

Record Custodian to Health Information Steward Best Practices in Record Retention, Storage, and Destruction

Indian Health Services Health Information Management Meeting

Sharon Lewis, MBA, RHIA, CHPS, CPHQ
Preferred Quality Consulting Services
EHR Consultant, InfoGard Laboratories

Objectives

- Health Information Stewardship
- Importance of the Medical Record
- Life Cycle of the Medical Record
 - Creation
 - Utilization
 - Maintenance
 - Destruction
- Disaster Preparedness
- Policies and Procedures

Record Custodian

beginnings: "if you do not organize now, you perhaps never will"

compiled by Anne Zender, MA

In 2003, AHIMA celebrates its 75th birthday. To commemorate the occasion, the *Journal of AHIMA* is taking a look back through the organization's archives. Throughout the year, we'll be telling the story of the people, ideas, and issues that brought AHIMA where it is today—a diverse organization of more than 42,000 HIM professionals. Where did it all begin?

At first there were very few with training to take charge of the records and so the record librarians, or record clerks as they were then called, simply grew as best they could. ...The lack of contact with other record clerks was a serious handicap to all of us. We had no one in the hospital and, in fact, no one in the community with whom to discuss record room problems. Our reference books were the Medical Dictionary, the Nomenclature, Gray's Anatomy, the available medical journals, and a brief course outlined by the American College of Surgeons. ...There was no standard curriculum and no organized supervision. The training was more in the nature of an apprenticeship.

—From "The Record Librarian of Yesterday, Today, and Tomorrow" by Enna C. Black, RRL, presented at Midwest Hospital Association meeting, April 1948



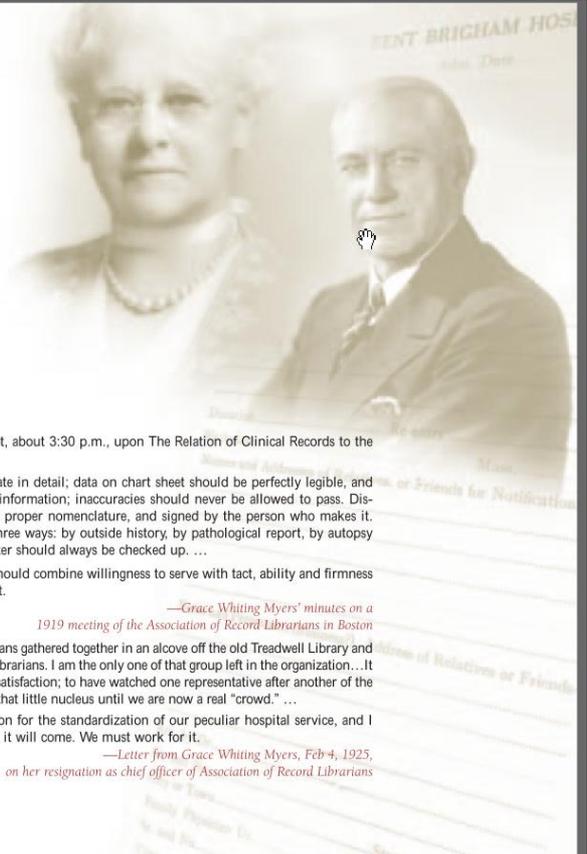
Five women serving as record clerks (some also called themselves historians or librarians) at Leavitt

In 1913, the American College of Surgeons (ACOS) is founded

(from left to right):

Grace Whiting Myers became the first ARLNA (later AHIMA) president in 1928. She was later appointed honorary life president.

Malcolm MacEachern, MD, associate director of ACOS, was among the early supporters of a national association for medical record librarians.



Nov. 6, 1919: Talk by Dr. R.C. Cabot, about 3:30 p.m., upon The Relation of Clinical Records to the Hospital Staff. ...

A Record Librarian should be accurate in detail; data on chart sheet should be perfectly legible, and every effort made to obtain correct information; inaccuracies should never be allowed to pass. Discharge diagnosis should be made in proper nomenclature, and signed by the person who makes it. End-results should be obtained in three ways: by outside history, by pathological report, by autopsy (the final confirmation). The two latter should always be checked up. ...

