



## THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

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HEALTH AFFAIRS

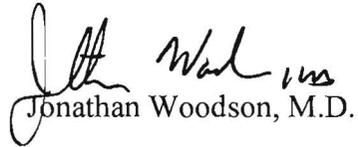
MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER  
AND RESERVE AFFAIRS)  
ASSISTANT SECRETARY OF THE NAVY (MANPOWER  
AND RESERVE AFFAIRS)  
ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER  
AND RESERVE AFFAIRS)  
COMMANDER, JOINT TASK FORCE NATIONAL CAPITAL  
REGION MEDICAL  
JOINT STAFF SURGEON

SUBJECT: Guidance for Requesting Correction of Erroneously Entered Information in the  
Armed Forces Health Longitudinal Technology Application

The attached guidance and high level process flow diagram describe the approved procedures to remove erroneously entered information in the Armed Forces Health Longitudinal Technology Application (AHLTA). In general, these procedures should be limited to Personally Identifiable Information (PII) or Protected Health Information (PHI) pertaining to one person or persons, but entered inadvertently into the record of a different person. They may also be applied to other information as deemed necessary after appropriate review. All efforts to correct documentation errors at the user level should be expended prior to requesting correction. This guidance also defines the process for responding to patient requests for amendment of PII/PHI in the AHLTA record under Department of Defense (DoD) 6025.18-R, Chapter 12, or any successor issuance. This guidance is for all DoD Military Treatment Facilities (MTFs) and is effective immediately. These procedures have been developed by a multidisciplinary TriService team representing key stakeholders and have been reviewed by the TRICARE Management Activity (TMA) Privacy Office and the TMA Office of General Counsel. Please disseminate to your facility Commanding Officers.

To protect the integrity of our medical record system, each request should be reviewed for clinical implications and appropriate end user actions prior to submission to the Service designated representative in the Office of the Surgeon General (OTSG) or Joint Task Force National Capital Region Medical (JTF CapMed). The attached guidance describes the procedures developed for that purpose.

My point of contact for this guidance is Colonel (COL) John Scott. COL Scott may be reached at (703) 681-1707, or John.Scott2@tma.osd.mil.



Jonathan Woodson, M.D.

Attachments:

1. Overview of Procedures for Requesting the Correction of Erroneously Entered Information in AHLTA
2. High Level Diagram for Requesting Correction of Erroneously Entered Information in AHLTA
3. Correction of Erroneous PII or PHI
4. Request for Correction of Erroneous Information Worksheet
5. Sample Request Template
6. Procedures for AHLTA Users to Follow When Correcting Erroneously Entered Information in the AHLTA Record

cc:

Surgeon General of the Army  
Surgeon General of the Navy  
Surgeon General of the Air Force

