedule N1- 330-10-003 "Service Treatment Records (STR)," February 18, 2010
- (p) National Archives and Record Administration Record Schedule N1- 330-01-002 "Consolidated Medical Records Schedule," January 30, 2002
- (q) National Archives and Record Administration Record Schedule N1- 330-11-003 "TRICARE Management Activity Systems," November 30, 2010
- (r) DoD Instruction 6025.18, "Privacy of Individually Identifiable Health Information in DoD Health Care Programs," December 2, 2009
- (s) DoD Instruction 8580.02, "Security of Individually Identifiable Health Information in DoD Health Care Programs," August 12, 2015
- (t) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013
- (u) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
- (v) DoD Instruction 6040.42, "Medical Encounter and Coding at Military Treatment Facilities," June 10, 2004
- (w) DoD Instruction 6400.01, "Family Advocacy Program (FAP)," February 13, 2015
- (x) DoD Instruction 6495.02, "Sexual Assault Prevention and Response (SAPR) Program Procedures," March 28, 2013, as amended
- (y) Part 2 of Title 42, Code of Federal Regulations
- (z) Title 10, United States Code

- (aa) DoD Directive 6010.04, “Healthcare for the Uniformed Services Members and Beneficiaries,” August 17, 2015
- (ab) Title 32, Code of Federal Regulations
- (ac) Assistant Secretary of Defense for Health Affairs Memorandum, “Policy for the Clear and Legible Report,” February 4, 2011
- (ad) U.S. Department of Health and Human Services, Nationwide Health Information Network Cooperative DURSA Team, “Data Use and Reciprocal Support Agreement (DURSA),” November 16, 2009
- (ae) Assistant Secretary of Defense for Health Affairs Memorandum, “Guidance for Requesting Correction of Erroneously Entered Information in the Armed Services Longitudinal Health Technology Application,” September 9, 2013
- (af) DoD Instruction 6055.05, “Occupational and Environmental Health (OEH),” November 11, 2008
- (ag) DoD Instruction 6055.01, “DoD Safety and Occupational Health (SOH) Program,” October 14, 2014
- (ah) DoD Instruction 6000.14, “DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS),” September 26, 2011, as amended
- (ai) Title 42, United States Code
- (aj) DoD Instruction 1000.30, “Reduction of Social Security Number (SSN) Use Within DoD,” August 1, 2012
- (ak) Assistant Secretary of Defense for Health Affairs Memorandum, “Approval for Interim Guidance for Use of the Healthcare Artifact and Image Management Solution (HAIMS) Service Treatment Record and Clinical Use,” July 24, 2013
- (al) DoD Directive 5400.07, “DoD Freedom of Information Act (FOIA) Program,” January 2, 2008
- (am) DoD Directive 1000.25, “DoD Personnel Identity Protection (PIP) Program,” July 19, 2004
- (an) Title 45, Code of Federal Regulations

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R):

a. Prescribes the policies, requirements, and responsibilities for the information life-cycle management of the DoD Health Record, Service Treatment Record (STR), Non-Service Treatment Record (NSTR), and Occupational Health Civilian Employee Treatment Record (OHTR), which apply regardless of media (printed or electronic) in which the information is recorded. Determines procedures for the release of STR information from the DoD to other federal agencies with which records are shared or transferred, such as the Department of Veterans Affairs (VA) and other organizations authorized by law.

b. Oversees the implementation of and compliance with this instruction.

2. ASD(HA). Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Oversees the Director, DHA, in the execution of programmatic and operational responsibilities in accordance with DoDD 5136.01 (Reference (t)).

b. Develops and coordinates joint policy guidance and implementation instructions as needed.

c. Facilitates provision of the DoD Health Record and the STR, NSTR, and OHTR to DoD Components, to the VA, and to partner health care systems in accordance with HIPAA and DHA approved memoranda of understanding. The memoranda are coordinated with the Military Services to ensure that all subordinate medical organizations have access to the electronic systems necessary for compiling and digitizing the paper portions of the DoD Health Record.

d. Facilitates transfer of the DoD Health Record and STR information and data from the Military Services by granting access to enterprise-wide systems to other agencies in accordance with law and in support of continuity of health care and Service members' and veterans' entitlement and benefits processing.

e. Coordinates improvement and reengineering of DoD Health Record and STR, NSTR, and OHTR information management processes with the Secretaries of the Military Departments to enable efficient and effective business practices and continuous evaluation within the DoD.

f. Coordinates with the Commander, U.S. Military Entrance Processing Command (USMEPCOM) and the Director, DoD Medical Exam Review Board (DoDMERB) to develop and implement life cycle management of the medical qualification records and medical

information related to Service accessions in accordance with the procedures in Enclosure 3 of this instruction.

g. Appoints MHS representatives, as needed, to all existing or newly developed work groups created by the Joint Executive Council or the Office of the National Coordinator Federal Health Architecture Management Board to identify and address emerging issues associated with DoD Health Record and STR, NSTR, and OHTR management.

3. DIRECTOR, DHA. Under the authority, direction, and control of the ASD(HA) and USD(P&R) and in addition to the responsibilities in section 6 of this enclosure, the Director, DHA, consistent with DoDD 5136.13 (Reference (u)):

a. Establishes a formal joint DoD Health Record Management Program, providing financial and personnel resources to monitor performance and compliance with this instruction, in coordination with the Military Departments.

b. Ensures that the enterprise electronic systems supporting the DoD Health Record and STR, NSTR, and OHTR are managed and sustained in accordance with DoDI 5015.02 (Reference (g)).

c. Ensures that the STR, NSTR, and OHTR contain the minimum core elements in accordance with Reference (g) and DoDI 6040.42 (Reference (v)).

d. Ensures that the STR archiving systems makes the STR available to the VA according to official memoranda of agreement or understanding between the DoD and VA and consistent with legal requirements.

e. Develops and issues implementation and procedural guidance in accordance with Reference (u) to specify documentation and management procedures for record systems that support the STR and other components of the DoD Health Record.

f. Ensures electronic systems containing elements of the DoD Health Record have disposition schedules approved by NARA.

4. ASSISTANT SECRETARY OF DEFENSE FOR MANPOWER AND RESERVE AFFAIRS (ASD(M&RA)). Under the authority, direction, and control of the USD(P&R), the ASD(M&RA) ensures that the Commander, USMEPCOM, implements life cycle management of the medical qualification records, STR data (prior military service), or medical information related to the Service accessions in accordance with the procedures in Enclosure 3 of this instruction.