Personality of Record Clerks: They should combine willingness to serve with tact, ability and firmness in adherence to the rules that protect.

—Grace Whiting Myers' minutes on a 1919 meeting of the Association of Record Librarians in Boston

It is nine years since five record librarians gathered together in an alcove off the old Treadwell Library and organized the Committee of Record Librarians. I am the only one of that group left in the organization...It has been to me nine years of intense satisfaction; to have watched one representative after another of the neighboring hospitals gather around that little nucleus until we are now a real "crowd." ...

My vision is of a national organization for the standardization of our peculiar hospital service, and I believe that somewhere in the future it will come. We must work for it.

—Letter from Grace Whiting Myers, Feb 4, 1925, on her resignation as chief officer of Association of Record Librarians





Health Information Steward

- Safeguards the confidentiality of health information so that only permitted uses and disclosures are made
- Maintains the integrity of health information, so that it is not corrupted or changed by unauthorized means
- Ensures the health information is readily available when it is needed



Health Information Steward

- Provides guidance on department policies
- Ensures health information is compliant with laws, regulations, and standards
- Strives to protect the privacy and security of health information
- Ensures the timely availability of health information
- Assures the ethical use of health information

Importance of the Medical Record

- Document reflecting care of a patient within your organization
 - Personal Information
 - Financial Data
 - Social Information
 - Medical Documentation
- Medical record may be paper, electronic, combination thereof (hybrid)

