Health Information Technology & Management

Chapter 4

ORGANIZATION, STORAGE, AND MANAGEMENT OF HEALTH RECORDS

BY : NOHA ALAGGAD

PAPER CHARTS

- Consist of one or more file folders containing handwritten notes, transcribed reports, test results, demographic information sheets, patient history forms, referral letters
- Also include The Health Insurance Portability and Accountability (HIPAA) authorizations, privacy notices, other documents signed by patient (in ambulatory setting)

PAPER RECORD STORAGE

- File folders with color coding and labels used to store paper documents.
- Metal filing cabinets or shelving units store file folders and require both floor and aisle الممر space within facility.
- Jackets, or large envelopes, store x-ray films and other radiology records; filed in separate filing location

STORAGE REQUIREMENTS

- Vary by type of filing unit selected
- Determined by OSHA Occupational Safety and Health Administration, which provides specifications for amount of space required for filing areas
  - Example: aisle between filing or shelving units must be at least 3 feet wide

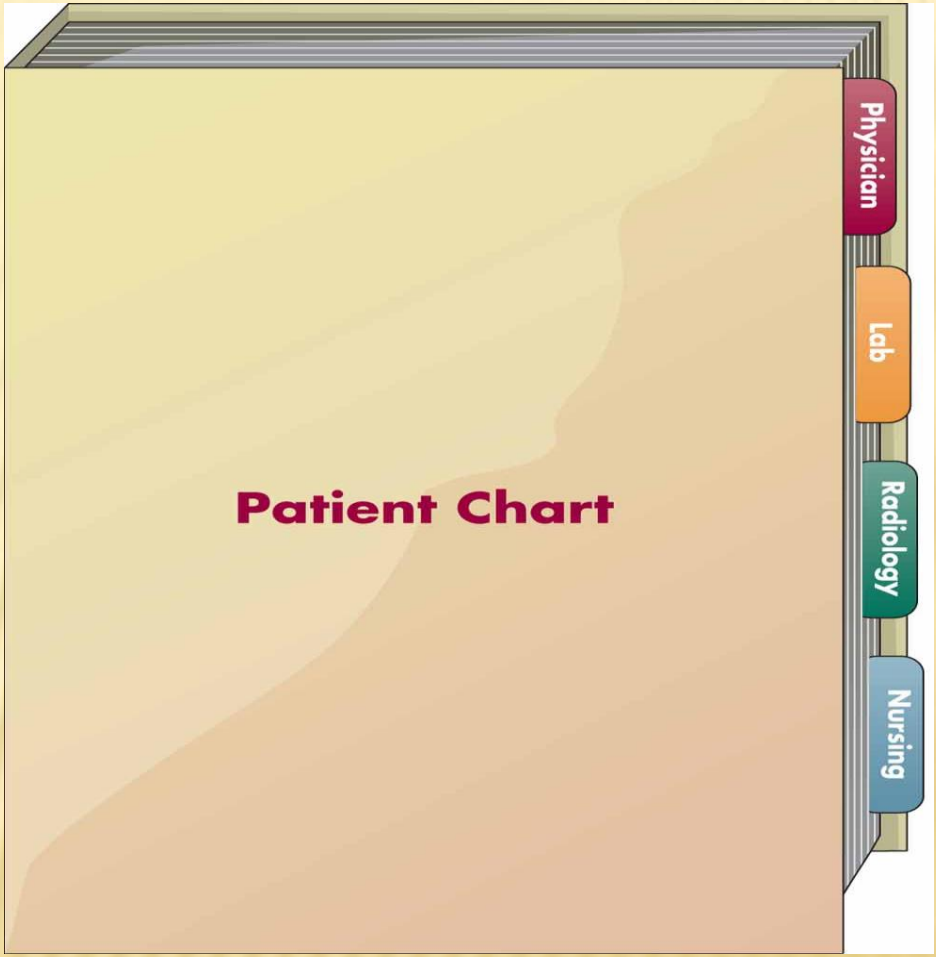
HOW PAPER CHARTS ARE ORGANIZED?