5. IG DoD. In addition to the responsibilities in section 6 of this enclosure, the IG DoD:

a. Monitors the other DoD Components' compliance with this instruction and conducts inspections as deemed appropriate on the DoD Health Record and STR, NSTR, and OHTR life cycle management.

b. May provide inspection reports and suggestions for resolution of issues to the USD(P&R) and the DoD Component heads.

6. DoD COMPONENT HEADS. The DoD Component heads establish a DoD Health Record Management Program that:

a. Adheres to the standards prescribed in References (g), (k), and (v), DoDD 6040.41 (Reference (l)), and the procedures detailed in Enclosure 3 of this instruction.

b. Creates, maintains, uses, preserves as needed, and disposes of the DoD Health Record and STR, NSTR, and OHTR to support routine DoD business operations and mission.

7. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT OF THE U.S. COAST GUARD. In addition to the responsibilities in section 6 of this enclosure, the Secretaries of the Military Departments and the Commandant of the U.S. Coast Guard:

a. Update the respective Military Department regulations for DoD Health Records or develop new regulations in accordance with this instruction.

b. Develop and implement policy and procedural guidance in accordance with this instruction and ensure that subordinate medical organizations have the necessary resources to comply with medical records procedures as detailed in Enclosure 3 of this instruction.

c. Establish a position and ensure that it is appropriately resourced to function as a liaison with federal agencies including the VA, to answer requests for active, Reserve, and National Guard personnel or their designated beneficiaries in regards to DoD Health Records and STRs.

d. Provide facilities responsible for DoD Health Record maintenance, in particular those responsible for the digitization of the STR, access to up to date rosters of individuals anticipating separation from military service weekly when possible but not less than monthly. .

ENCLOSURE 3

PROCEDURES

1. DoD HEALTH RECORD COMPONENT RECORDS

a. The DoD Health Record includes component records that are subsets of the entire medical record for a person. The component records include the STR, the NSTR, and the OHTR. Each component record is a defined subset of the DoD Health Record to serve a specific purpose. The type of component record is principally determined by beneficiary category: Service member, DoD civilian employee (for occupational health purposes), and non-active duty beneficiary.

b. The STR:

(1) Includes all of the essential information necessary for continuity of care, determination of medical readiness, and determination of benefits for a member of any of the Military Services. It is a principal component record of the DoD Health Record for the Service member.

(2) Integrates applicable industrial hygiene, environmental hazards, and safety information across the full range of military operations and operational environments.

(a) The STR is used for patient care, medico-legal support, benefits adjudication (including, but not limited to, disability compensation benefits payments as described in DoDI 1332.18 (Reference (j)), billing, and certain other authorized purposes.

(b) The STR includes all documentation regardless of media format (paper or electronic) as captured in a composite record produced by the DoD EMR system (for example the Armed Forces Health Longitudinal Technology Application (AHLTA) Web-Print file), reports of all TRICARE and contracted care received, any inpatient discharge summaries, documentation of all shipboard care, and summaries of all care documented in the theater record systems.

(c) Documentation will be inclusive from the date of accession through the end of a military career (e.g., discharge, separation, retirement, or death).

(3) Is used for tracking and determining force medical readiness and force health protection requirements, as described in section C7.11 of Reference (k). It supports standardized personnel administrative functions related to medical readiness determinations, case management, individual medical readiness tracking, special duty qualifications, theater location reporting requirements, public health and environmental incidents, longitudinal health status tracking, registries, and related medical status determination needs of both active duty and Reserve Components.

(4) Includes documentation of care performed in operational environments, for example shipboard and battlefield care. Information from the systems used to document that care will be integrated or copied into the primary record systems that comprise the STR.

(a) The Military Services will develop, publish, and implement procedures to integrate the medical, dental, and mental health care documentation generated at all theaters of operation and contingency operation locations with the member's DoD Health Record and STR. Summary documents designed to include all information from a period of service in an operational environment essential to continuity of care and future benefits determination, as determined by the Service, may be used to meet this requirement.

(b) Any paper medical, dental, or mental health records generated at all theaters and contingency operation locations will be collected and transferred to the Deployment Medical Records Processing Center, Patient Administration Systems and Biostatistics Activity, Fort Sam Houston, Texas, for scanning. These documents will be made available as images through an electronic document management system that is integrated with the EMR, until complete integration of this documentation into the electronic record systems comprising the STR is achieved. The paper elements will be integrated with the member's DoD Health Record and STR located at their permanent duty station and Reserve and Guard units until the record is accessible in electronic medium.

(5) Is determined to be complete when a Service member has separated from active service and the archived copy of the record has been reviewed to ensure that it includes all required elements. A completed DD Form 2963, "Service Treatment Record (STR) Certification," may be added to a paper STR folder to indicate that all available paper documentation has been included as part of the archiving process. When the paper STR folder has been scanned and uploaded into the electronic archiving system, the DD Form 2963 is then separately uploaded to the electronic record archive, indicating that the electronic archive constitutes a complete STR. The DD Form 2963 is the last document to be uploaded when archiving the STR.

c. The Military Services will:

(1) Develop procedures to ensure that the STR is compiled into an archival copy and stored in a repository made available to the VA within agreed upon timelines (based upon the date of separation of an active duty Service member or receipt of a valid VA benefits claim on a Reserve Component member) and in accordance with section 525 of Public Law 113-66 (Reference (f)).

(2) Collaborate with the DHA-designated office to develop standard checklists for STR quality assurance and completeness.

(3) Establish procedures for documenting all activities taken to ensure a Service member's STR is complete and accurate at the time of the Service member's separation or retirement.

(4) Establish custodial duties for STRs as the responsibility of the MTF where the member is enrolled and receives primary care, regardless of member's Service affiliation. For Reserve Component members, the Services will develop agreements for STR custodial responsibilities.

(5) Coordinate with the DHA to formalize policy and procedures to document completion of annual reviews of the STR and provide the Service member an opportunity to review key elements of the record, such as the problem list and documentation of care performed outside of the MHS. Where the annual review indicates that an STR is incomplete, the Military Services will develop processes to document the steps taken to remediate an incomplete STR.

d. The NSTR adheres to the same standards of health care documentation as the STR, but is created and maintained for beneficiaries other than active duty Service members.

e. The OHTR will contain all medical, dental, and required environmental, safety, and industrial hygiene data documentation related to an individual's employment during all periods of health system involvement.