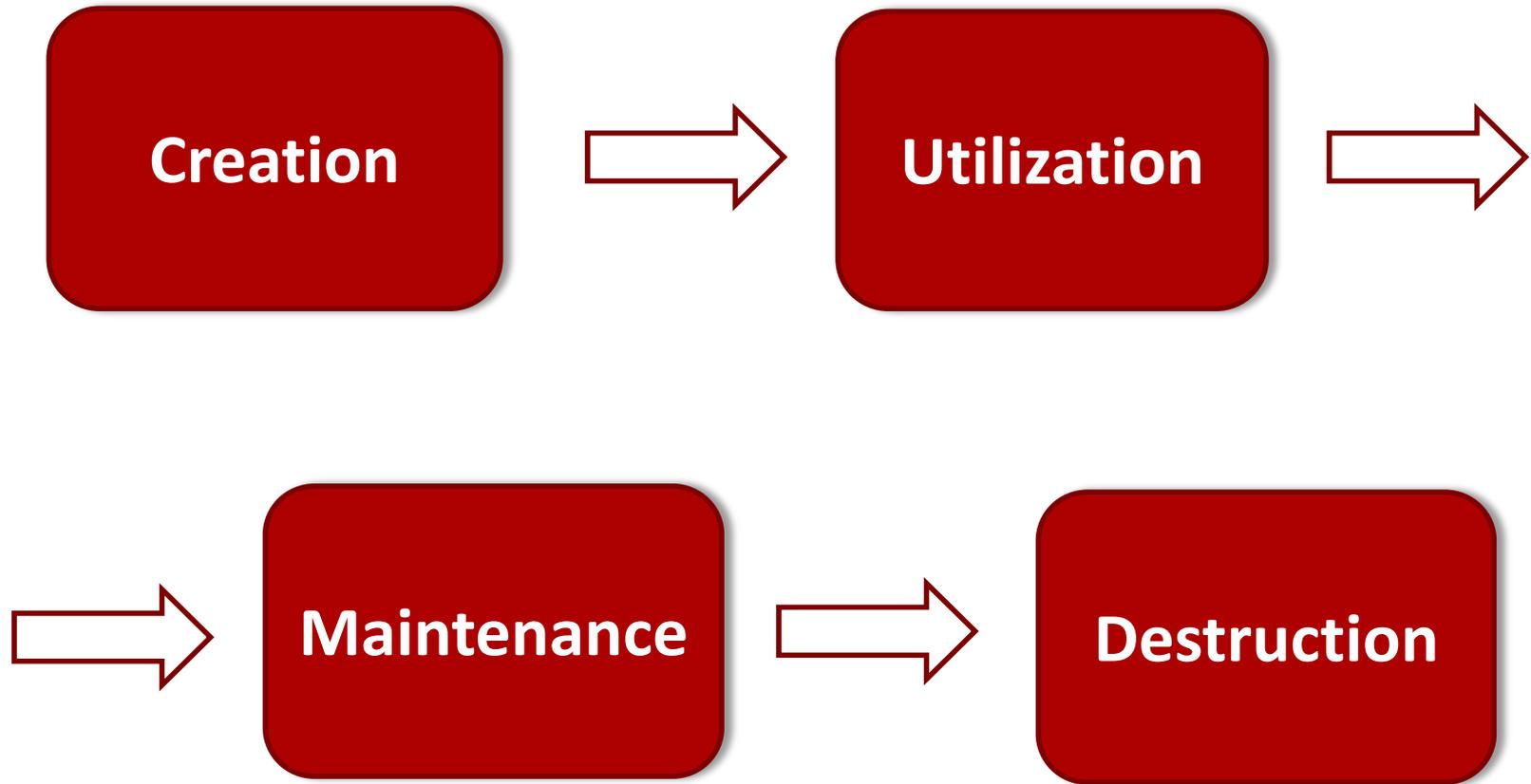
Importance of the Medical Record

- Secondary uses such as
 - Payment
 - Performance improvement
 - Research
 - Regulatory Compliance
 - Meaningful Use
- “Best evidence” in the event of a legal action

Health Information Regulations

- California Code of Regulations – Licensing and Certification
 - Title 22
- Accreditation Regulations
 - The Joint Commission, DNV, HFAP
- Centers for Medicare and Medicaid Services (CMS)
 - State Operations Manual
- HIPAA