## ATTACHMENT 1

### **OVERVIEW OF PROCEDURES FOR REQUESTING THE CORRECTION OF ERRONEOUSLY ENTERED INFORMATION IN AHLTA**

#### **Background:**

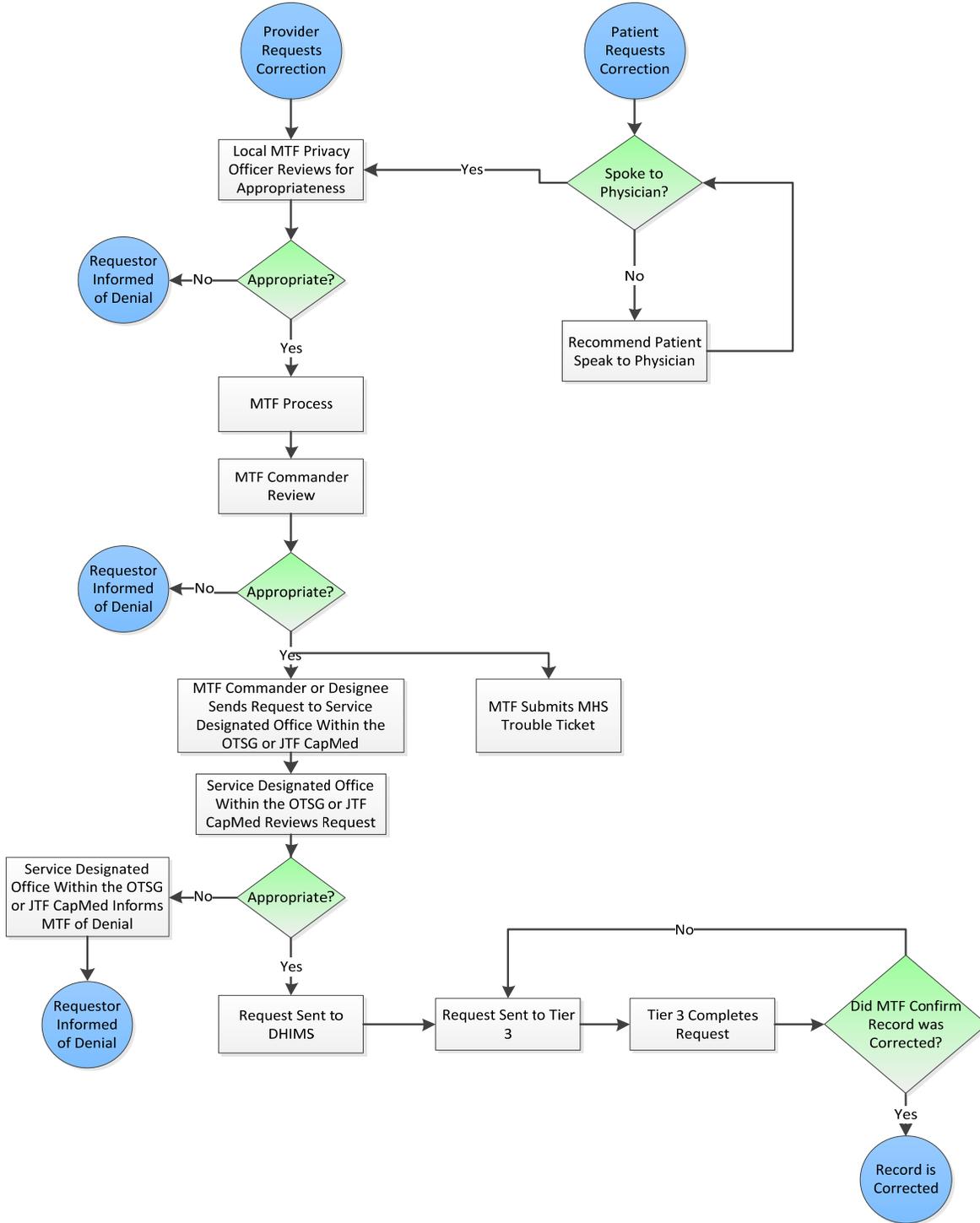
As an electronic medical record system, AHLTA is required to adhere to principles of systems of records to safeguard the confidentiality, integrity, and availability of the information it contains and to support the clinical care of DoD beneficiaries. While the system should allow efficiency when entering information by clinicians, it must also follow additional information technology requirements to protect the integrity of information that has been incorporated into the official record system. For these reasons, the correction of information by the Program Office, as opposed to the end user correction or updating of information allowed by the system, must follow strict procedures. The processes outlined in these guidelines and attachments are to ensure that appropriate actions are taken by clinicians and medical decision makers prior to submitting requests to the Program Office.

#### **Process Overview:**

When an AHLTA user recognizes that information has been erroneously entered into AHLTA, he/she should first use the AHLTA system to correct the error as outlined in Attachment 6 (Procedures for AHLTA Users to Follow When Correcting Erroneously Entered Information in the AHLTA Record). If the user believes that correction of the erroneous information is necessary, then MTF protocols should be followed to initiate the correction process. If the MTF Commander or designee approves the request, it will be directed to the appropriate OTSG or JTF CapMed Commander's office. Patient requests are handled per MTF policy. The MTF is responsible for ensuring appropriate procedures, to include that the end user actions as detailed in Attachment 6 (Procedures for AHLTA Users to Follow When Correcting Erroneously Entered Information in the AHLTA Record) have been followed prior to submitting the request. The Service designated office within OTSG or JTF CapMed reviews the request and submits it to the Electronic Health Record Core Program Management Office for action when it has been deemed appropriate. Attachment 2 (High Level Diagram for Requesting Correction of Erroneously Entered Information in AHLTA) provides a high level diagrammatic representation of this process.