(1) For an active duty Service member, this information is included in the STR.

(2) For a DoD civilian employee who receives health care in DoD facilities, the OHTR documentation may be maintained in the same record system as the NSTR.

(3) The system must support an output of the information pertaining to the OHTR without also disclosing non-OHTR information. That is, the system must be capable of an output that includes only the OHTR information.

2. DOCUMENTATION INCLUDED IN THE DoD HEALTH RECORD

a. Mental health documentation is included in the DoD Health Record, unless specifically excepted due to its sensitive nature, and not necessary for continuity of care.

(1) An example of excepted documentation is psychotherapy notes, which may include detailed psychiatric notations of evaluations and consultations provided on an outpatient or inpatient basis.

(2) Mental health care documentation included in the DoD Health Record must convey the information necessary to support the diagnosis, treatment plan, and appropriate patient disposition made by the mental health care professional.

(3) Such documentation supports continuity of health care in collaboration with ongoing medical-surgical care across the boundaries of time, space, and varying medical, surgical, and behavioral health specialty providers. Elements pertaining to mental health care that must be documented in the DoD Health Record include:

- (a) Medication prescription and monitoring.
- (b) Counseling session start and stop times.
- (c) The modalities and frequencies of treatment furnished.
- (d) Results of clinical tests.
- (e) Any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

b. Working materials, including notes and papers, used by a provider to complete a final report for an individual patient are not part of the DoD Health Record unless they need to be made available to others providing medical or dental care to that patient. Examples of working materials that are not part of the DoD Health Record include, but are not limited to:

- (1) Mental health assessment instruments.
- (2) Psychotherapy notes.
- (3) Paper forms used in clinical work flows, when the substantive information they help acquire is transcribed into the digital documentation of that encounter.

c. The Family Advocacy Program records are not part of the DoD Health Records. These records contain detailed confidential information regarding alleged or verified family maltreatment in accordance with DoDI 6400.01 (Reference (w)). Reference in the DoD Health Record to the events that led to referral to the Family Advocacy Program may be necessary to assure continuity of care when treatment is required. Summary documentation provided by the Family Advocacy Program may be used for this purpose; however, protected health information (PHI) or personally identifiable information (PII) of other family members may not be included in the DoD Health Record of the individual receiving health care.

d. Sexual assault forensic examination reports are not included in any component of the DoD Health Record. Clinically relevant documentation of care provided to victims of sexual assault is part of the DoD Health Record in accordance with DoDI 6495.02 (Reference (x)).

e. In accordance with part 2 of Title 42, CFR (Reference (y)), records of application to or treatment in substance abuse program(s) are protected from public disclosure and only releasable under the circumstances listed in Reference (y). These records are not included in any component of the DoD Health Record, though documentation of related medical conditions will be recorded in the DoD Health Record, as may be necessary for safe and proper health care.

f. Audio files generated as a result of a patient encounter or developed during treatment of a patient may be captured by the electronic document management system. Examples include, but are not limited to:

(1) Digital Dictation. Once digital dictation is captured in transcript form and the integrity of the transcript verified, the digital dictation may be destroyed.

(2) Voice Recognition (Where Enabled). Military Services will develop procedures for verification of transcribed elements. The provider must verify the transcription.

g. Medical and dental information provided by the patient from other healthcare providers, facilities, or devices will be captured or recorded in the electronic health record (EHR) or document management system at the discretion of a health care provider or authorized medical record administrator.

h. Medical department personnel will note the existence of an advance directive in the DoD Health Record in accordance with Service-specific guidance. Appropriate metadata tags will identify advance directive documents when they are captured in the electronic document management system. Section 1044c of Title 10, U.S.C. (Reference (z)) provides for military advance medical directives that are exempt from any requirements of form, substance, formality, or recording required by State law.

i. When provided by the patient, the documents comprising a power of attorney will be maintained with the other administrative documents in the record. Paper documents will be appropriately digitized and metadata tagged in the electronic document management system. After discharge, the patient may take any original paper documents and return the documents if admitted again at some future date if required by Service policy.

3. DoD HEALTH RECORD CREATION AND DOCUMENTATION

a. The DoD Health Record is initiated as one of the component records described in section 1 of this enclosure either upon accession into the Service or upon the first presentation to a DoD medical facility for health care.

b. For Service members, the initial elements of the DoD Health Record include the medical examination performed by USMEPCOM or DoDMERB personnel, including associated DoD and non-DoD health care documentation in paper or digital format, as required. The accession medical record serves as the foundation of the Service member's STR.

c. Eligibility for medical and dental benefits is determined in accordance with DoDD 6010.04 (Reference (aa)) and part 199 of Title 32, CFR (Reference (ab)). DoD MTF personnel are responsible for verifying eligibility and providing care in accordance with the beneficiary entitlement.

d. The OHTR for DoD civilian employees is created at the first medical encounter after employment begins.

e. The OHTR for DoD-covered contractors is created at the first medical encounter after their contract begins.

f. The NSTR for DoD family members is created at the MTF or where the beneficiary is first seen.

g. MTFs will establish procedures to ensure that only personnel with specifically designated permissions may make entries in the DoD Health Record. All personnel will receive training in accordance with References (k) and (r). Those designated personnel must comply with the standards for record entry as described in this instruction.

h. Entries in medical, dental, and mental health records must contain information to:

- (1) Identify the patient.
- (2) Support the diagnosis and condition.
- (3) Justify the care, treatment, and service rendered.
- (4) Accurately document the results of care, treatment, and service rendered.
- (5) Support continuity of care.

i. Health care personnel making authorized entries in the electronic DoD Health Record use digital signatures to uniquely associate the signer with the document's contents, ensuring data integrity and non-repudiation of the electronic transaction. Any document generated and signed electronically that is subsequently printed does not require an additional handwritten signature.

j. Handwritten signatures with dates are required for each entry and for any documentation generated and signed exclusively in paper format. Editing of documentation in the paper record requires a single line through the erroneous entry; the new entry is written including date, time, and initials with a brief note as to why it was changed, such as Entry Error, Wrong Chart, Late Entry.