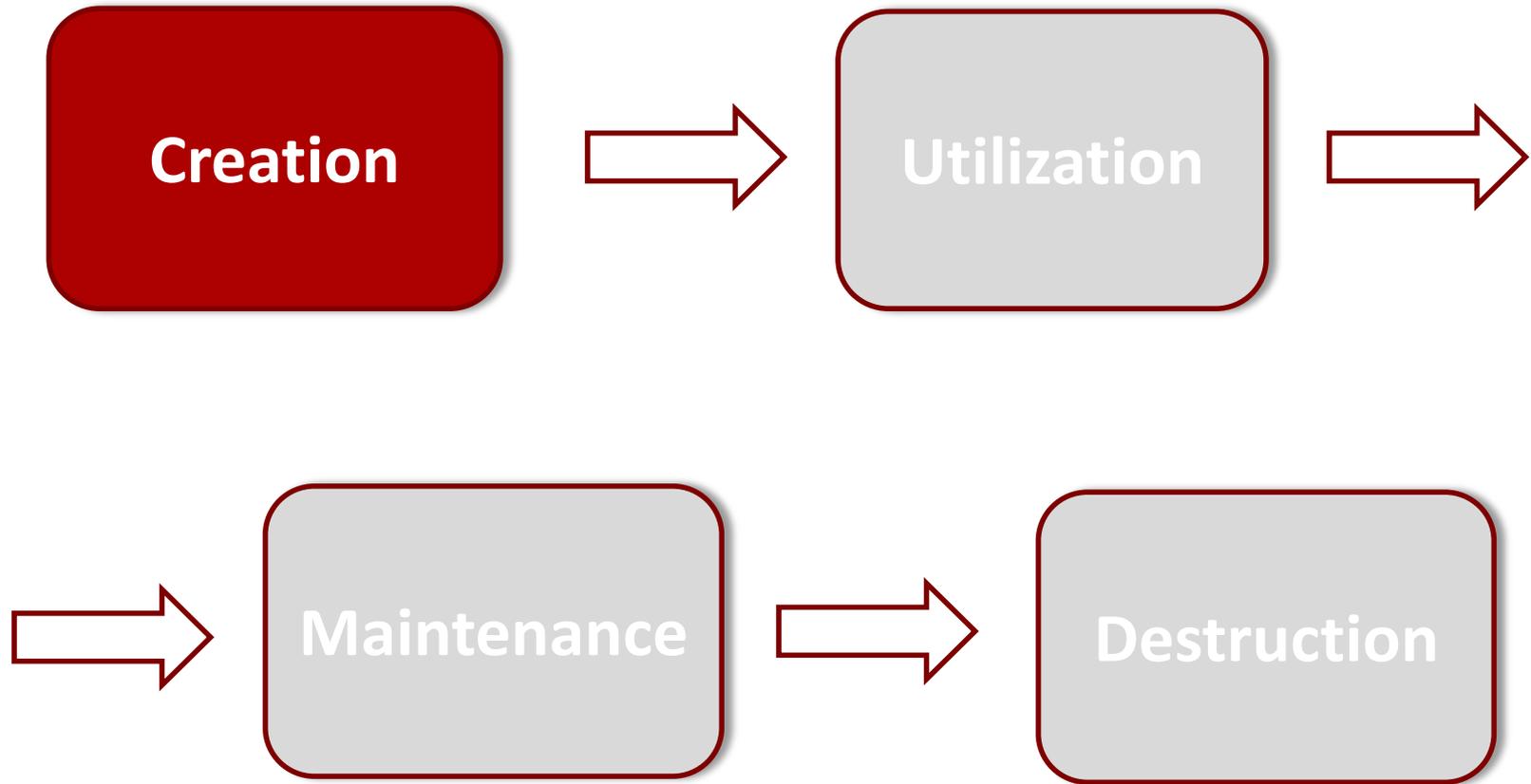
Record Life Cycle



Policies and Procedures

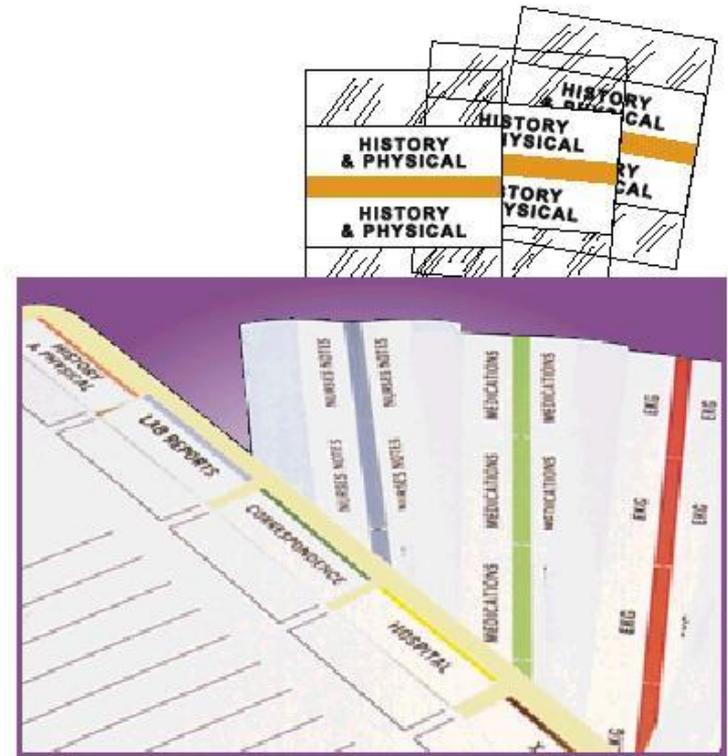
- Legal Health Record (Creation)
- Medical Record Availability (Utilization)
 - Active Records
 - Inactive Records
- Records Management Policy (Maintenance and Destruction)
 - Records Retention
 - Records Disposal

Record Life Cycle – Creation



Record Creation

- Unit Record
 - Visits Combined?
 - Visits Stored separately?
- Contents
 - Advance Directives
 - Release of Information requests
 - Outpatient, i.e., lab, x-ray
 - Coding Query forms
- Regulatory Requirements