- There are several standard schemes for organizing a paper chart :
- 1. Source-oriented Record
- 2. Problem-Oriented Record
- 3. Integrated Record
- 4. Mixed Formats

SOURCE-ORIENTED RECORDS

- Organize contents according to document's source
- Separate sections by labeled dividers within folder
  - Example: physician notes grouped in one section, nursing notes in another, and so on
- Used more frequently in inpatient settings

SOURCE-ORIENTED RECORDS



SOURCE-ORIENTED RECORDS

PROBLEM-ORIENTED RECORDS

- Organize contents by diagnosis or medical problem
  - Example: patient with several chronic diseases will have separate sections of chart for each condition Includes problem list as index in front of chart

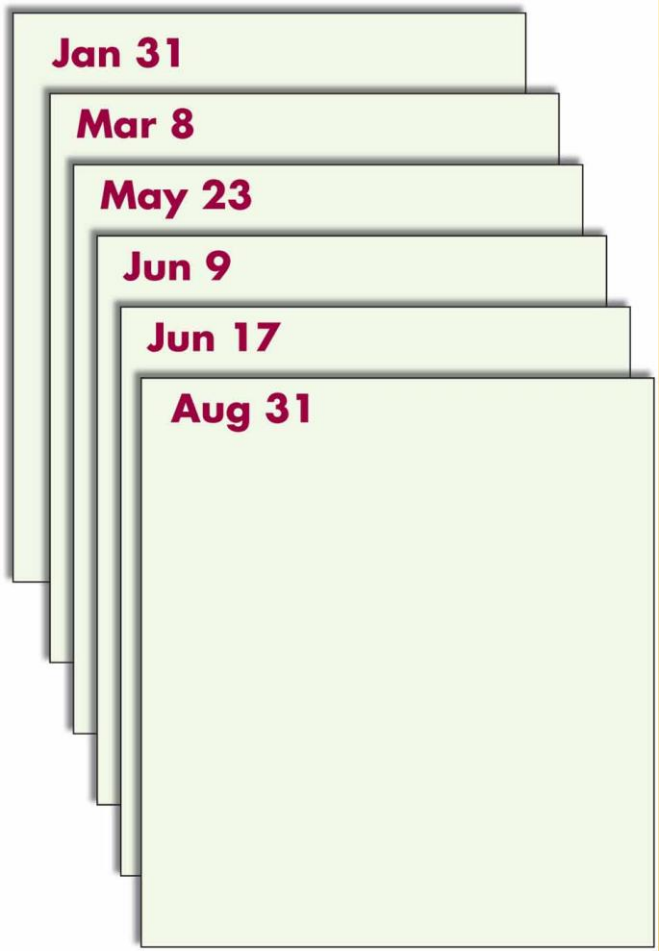
DIFFERENCES BETWEEN SOURCE ORIENTED RECORDS & PROBLEM ORIENTED RECORD

- In a SOMR or source oriented medical record, the record is kept together by subject matter (labs are all together, progress notes are all together).
- Progress notes in a SOMR are written in paragraph format
- In a POMR or problem oriented medical record, the record is kept together by problem number (a number is assigned to each problem.
- Progress notes in these records are kept in SOAP format.

INTEGRATED RECORDS

- Integrated health record format organizes all the paper forms in strict chronological order and mixes the forms created by different departments.
- Use reverse chronological order most frequently because it makes most recent information easier to view

INTEGRATED RECORDS



MIXED FORMATS

- Some inpatient facilities may use source-oriented method for overall chart, but organize one or more sections using integrated- or problem-oriented methods
  - Example: physician and ancillary therapy progress notes may be organized using integrated record
  - Examples: nursing notes may be organized using problem-oriented method

HYBRID HEALTH RECORD

- A hybrid health record is a patient health record that includes both paper and electronic documents, and uses both manual and electronic processes to access patient information.
- For example, dictation, lab, and x-ray results might be available electronically, whereas progress notes, provider information, and doctors' orders remain on paper. Other health information may be maintained on various other media types such as film, video, or an imaging system.