k. All notes made in a patient's DoD Health Record describing treatment or counseling will be completed by health care providers who have either directly or indirectly provided care to that patient. Documentation of indirect care is made when, for example, a provider is asked to consult on a patient, review data from the record, and enter a comment based on the review without interacting directly with the patient.

l. Entries in the DoD Health Record used to describe an interaction with a patient during the course of treatment, generally referred to as Progress Notes, will comply with the standard "Subjective, Objective, Assessment, and Plan" note format. EMR templates conforming to this outline will be used whenever possible.

m. Documentation of medical, dental, and mental health care provided at an MTF that cannot be entered through direct use of the primary EMR system will be captured and maintained on forms that are specified by Service level instructions, either on paper or in

electronic form. When possible, documents created in this manner will be uploaded into the electronic document management system to be included as part of the DoD Health Record. These documents need not be appended to notes written in the primary EMR system, but should be associated with such entries as supported by the system. Once digitized and verified, the original document may be destroyed in accordance with NARA disposition schedules (References (o) through (q)). If inclusion into the electronic document management system is not possible, paper documentation must be maintained in accordance with Service instructions and References (k) and (r).

n. Artifacts created by supplemental documentation systems, such as electrocardiogram tracings and other reports of medical testing or procedures, including both reports printed on paper and electronic file formats, will be incorporated into the DoD Health Record by use of a DoD-approved electronic document management system whenever possible. The document management system must be sufficiently integrated with the EMR to ensure access to all clinicians and administrators responsible for the kind of information contained in the artifact. Military Service level instructions will govern the management of such artifacts when they are maintained in paper format, and must be in compliance with STR procedures in this instruction.

o. In accordance with the ASD(HA) Memorandum (Reference (ac)), DoD organizations maintaining DoD Health Records must ensure that documentation delivered to them by partner organizations or by individual patients of medical, dental, and mental health care provided by non-DoD practitioners, referred to as consult reports or clear and legible reports, are filed with the patient's medical or dental record, as appropriate. These records must be individually stored or digitized in the electronic document management system.

p. Clinicians writing notes in the DoD Health Record that include any references to reports, images, or artifacts that are not contained within the documentation being generated must indicate, at a minimum, the section of the record or the system in which the referenced reports, images, or artifacts reside.

q. Pre-natal care documentation is included in the DoD Health Record of the mother. After the birth of an infant and establishment of the infant's record, copies of documentation of care from the infant's prenatal period may be added to the infant's record.

r. In accordance with DoD 5400.11-R (Reference (i)), patients and their authorized representatives have the right to access their DoD Health Records and request amendment, if they think the documentation is in error. The request to amend the record must be made in writing and be signed by the patient or authorized representative. While the medical department is not obligated to make the requested change, it is obligated to review the request, and act upon it in accordance with the timeframes in Reference (i).

4. DoD HEALTH RECORD CONFIDENTIALITY AND SAFEGUARDS

a. In addition to the confidentiality safeguards required by Reference (k), safeguards will be instituted to maintain compliance with any other applicable confidentiality requirements under law or DoD policy.

b. The Military Services will develop policies and procedures for defining levels of access to paper and digital health information at all locations where such access is necessary. Access for individuals or groups of individuals (work centers) must be based on requirements for fulfillment of assigned duties and in accordance with law and DoD policy.

c. DoD Health Record management policies and procedures will support the creation, maintenance, use, sharing, storage, and disposition of a complete and accurate DoD Health Record for patients in accordance with References (g), (k), and (s).

d. DoD Health Records in paper and digital form are protected by the HIPAA Privacy, Breach Notification, and Enforcement Rules as described in Reference (k). Additionally, DoD Health Records maintained in digital form (with the possible exception of the OHTR) are subject to the HIPAA Security Rule as described in Reference (s). Collectively known as the HIPAA Rules, these requirements are implemented throughout the DoD by References (k) and (s). In addition to the HIPAA Rules, the Privacy Act (implemented at DoD through References (h) and (i)) also protects DoD Health Records.

e. Record entries may include draft and final entries. A draft entry will be indicated as draft and may not be accessible to other clinicians. An entry made in the DoD Health Record that is left in draft form beyond a specified period of time may be closed out so that it can be accessed by other record users, either by an administrator who has been given such permission by the MTF commander, or by another clinician with permissions to enter the same kind of information that has been left in a draft form. Entries made final in this manner will be distinguishable from regularly signed final entries. The length of time that entries may remain in draft form due to prolonged unavailability of the entering provider may be defined by Service level instruction, but will not exceed 30 days.

f. The Military Services will establish procedures to identify and safeguard medical information designated as sensitive due to the content or a patient's special status (e.g., President, Special Operations) to facilitate additional precautions against improper or inadvertent disclosures to users with limited DoD Health Record access.

5. EHR INFORMATION SHARING AND DISCLOSURE

a. DoD Health Records are subject to the following procedures related to health information exchange. All personnel having access to the DoD Health Record will at a minimum protect the privacy of PHI and PII, in accordance with References (h), (i), (k), and (r).

(1) Organizations that share electronic health data with the MHS through the health exchange protocols established or endorsed by the Health and Human Services Office of the National Coordinator, referred to as the eHealth Exchange, must abide by the privacy and

security provisions of the Data Use and Reciprocal Support Agreement (Reference (ad)) or other applicable agreement.

(2) Organizations that are not a part of the eHealth Exchange that wish to engage in health information exchange with the MHS must enter into an agreement with the MHS that specifies privacy and security requirements. The agreement must address re-disclosure of the data received by the organization.

(3) If an outside organization seeks access to MHS EHR systems, such access will be allowed only to the extent permitted by the Privacy Act and References (h), (i), (r), and (s), and only after entering into agreement with the MHS approved by the DHA. Such agreement requires the organization to abide by MHS system protections for sensitive information, and requires periodic auditing as to whether, and to what extent, sensitive information has been requested.

(4) When preparing DoD Health Record elements for electronic exchange, appropriate procedures must be followed with respect to sensitive information. Sensitive health information, regardless of its format, may be specifically labeled or segmented within the DoD Health Record. Appropriate physical and, when technically feasible, electronic access controls, such as auditing use, must be implemented to prevent unauthorized or inadvertent access to, or transmission of, sensitive health information in paper and digital formats.