Record Creation

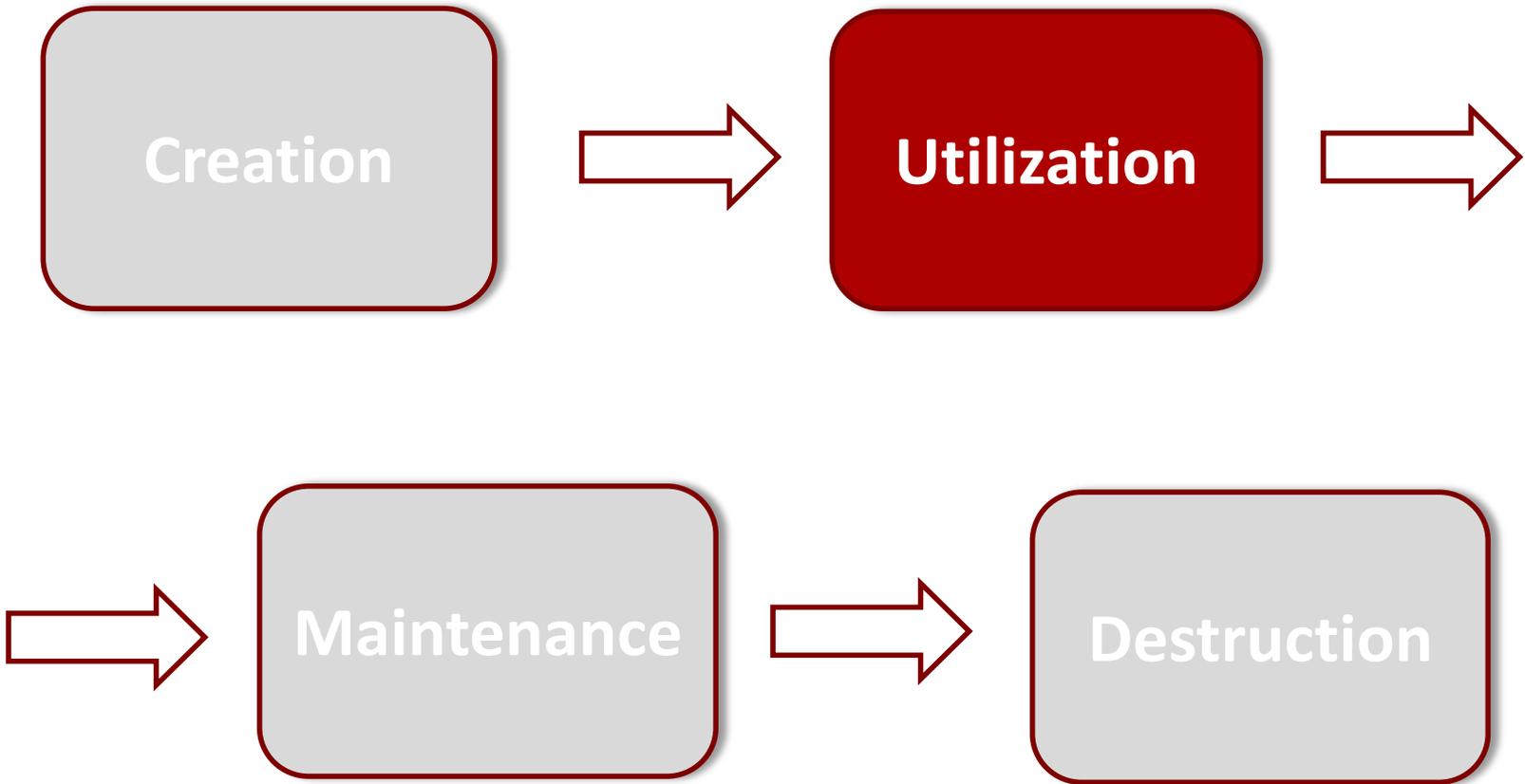
Media Considerations

- Paper (PHI)
- Electronic (ePHI)
- Hybrid (Combination of PHI/ePHI)

HIPAA Safeguards

- Administrative/Physical (PHI) – Privacy Rule
- Administrative/Physical/Technical (ePHI) – Security Rule