## ATTACHMENT 2

### HIGH LEVEL DIAGRAM FOR REQUESTING CORRECTION OF ERRONEOUS INFORMATION IN AHLTA



## ATTACHMENT 3

### CORRECTION OF ERRONEOUS PII OR PHI

1. SCENARIOS WHICH CAN BE CORRECTED AT THE MTF LEVEL AND DO NOT REQUIRE A MILITARY HEALTH SYSTEM (MHS) TICKET:
  - a. Non sensitive erroneous information entered in the right patient encounter (example: wrong symptom).
  - b. Non sensitive erroneous information entered in the wrong patient encounter (example: wrong symptom).
  - c. Problem List entry that was in error or has become inactive (any provider may correct the Problem List, choosing to “delete” or “inactivate” any problem that the provider does not wish to appear on the active Problem List).
  - d. Clinical Note entry that has been “saved” but not “signed.” The user who entered the information can edit the erroneous note and remove or correct the information.
  
2. SCENARIOS WHICH REQUIRE A MHS TICKET AND A LETTER FROM MTF COMMANDER:
  - a. Sensitive erroneous information entered into the right patient encounter (example: AIDS diagnosis).
  - b. Sensitive erroneous information entered in the wrong patient encounter (example: AIDS diagnosis).
  - c. Scanned erroneous information containing PII/PHI into the wrong patient record (example: outside consult).
  - d. Patient request under the Health Insurance Portability and Accountability Act (HIPAA) for information correction in appropriate cases of extreme sensitivity or HIPAA compromise.
  
3. REQUESTING CORRECTION OF ERRONEOUS INFORMATION:

After local review, Command approval, and completion of actions to correct the record (see Attachment 6), the MTF submits an MHS ticket that includes pertinent information regarding the erroneous information (see Attachment 4, Request for Correction of Erroneous Information Checklist).

- a. The request must contain the MHS ticket number (which will be used to track the request throughout the process, the reason for the request, the clinical implications and appropriateness of the request, the type of PII/PHI to be removed, and the MTF Points of Contact (POCs). No other personal information is needed. **Do NOT send PII or PHI in e-mail or in the request letter.**
- b. The MTF Commanding Officer or designee signs the request. The request is sent to the Service designated office within the OTSG or JTF CapMed for approval.
- c. The Service designated office within the OTSG or JTF CapMed reviews the request

- and contacts the MTF POC for clarification as needed. Once approved, the Service designated office within the OTSG or JTF CapMed will forward the request to the Defense Health Information Management System (DHIMS) for action. If the request is denied, the Service designated office within the OTSG or JTF CapMed will notify the MTF Commander.
- d. DHIMS will task AHLTA Tier 3 to remove the erroneous information from the AHLTA record as described in the approved request. AHLTA Tier 3 maintains a log of all changes for the lifetime of the record.

#### 4. PATIENT-INITIATED REQUESTS:

- a. A patient-initiated request for correction of information is handled per local MTF policy. If the patient's request is not acceptable to the MTF in whole or part, then the MTF must satisfy the HIPAA amendment procedures stated in DoD 6025.18-R, Chapter 12, or any successor issuance.
- b. The HIPAA procedures address denial of patient requests for amendment, plus follow-up requirements when amendments are made. For further information, see the TMA Privacy and Civil Liberties Office's Information Paper, Amendment of Protected Health Information, February 2012 ([http://www.tricare.mil/tma/privacy/downloads/20121210/Amendment\\_of\\_PHI%20\\_February\\_2012.pdf](http://www.tricare.mil/tma/privacy/downloads/20121210/Amendment_of_PHI%20_February_2012.pdf))

## ATTACHMENT 4

### REQUEST FOR CORRECTION OF ERRONEOUS INFORMATION CHECKLIST

**Note: DO NOT SEND PII or PHI EXCEPT IN YOUR REQUEST**

1. Why does the AHLTA encounter record need to be modified?
  - a. State reason for the request (i.e., Provider documented on wrong patient, incorrect image was scanned into patient's record, encounter was created for incorrect patient, etc.).
  - b. Does the accidentally documented information contain PII or PHI which would violate HIPAA?
2. If HIPAA was not violated, the MTF provider should make the correction as noted in Attachment 6.