(5) The Military Services will develop procedures for responding to requests for electronic health information access in accordance with Reference (g) and any other DoD policy describing the circumstances in which PHI may be disclosed.

b. The MHS shares the health information of active duty and non-active duty individuals through health information exchanges (HIE) in which MHS participates. Information sharing includes publishing PHI to the HIE and subscribing to PHI from other HIE participants.

(1) Active duty personnel cannot limit MHS subscription to their PHI. For example, active duty personnel cannot restrict sharing of their PHI with the MHS by opting out through an eHealth Exchange participant.

(2) Active duty personnel cannot opt out of MHS publishing their PHI to an HIE.

(3) The MHS must advise active duty personnel that for reasons of medical readiness, the MHS shares their PHI bi-directionally through HIE, with opting out available only to non-active duty beneficiaries.

(4) The Military Services will develop policy and procedures for medical department compliance with the current NARA disposition schedule (Reference (q)). This guidance includes appropriate procedures to manage non-Service member beneficiary opt-out requests.

c. When information is shared through electronic exchanges, management controls, such as limiting the permissions given to specific users or requiring additional acknowledgements by

users, will be employed to avoid undermining the additional precautions taken to safeguard entries designated as particularly sensitive.

d. In accordance with References (i) and (k), DoD Health Records personnel must provide beneficiaries or their authorized representative copies of medical documentation in their DoD Health Record when requested. The documentation will be provided in either paper or digital format as specified by the beneficiary or authorized representative. If the documentation is provided in digital format, Military Services must ensure their facility is in compliance with HIPAA in accordance with References (k) and (r) and DoD policies in regard to format and method of transmission to the beneficiary.

6. RE-ENTRY OF FORMER SERVICE MEMBERS

a. When a Service member has been discharged from military service and decides to re-enter (re-enlist), or is recalled from retirement to active duty, the DHA will support the agency performing the entrance evaluation (USMEPCOM, DoDMERB, or the gaining unit's oversight Command Surgeon's office) by coordinating access to records for review of the re-entering Service member's health history, to include:

(1) Any past STR, OHTR, or NSTR.

(2) Any available documentation of medical, mental health, or dental care received from non-DoD care providers, including the VA.

b. For former Service members who were discharged before January 1, 2014, requests for past STRs are submitted to the VA in accordance with the Memorandum of Understanding (Reference (d)). For former Service members who were discharged on or after January 1, 2014, the past STRs, once processed, will be obtainable from the electronic repository established to archive STRs. For former Service members with more than one previous discharge, requests may need to be made to the VA and other DoD Components to obtain all past STRs.

c. The agency performing the entrance evaluation for re-entry will provide available past STRs and other medical records that were reviewed along with the new accession medical documents, in paper or electronic format, for inclusion in a new DoD Health Record. If the technical capability is available, the agency will digitize relevant portions of available past STRs that are in paper format and all new accession medical documents. The Military Services will develop procedures to incorporate information provided in electronic format and for digitization of any paper elements provided into an electronic document management system when available.

d. The Military Services must develop procedures for converting paper DoD Health Records to digital for Service members and beneficiaries transferring between Military Services.

e. The Military Services must develop processes and publish guidance about how to incorporate past paper STRs into the electronic document management system in digital format.

7. DoD HEALTH RECORD USE

a. Medical personnel documenting direct patient care services make their entries into the DoD Health Record at the time of observation, treatment, or care. Indirect services such as case reviews, consults, record reviews, record corrections, documenting late and loose-flowing (LLF) documents, and entries for care evaluations without face-to-face contact are allowed to the extent permitted by DoD and Service policy. Indirect entries will be clearly marked as to the nature of service provided or action taken relative to the DoD Health Record.

b. If a printed copy of the DoD Health Record or elements thereof are required, that printed copy must be assembled in the order described for that specific purpose in a Military Service guidance.

c. Legal correction of erroneous data is currently governed by the ASD(HA) Memorandum (Reference (ae)). Medical departments will implement procedures in compliance with Reference (ae), this instruction, or DHA procedural guidance.

8. DoD HEALTH RECORD MAINTENANCE AND STORAGE

a. When medical documentation must be made on paper, and that documentation may be required for subsequent care, evaluation, or benefits determination of the patient, the documentation must be captured and verified in the electronic document management system. If the paper documentation is not required for observation, treatment, or care of the patient, it will be managed in accordance with Reference (g) and the current NARA disposition guidance.

b. The electronic document management system must be used for the processing of artifacts and documents that are to be included in the DoD Health Record. The following types of documentation, which may be provided on paper, digitally, or other media, may be captured, indexed, displayed, and stored in the electronic document management system:

- (1) Paper documents not previously rendered in digital format.
- (2) Digital images.
- (3) Photographs.
- (4) Video files.
- (5) Audio files (including but not limited to voicemails and digital dictation).
- (6) Waveforms.
- (7) Email.

c. Paper records may be required to support continuity of care for missions that cannot be supported by electronic record systems. The Military Services will develop policy and procedures for the storage of such paper records in medical unit health record storage facilities in accordance with References (g) and (k). When possible, and in all cases within 45 business days following separation of the member from Military Service, such paper records will be digitized and uploaded into the electronic document management system.

d. Paper records may be dispositioned after capture in the electronic document management system in accordance with NARA policy and Reference (g).

e. Military Services must develop policy and procedures for amendments or corrections to the components of the DoD Health Record contained within the electronic document management system. Amendments and corrections will be made at the time that inconsistencies are noted, to the extent possible.

f. DoD Health Record documentation provided electronically or on media other than paper may be destroyed after its conversion to the appropriate format and captured by the electronic document management system. After verification that its contents have been captured, that media may be destroyed according to but not limited to Reference (g) and NARA disposition rules. This does not preclude copies of the same documentation being kept in other DoD or VA approved record management systems; in such cases the copy in the DoD Health Record document management system will be considered a part of the official DoD Health Record.

g. In accordance with Reference (u), medical departments will ensure an outpatient and inpatient coding compliance plan is available at their facility. Service specific checklists exist to review the entire record to ensure completeness and accuracy of diagnostic and procedure information included in the DoD Health Records.

h. When Service members or beneficiaries relocate, closing out, printing, and transferring records maintained in electronic systems is not necessary as long as authorized users in the gaining facility have full access to those systems. This applies to the entire DoD Health Record.