Record Life Cycle – Utilization

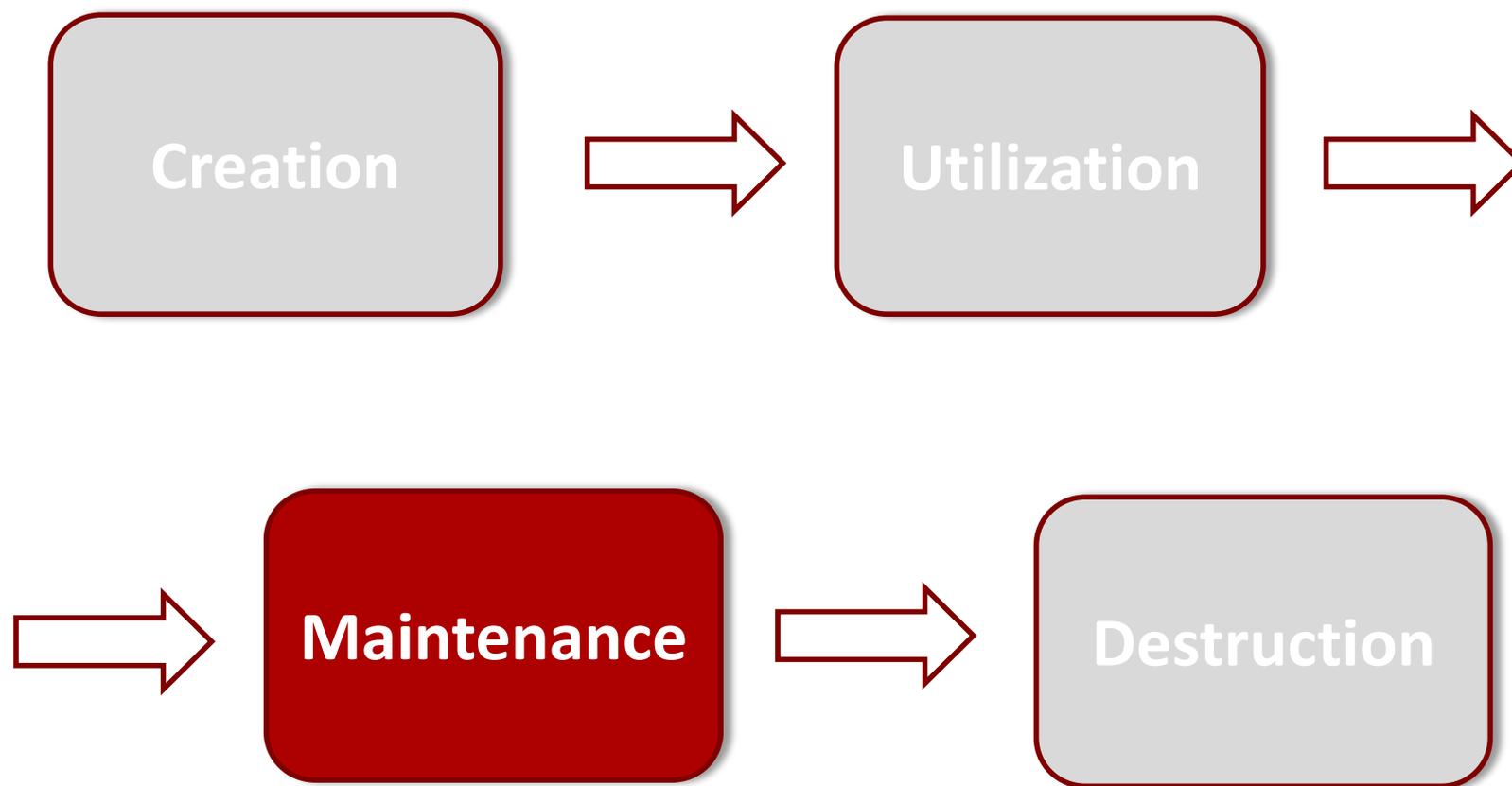


Record Utilization

- Continuity of Patient Care
- Performance Improvement
- Peer Review
- Research
- Record Completion
- Regulatory Compliance



Record Life Cycle - Maintenance



Record Storage

- Active Records
- Inactive Records
- Onsite Location
- Offsite Location
- Boxes
- Files Cabinets
- Physical safeguards
- Administrative safeguards