If HIPAA was violated, a MHS ticket will need to be submitted along with a letter from the MTF Commander requesting the correction of the information from the patient's record. The Service designated office within the OTSG or JTF CapMed must approve the request before Tier 3 can process the MTF's request. The following information should be included with the MHS ticket and approval letter (see Attachment 5, Sample Request Template):

- a. MHS Help Desk Ticket Number
- b. Patient Internal Entry Number (IEN)
- c. Encounter Number or Clinical Note
- d. Date/Time of Encounter/Clinical Note
- e. Appointment IEN/Appointment Identification
- f. Clinic IEN
- g. Provider IEN
- h. What needs to be removed? Be very specific, and include dates if applicable.
  - o For example: Change History, Add Note, Autocite information.
  - o Does the entire encounter need to be moved to another patient's record? If so, provide Patient IEN and name of the other patient.
  - o If the erroneous information is the result of scanning, describe what information needs to be removed or if the entire encounter needs to be removed.
- i. Include the following POCs for questions and results in the MHS ticket and in the Request Letter:
  - o Site POC for issue with their contact information.
  - o HIPAA Privacy Officer (Primary POC) name and contact information.
  - o SGH (alternate POC) name and contact information.

**ATTACHMENT 5**

**SAMPLE REQUEST TEMPLATE. MUST BE ON MTF AGENCY LETTERHEAD**  
**Note: IF SENT ELECTRONICALLY, DOCUMENT MUST BE ENCRYPTED TO**  
**PROTECT PII or PHI**

**SAMPLE**

MEMORANDUM FOR THE [Service designated office within the OTSG or JTF CapMed]

FROM: COMMANDING OFFICER/COMMANDER XYZ MTF

SUBJECT: Request for Correction of Personally Identifiable Information or Protected Health Information Entered Erroneously in the Armed Forces Health Longitudinal Technology Application

1. The purpose of this memorandum is to request correction of erroneously entered Personally Identifiable Information (PII) or Protected Health Information (PHI) from a patient's record in the Armed Forces Health Longitudinal Technology Application.
  - a. The MHS Help Desk ticket number is:
  - b. Reason for information correction (for example, due to incorrect documentation or scanned PII or PHI)
  - c. The following information is viewable in the wrong record (i.e., Date of Birth/Social Security Number/Name)
  - d. What erroneous information is to be removed (for example, the entire clinical note dated):
2. Please address any questions and send the results to:
  - a. Privacy Officer (Primary Point of Contact (POC)) Maj John Doe  
john.doe@amedd.army.mil  
DSN 772-1234 or commercial (000) 234-1234

- b. SGH, Executive Officer (Alternate POC)  
LTC John Smith  
john.smith@amedd.army.mil  
DSN 777-5588 or Commercial (001) 234-5678

Colonel John D. Sample,  
USAF, MC Commander XYZ  
MTF

## ATTACHMENT 6

### **PROCEDURES FOR AHLTA USERS TO FOLLOW IN CORRECTING ERRONEOUS INFORMATION ENTERED INTO THE AHLTA RECORD**

1. REMOVING ERRONEOUS INFORMATION BEFORE THE ENCOUNTER HAS BEEN SIGNED
  - a. If incorrect information is entered into the AHLTA record and the encounter has not yet been signed, all erroneous information can be deleted or amended.
  - b. If the encounter was opened on the wrong patient and the encounter has not been signed, the information should be deleted and the appointment should be “Facility Cancelled.”
  
2. REMOVING ERRONEOUS INFORMATION AFTER THE ENCOUNTER HAS BEEN SIGNED:
  - a. Criteria Required to Amend the Encounter
    - This process must be performed by the provider who entered the erroneous information.
    - A signed encounter cannot be deleted nor the underlying appointment be cancelled by the MTF.
    - The process below will remove the information from the main body of the encounter, but it remains in the Change History portion of the encounter, designated as erroneous.
  - b. Steps to Amend the Encounter
    - Open the AHLTA record for the patient from which the information should be removed.
    - Go to Previous Encounters, select the improperly documented encounter, and click on the Amend Encounter button. This will open the encounter, allowing all information to be removed from the main body of the encounter note (and remain only in the Change History portion of the note). Go into each section containing erroneous information, and remove it as appropriate.
  