i. Healthcare documentation created on paper or on electronic systems in the operational medicine environment (shipboard and battlefield care) must be managed in accordance with HIPAA and other applicable laws to the extent possible. Unless specifically excluded by other provisions of this instruction, the information from the operational environment will be copied into the systems that comprise the STR. Summary documents containing the essential information may be created to meet this requirement.

j. When a beneficiary's status changes, the relevant information in the existing DoD Health Record will be incorporated into a new DoD Health Record as needed. Records personnel will evaluate whether such a change may require a different record retention period in compliance with existing NARA disposition schedules for the different categories but will not be shortened beyond the date any previous category required. Inclusion or exclusion of information in the

new DoD Health Record will be evaluated at that time. The medical records personnel will follow Service-specific policy for noting changes in beneficiary status.

k. Before any permanent change of station reassignment, personal geographic location move, MTF reassignment, or change to TRICARE enrollment location, medical records personnel will take all steps necessary to ensure the gaining MTF has access to the beneficiary's complete STR, NSTR, or OHTR in digital format whenever possible.

l. If a Service member or beneficiary is moving or being assigned to a duty location that does not have access to the current DoD EHR system, the losing medical department will provide the beneficiary a paper or digital copy (whichever is the beneficiary's preference) of all historical patient encounter notes, and all laboratory and radiology results.

m. Upon discovery, LLF or orphaned medical documents must be labeled with adequate patient identification information and integrated with the original DoD Health Record using the electronic document management system as quickly as possible but no later than 30 days after discovery. If a document management system is unavailable, the documents must be combined with the appropriate DoD Health Record according to existing Service policy.

n. MTF medical records managers will implement procedures in accordance with Service and DHA guidance to ensure STRs contain all documented medical, dental, and mental health care, including care provided by non-DoD practitioners, healthcare documented in EHR system(s) and electronic dental record system(s), and STR artifacts and images maintained in other electronic document management systems that are made available to them.

o. Medical records managers will follow Service guidance for review and reporting of deficiencies in the DoD Health Record.

p. When paper-based medical records are in use, local medical department records management policy must include measures to:

(1) Establish a methodology to obtain beneficiary medical records upon arrival on station or upon initial enrollment and to digitize them, when possible.

(2) Establish custody of the DoD Health Record upon the patient's initial visit and digitize at least the material necessary for continuity of care, when possible.

q. When electronic systems are unavailable, personnel will transition to temporary paper-based documentation. This paper will be digitized within 3 business days after the electronic systems become available, except operational medicine (battlefield) locations. Military Services will develop procedures for digitization of paper documentation after a system outage either through direct entry into the electronic system(s), or through capture and integration into the electronic document management system, depending on the duration of the system outage. The U.S. Coast Guard will develop timelines and procedures specific to the documentation system in use in the facilities for which it has responsibility.

r. Military Services will develop maintenance (downtime) procedures, for scheduled (planned) or unscheduled (unplanned) non-functioning information systems in accordance with this instruction and DoDI 6055.05 (Reference (af)). Included within the procedures is the process for verifying the integrity of information entered immediately before the downtime, and immediately after the system is back up, and ensuring records are sent to the right location and arrive there intact. The maintenance (downtime) procedures will be part of the Military Services' overall continuity of operations plan to preserve, maintain, and reconstitute operations under adverse conditions, internal or external.

9. ACCESS TO DoD HEALTH RECORD AND PHI AND PII

a. Medical record management personnel must ensure that records are protected against loss, unauthorized destruction, tampering, and unauthorized access or use. Health information that is transmitted electronically must follow the requirements in References (u) and (af) and DoDI 6055.01 (Reference (ag)) and DoDI 6000.14 (Reference (ah)). Service-specific guidance assigns the responsibility for the security of DoD Health Records to appropriate individuals. All personnel having access to the DoD Health Record will protect the privacy of PHI and PII in accordance with References (i), (k), and (r). MTF leaders with responsibilities for medical record management must evaluate and implement administrative, technical, and physical safeguards to reasonably protect health information from unauthorized use or disclosure, and to limit instances of incidental disclosure in compliance with Service policy and all applicable rules and regulations.

b. DoD Health Record documentation must be maintained in a secured area, room, or appropriate secured, paper-file storage enclosure, and system to ensure safekeeping. In some locations, it may be necessary to secure health record documentation with a 24-hour watch, when possible (except operational medicine locations). MTFs will implement physical safeguards for health information system components in accordance with Reference (s).

c. Access to all open record or electronic media storage areas must be restricted to authorized personnel who require the paper data in the performance of their official duties. Personnel granted access must be trained on HIPAA Privacy and Security and the requirements in this instruction regarding safeguarding PHI maintained in the medical department. The procedures and requirements in this instruction and References (r) and (s) will be used to expand existing Service training materials for appropriate access to and handling of PHI and PII. MTF commander approval or authorization is required for unescorted access to medical records areas.

d. DoD Health Records will be made available on a tiered schedule based on the need that the record supports. The categories of availability are:

(1) Immediate availability, where the response time from inquiry is less than 3seconds. Computable elements are necessary for clinical decision support (e.g., Problem List). This includes all items necessary in accordance with the meaningful use criteria described in section 201 of Title 42, U.S.C, also known as "The Health Information Technology for Economic and Clinical Health Act" (Reference (ai)).

(2) Archival availability, with a response time from inquiry of 1 business day:

(a) Digital images and other working papers, if available, may be archival documents.

(b) Archived records: When a patient is no longer eligible for care, that is, no longer a beneficiary of the DoD, then the entire DoD Health Record may be archived.

e. A patient may request an account of disclosures of PHI and PII for the previous 6-year period. Medical departments will account for disclosures in accordance with Reference (k).

f. Each MTF will establish a mechanism that tracks disclosures of PHI within the guidance outlined in DHA- and Service-level policies as required by law. Military Services will use a standardized tracking mechanism for accountable HIPAA disclosures at their MTFs. When technically feasible, this disclosure tracking data must be centralized, and the tool used capable of accounting for disclosures made throughout the MHS, conforming to all privacy and security safeguards. The tracking mechanism will allow qualified individuals to generate and review a report on disclosure activity in accordance with Reference (k).

g. Commanders of MTFs, senior-level Reserve Component medical authorities, and HIPAA security officers (as established in accordance with Reference (s)) will determine by category of personnel, derived from their job requirements, the appropriate role-based access to PHI.