Record Retention Schedule

Federal Requirement	State of CA Requirement	California Hospital Association	AHIMA Recommends
<p><u>Hospitals:</u> Five years. Conditions of Participation 42 CFR 482.24(b)(1)</p>	<p>§ 70751. Medical Record Availability. (c) Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.</p>	<p><u>Adults and emancipated minor:</u> 10 years following discharge or final treatment <u>Unemancipated minor:</u> At least one year after patient has attained age 18, but in no event less than 10 years following discharge or final treatment <u>Alternative Retention Period:</u> 25 years</p>	<p>Patient health and medical records (adults) 10 years after the most recent encounter</p>

Record Retention Considerations

- Ensure patient health information is available to meet the needs of continued patient care
- Readmission rates
- Type of Healthcare Organization
 - i.e., Ambulatory Clinic, Surgery Center, Inpatient Hospital
- Facility Specific Policy
- Organization-wide (IHS) Policy

Purging



Purging Considerations

- Defining Active / Inactive records
 - Active Records: records are consulted or used on a routine basis
 - Inactive Records: records are used rarely but must be retained for reference or to meet full retention requirement
- Physical File Space
- Amount of research done
- Availability of Offsite Storage
- Routine process

Purging Process

- Separate active from inactive records
- Establish a “cutoff date”, i.e., discharge date
- Maintain entire folder / Purge within the folder
- Example: Record Number 00-00-01

Record Type	Discharge Date
Emergency Department	June 15, 2010
Inpatient Stay	May 12, 2009
Inpatient Stay	August 31, 2008
Same Day Surgery	July 10, 2007
Urgent Care Clinic	November 12, 2006

Purging Options

- Separate storage
 - Onsite (different room)
 - Offsite - “Approved Storage Facility” i.e, IronMountain, SourceCorp, etc.
 - Offsite - Title 22 “Program Flexibility” required
- Open Files
- Boxes
- Scanning
- Microfilm
- Don’t forget HIPAA Safeguards!