3. REMOVING INFORMATION WHEN IT APPLIES TO A DIFFERENT PATIENT, AND STEPS TO TRANSFER THAT INFORMATION TO THE RIGHT PATIENT, IF NEEDED:
  - a. If the Encounter has not yet been signed, skip step one and start at step two; if the Encounter is already signed, use the following steps.
    - Go to Previous Encounters, select the improperly documented encounter, and click on the Amend Encounter button.
    - Start at the ‘Summary’ screen or SF600 view (the screen showing the AutoCites).
    - Click the ‘Save As Template’ button on the Action Bar icon at the top, or click ‘Actions’ on the file menu dropdown, and select ‘Save as Template.’

- The ‘Save List Note Template’ window will appear, name the Subjective and Objective (S/O) portion of the template ‘correction-S/O,’ and leave the Share this Template checkbox ‘unchecked’ (i.e., do not share this template). Press ‘Save.’
- Next, the Template Management Module will display. Click ‘Save,’ and the ‘Save Encounter Template’ dialogue will appear. Name this template ‘correction – encounter,’ and click ‘Save.’
- Close Template Management, and navigate to the S/O section.
- At the Encounter S/O Notes selection window, select each of the S/O Notes that need to be deleted, and press the ‘Delete’ button. Repeat as needed.
- Navigate to Assessment and Plan (A/P). Delete the Diagnoses from the A/P module.
- Delete all orders (laboratory, radiology, medications) from the A/P module.
- In the Add Note section, document a short explanation, e.g. “The entries below in the Change History Section are to be disregarded and were recorded in the wrong patient or were made in error.” This text can be enlarged and bolded to make it stand out.
- On the Appointment list, perform a “Facility Cancel” in AHLTA for this patient.
- In Composite Health Care System I for the End-of-Day process, “ADMIN out” the facility cancelled appointment.
- Next, open the correct Patient’s Encounter, and add in the correct information by loading the “correction - encounter” template.
- This template will include items in S/O and A/P (except consults and any Free Text Comments). Reselect the S/O (+)(-) boxes, as appropriate. The free text associated with the terms should automatically be included. In the A/P section, the tabs; Dx, Order Set, Procedures, and Other Therapies will contain information that you can add back into the record. If there were orders placed, select the Order Set tab, and re-submit the orders for this patient.
- The templates created (correction S/O template and correction – encounter) may now be deleted.

#### 4. ERRONEOUSLY PASTED DOCUMENT OR IMAGE INTO A CLINICAL NOTE THAT HAS BEEN SAVED BUT NOT SIGNED

- a. In the Clinical Notes section, notes that have been saved but not signed are indicated as “Resolved” as opposed to “Final.”
- b. If the user erroneously scanned a document or image into the Clinical Notes Module, and the note has not been signed, use the following steps to edit the note:
  - Select the note from the list of notes in the Clinical Notes Module. The text of the note displays in the right half of the workspace.
  - Click Edit on the Action bar. The Edit window opens.
  - Make the applicable changes.
  - Click Save. The modifications display in the note.

\*Note: Text notes that are uploaded (as opposed to pasting selected text) from non-

AHLTA systems cannot be edited within the document, but the entire document can be deleted.

5. ERRONEOUSLY PASTED DOCUMENT OR IMAGE INTO A CLINICAL NOTE THAT HAS BEEN SIGNED

- a. In the Clinical Notes section, notes that have been signed are indicated as “Final.”
- b. Signed notes cannot be deleted or edited. If privacy of another patient may be compromised, or if the note contains information deemed potentially harmful, then a request for correction is appropriate.

6. ERRONEOUSLY SCANNED DOCUMENT OR IMAGE INTO THE ADDNOTE SECTION THAT HAS NOT BEEN SIGNED

- a. If the user erroneously scanned a document or image into the AddNote section, use the following steps:
  - o If the note has not been signed and is still located in the AddNote section of the encounter, the user can amend the encounter and click on the AddNote button.
  - o Select the erroneous note and select EDIT NOTE.
  - o DO NOT SELECT “DELETE NOTE”\*. Deleting the note will put the erroneous information in the Change History section.
  - o Highlight the information and click Backspace.
    1. Click Note Complete.
    2. Sign encounter.

\*Note: When viewing the encounter through Previous Encounters, there will be two documents for this encounter. The first document will be the correct information that is viewable to other users and can be printed for the patient.