(1) Appropriate implementation and compliance with the minimum necessary standard in the HIPAA Privacy Rule requires that access controls be in place so that only information needed to perform assigned job functions is accessed. Specific access permissions based on the user's role (role-based access) is the preferred method to accomplish this requirement.

(2) The HIPAA security officer will work with information managers to determine the different roles needed and the information required for each role for effective job performance.

(3) System access is provided in accordance with Service-level guidance, and access is contingent upon successful and timely completion of information assurance and other systems compliance training. MHS standard training must be used when available.

h. Within MTFs and Reserve Component facilities, the following individuals may use the information in DoD Health Records for treatment, payment, and health care operations purposes. Access to substance abuse treatment records is limited in accordance with Reference (y).

(1) Medical personnel.

(2) Patient administration officers and associated personnel who need DoD Health Record access to perform patient administration functions.

(3) Other MHS personnel as determined necessary and documented by health care facility commanders for treatment, payment, and health care operations purposes.

i. Information from the DoD Health Record may only be disclosed according to the requirements in Service guidance and as permitted in accordance with References (d) through (k), DoDI 1000.30 (Reference (aj)), and ASD(HA) Memorandum (Reference (ak)). Accounting for disclosures must comply with the HIPAA Privacy Rule as established in Reference (k).

10. PATIENT IDENTITY MANAGEMENT

a. Military Services will develop procedures for establishing and maintaining a single, unique DoD Health Record for each beneficiary based upon the Defense Eligibility and Enrollment Record System (DEERS) identity.

b. DoD uses the DoD identification number (also known as electronic data interchange person identifier (EDI-PI)) as the unique means for identifying individuals. This number is cross-referenced against other unique identifiers collected, such as the Social Security Number (SSN). Military Services will establish procedures to align the DoD Health Record with the EDI-PI identification number and will comply with Reference (aj) regarding the reduction of the use of SSNs at DoD.

c. The installation Military Personnel Section is responsible for validating a beneficiary's eligibility for DoD benefits. Designated MTF personnel perform a two-step check to confirm the patient's identity and verify entitlement:

(1) Complete a physical check of the Common Access Card or Uniformed Services Identification card.

(2) Verify status in DEERS. Military Services will develop procedures for instances where beneficiary status cannot be clearly determined to reduce the number of potential duplicate DoD Health Records.

d. The Military Services will develop procedures for particular facility constraints to ensure that newborns are clearly and uniquely identified in documentation to supplement the EDI-PI when that is available. The sponsor SSN may be used in systems that do not yet support the EDI-PI. Administrators must follow record system procedures to update a newborn's personal identification in their DoD Health Record as soon as the EDI-PI becomes available.

e. Military Services will develop policy and procedures directing the MTF records managers to identify the appropriate category for episodes of care for dual- or multiple-eligibility patients to the extent possible using the appropriate DoD Benefits Number. At a minimum, all entries must be appropriately dated to facilitate resolution when an acceptable solution to account for dual- or multiple-eligibility beneficiaries is developed.

f. Military Services will develop procedures for establishing and maintaining a single, unique DoD Health Record for non-beneficiaries – humanitarian patients and special designees (e.g., allies, detainees, foreign national exchange/training participants).

11. DoD HEALTH RECORD DISPOSITION. Documentation that is part of the STR, NSTR, or OHTR will be governed by the NARA disposition requirements for the specific component record.

a. When an item of documentation is included in the DoD Health Record, the disposition of the item is determined by the schedule pertaining to the component record of which it is a part, and not the original disposition schedule for the stand-alone version of the original format of the record item.

b. Documentation elements in the DoD Health Record that could belong to multiple categories (STR, NSTR, OHTR) must be maintained according to the disposition requirement of the most stringent (longest duration) component record.

c. Any electronic record system (including document management system) that has been determined to comprise the record copy of the STR, NSTR, or OHTR must maintain that record copy for the minimum period of time specified in the applicable disposition schedule. The disposition schedules for the STR, NSTR and OHTR are:

(1) STR: Maintained in accordance with the current NARA disposition schedule (Reference (o)).

(2) NSTR: Maintained in accordance with the current NARA disposition schedule (Reference (p)).

(3) OHTR: Maintained in accordance with Reference (q). Components of the OHTR must revert to the NSTR schedule.

d. A copy of the STR or NSTR, as appropriate, will be provided to DoD beneficiaries or their authorized agent upon written request in accordance with DoDD 5400.07 (Reference (al)) at any time prior to the end of the disposition period for that record.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AHLTA	Armed Forces Health Longitudinal Technology Application
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
CFR	Code of Federal Regulations
DEERS	Defense Eligibility and Enrollment Record System
DHA	Defense Health Agency
DoDD	DoD Directive
DoDI	DoD Instruction
DoDMERB	Department of Defense Medical Exam Review Board
EDI-PI	electronic data interchange personal identifier
EHR	electronic health record
EMR	electronic medical record
HIPAA	Health Insurance Portability and Accountability Act
IG DoD	Inspector General of the Department of Defense
LLF	late and loose-flowing (documents)
MHS	Military Health System
MTF	military treatment facility
NARA	National Archives and Records Administration
NSTR	non-Service treatment record
OHTR	occupational health civilian employee treatment record
PHI	protected health information
PII	personally identifiable information

SSN	Social Security number
STR	Service treatment record
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMEPCOM	United States Military Entrance Processing Command
VA	Department of Veterans Affairs

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this instruction.

AHLTA (noun). The EMR system used by the DoD since its initial implementation in January 2004. Though the term has sometimes been described as an acronym (Armed Forces Health Longitudinal Application), the term itself is the correct name of the system.

archive (verb). To remove objects no longer in day-to-day use from the online system and place them into long-term, retrievable storage.

archive (noun). According to context, the copy of a record that has been archived or the collective DoD repository containing archived records. The archive is distinct from the “live” electronic record system supporting ongoing care.

accession medical record. The foundation of the Service member’s longitudinal DoD Health Record. It includes the medical examination performed by the USMEPCOM or DoDMERB personnel, including associated internal and external records (paper or digital), as required.

advance directive. Legal document stating the patient’s oral and written instructions about future medical care, in the event that the patient is not able to communicate these instructions. Examples include a living will and do not resuscitate orders.

authorized personnel. Personnel who, through a verification process, have presented a legitimate requirement to access medical records and been approved.

beneficiary. A person eligible to receive care in an MTF.

clear and legible reports. Specialty care consultation and referral reports, histories and physicals, progress notes, notes on episodes of care, and other patient information (such as laboratory reports, x-ray readings, operative reports), and discharge summaries for beneficiaries referred by

an MTF, or reports of any other such care provided without a referral, in accordance with Reference (y).