Disaster Preparedness



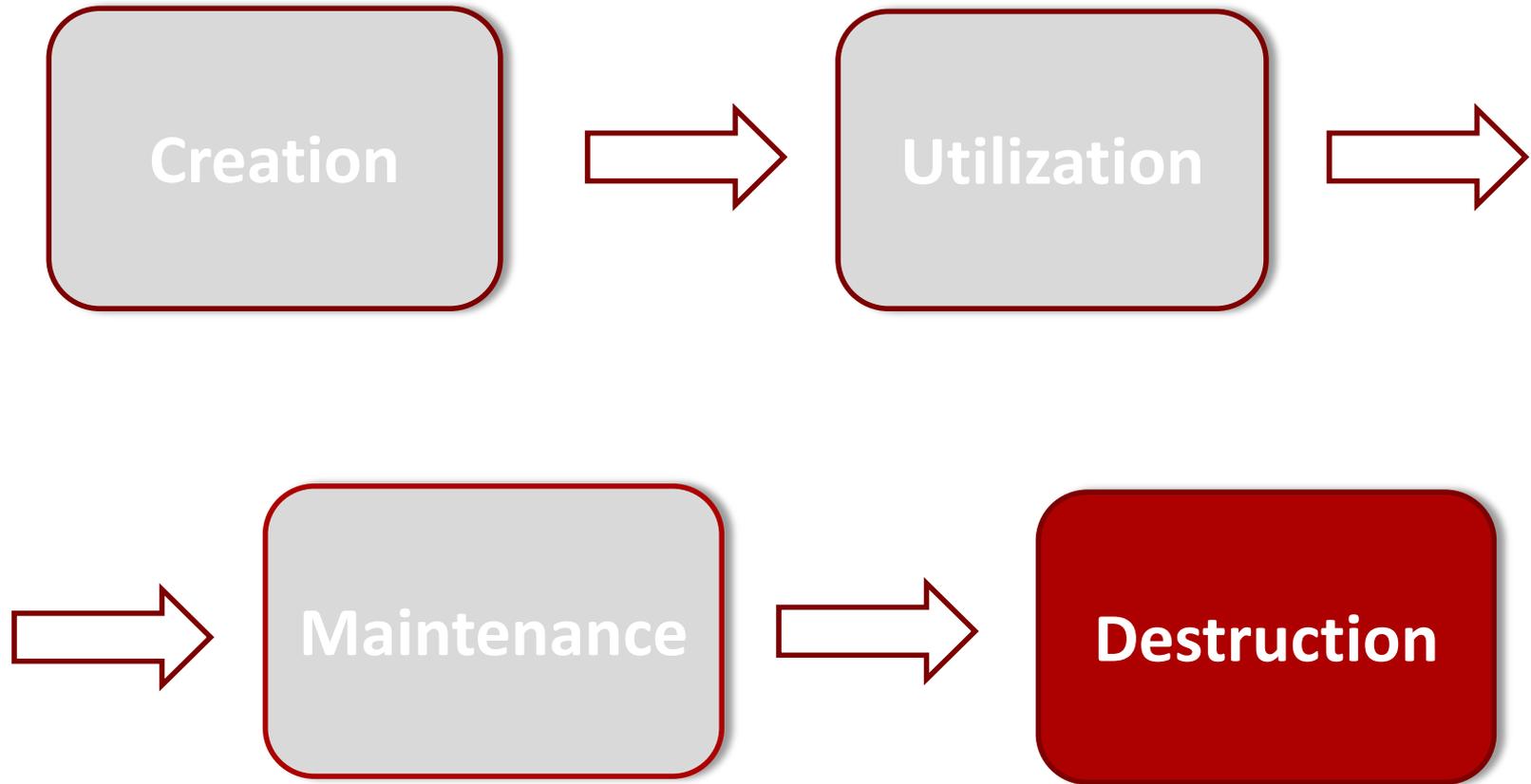
Disaster Preparedness

- Guard health record against unexpected losses due to a natural or other disaster
 - Physical, Administrative, and Technical Safeguards
- Contact several fire, water, storm damage restoration companies to determine available services in your area
- Review Disaster Plan and ensure staff are aware
 - Orientation, Training, Competency Review

Disaster Preparedness

- AHIMA Disaster Planning Resources:
 - Disaster Planning and Recovery Website
<http://www.ahima.org/disaster/>
 - Disaster Planning Practice Brief
 - Practical Disaster Planning for Healthcare Facilities
 - Complying with the HIPAA Privacy Rule During a Disaster
 - Checklists and Tools

Record Life Cycle



Record Destruction

- Destruction to be completed in accordance with federal and state laws
- Civil Code 56.101 – providers must destroy/dispose of records in a manner that preserves the confidentiality of the information
- Destruction methods to include:
 - Shredding;
 - Erasing; or
 - Otherwise modifying personal information to make it unreadable or undecipherable

Record Destruction

- Examples of destruction methods
 - Burning, shredding, pulping, pulverizing
 - Microfilm methods of destruction include recycling or pulverizing
 - Laser discs used in write once-read many document-imaging applications are destroyed by pulverizing
 - Computerized data are destroyed by magnetic degaussing
 - DVDs are destroyed by shredding or cutting
 - Magnetic tapes are destroyed by demagnetizing

Record Destruction

- Documentation to include:
 - Date of destruction
 - Method of destruction
 - Description of the disposed records
 - Inclusive dates
 - A statement that records were destroyed in the normal course of business
 - Signatures of individuals supervising and witnessing the destruction

Record Destruction

- Outsourcing to a Business Associate - contract requirements:
 - The method of destruction or disposal
 - The time that will elapse between acquisition and destruction or disposal
 - Safeguards against breaches
 - Indemnification for the organization or provide for loss due to unauthorized disclosure
 - Require the BA to maintain liability insurance

Policies and Procedures

Paper Records

- Medical Record Availability
 - Department Hours
 - Physical Safeguards
 - Location of active/inactive records
 - How records are accessed and by whom
- Record Retention Policy (include record destruction practices)
- Disaster Recovery Plan
- Emergency Operations Plan

Questions?