DEERS. Defined in DoDD 1000.25 (Reference (am)).

digital signature. The electronic analog of a written signature used by a third party to determine that the entity named in the signature did sign the information. A digital signature is configured to automatically include a date and time and indicates that the information to which it is attached has not changed since the signing.

direct services. The provision of services to a patient that require some degree of interaction between the patient and the health care provider. Examples include assessment, performing procedures, teaching, and implementation of a care plan.

document management system. Used to capture, index, display, or store the following types of documentation, which may be provided on paper, electronically, or on other media and can include:

Paper documents not available in digital format.

Digital images.

Photos.

Video files.

Audio files (including but not limited to voicemails).

Waveforms.

Email.

DoD Benefits Number. A unique identifier assigned to a beneficiary based on association with a DoD sponsor and used to determine benefits. DoD beneficiaries who have multiple sponsors will be assigned unique DBNs for each relationship.

DoD Health Record. Includes all medical and dental care documentation, including mental health care documentation, that has been recorded for that individual. Information may be recorded and maintained in paper or electronic media. Three principal component records maintained within the DoD health care system, each of which is a specific subset of the information in the DoD Health Record are the STR, NSTR, and OHTR. Inpatient records are also a part of the DoD Health Record for an individual. Certain documents from an inpatient record are also included in the STR and OHTR. Administrative documents created to communicate copies of information contained in the health record to non-health care related activities are not part of the DoD Health Record.

DoD identification number. A unique 10-digit identifier assigned to each person who has a record in the DEERS database, including all military personnel, family members, employees, most contractors. The DoD identification number identifies the individual in all interactions with DoD. Also known as the EDI-PI.

downtime. The time during which a functional machine or system is not functioning properly or is otherwise unavailable to users.

draft record entry. An entry in the record that is saved but not finally signed by the entering provider. Draft entries can be documents, notes, or other elements of the health record.

EDI-PI. See DoD identification number.

eHealth exchange. Formerly the Nationwide Health Information Network Exchange. A community of organizations and health systems who share information under a common trust framework and a common set of rules. Participants include federal agencies, states, and health information organizations and health systems, which represent hundreds of hospitals, thousands of providers, and millions of patients. The eHealth Exchange improves the health and welfare of all Americans through health information exchange that is trusted, scalable, and enhances quality of care and health outcomes by supporting comprehensive longitudinal health records.

healthcare operations. Healthcare related management activities performed in accordance with References (i) and (k) and governed by the Privacy Rule defined in part 164 of Title 45, CFR (Reference (an)).

HIPAA security officer. An official with statutory or operational authority and responsibility for the development, implementation, maintenance, oversight, and reporting of security requirements for electronic PHI in accordance with Reference (r) and parts 160, 162, and 164 of Reference (an).

indirect services. Related to patient care but does not require interaction between the health care provider and the patient. Examples include record reviews and record corrections.

inpatient. A patient who is admitted to a hospital or clinic for treatment that requires at least one overnight stay.

inpatient record. The set of health care documentation recorded during a period of hospitalization.

The Joint Commission. An independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States reflecting an organization's commitment to meeting certain performance standards.

LLFs. Documents that are discovered unattached to a medical record folder (orphaned or loose flowing) or that are received or discovered after a record has been archived (late). Generally

applied to documents pertaining to an STR and discovered in an MTF after the STR has been archived or sent away.

MTF. A military facility established for the purpose of furnishing medical and dental care to eligible individuals.

metadata tag. In information systems, a non-hierarchical keyword or term assigned to a document or other piece of information. The entry of metadata information about a scanned document allows for categorization of the data so the document can subsequently be located.

minimum necessary standard. When using or disclosing PHI in any form or when requesting PHI from another covered entity, all reasonable efforts to limit the use, disclosure, or request of PHI to that necessary to accomplish the intended purpose of the use, disclosure, or request.

NSTR. Chronology of outpatient medical, dental, and mental health care received by non-Service members and applies to anyone that does not meet the criteria for STR.

occupational health. The identification and control of the risks arising from physical, chemical, and other workplace hazards to establish and maintain a safe and healthy working environment.

OHTR. The occupational health record for all categories of DoD civil service workers, covered contractors, or other groups provided occupational health services by the DoD.

outpatient. A patient who is not admitted into a hospital. Outpatient care includes care in emergency rooms, same day surgery centers, and ambulatory procedure clinics for patients who are not subsequently hospitalized overnight during the episode of care.

PII. Defined in Reference (h).

PHI. Defined in Reference (k).

patient identity. Defined in Reference (am).

psychotherapy notes. Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session, and that are separated from the rest of the individual's medical record.

role-based access. The operational capabilities employed by a record system to control the availability of information to individuals based on their position and responsibility within the organization.

sensitive information. Information determined by the MHS or an individual healthcare provider to deserve special precautions to prevent inadvertent disclosure by or to medical record system users.

STR. The chronologic record of medical, dental, and mental health care received by Service members during the course of their military career. It includes documentation of all outpatient appointments (i.e. without overnight admittance to a hospital, clinic, or treatment facility), as well as summaries of any inpatient care (Discharge Summaries) and care received while in a military theater of operations. The STR is the official record used to support continuity of clinical care and the administrative, business-related, and evidentiary needs of the DoD, the VA, and the individual.

STR certification form (DD Form 2963). A form used to indicate that a paper STR folder is complete. When uploaded to the electronic record archive, this form certifies that the STR is complete as of the form completion date. It is an administrative document added to an STR.

TRICARE. The DoD health care program that provides health care coverage for medical services, medications, and dental care for military families, retirees and their families, and survivors.

voice recognition. Computer analysis of the human voice, especially for the purposes of interpreting words and phrases or identifying an individual voice.