EHR FEATURES

- Not restricted by same organizational limitations as paper records because random access storage permits data to be displayed in many different ways
- Considered hybrid health record when portion of chart stored electronically and other portion on paper

FILING SYSTEM GOALS

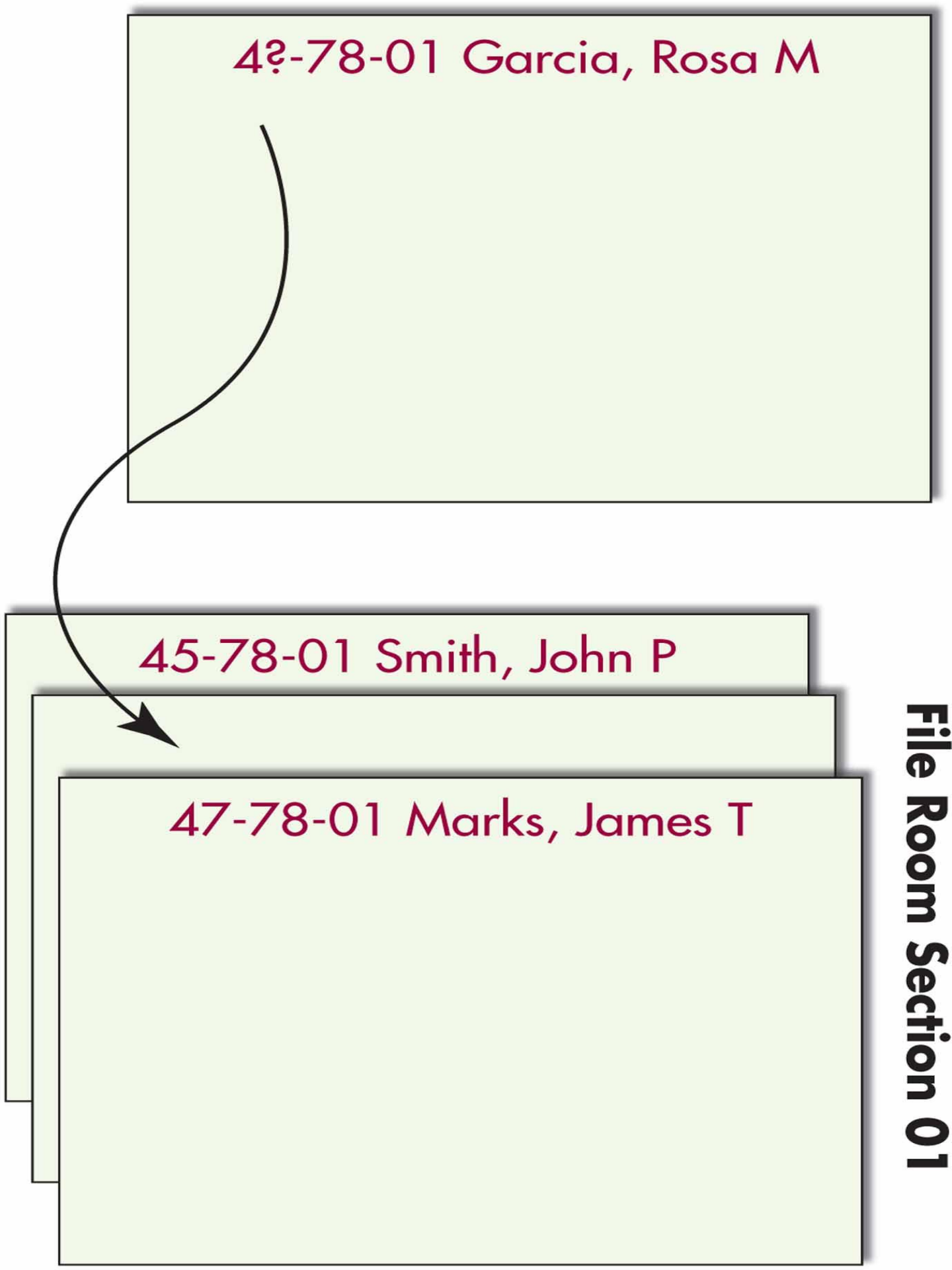
- Ensure files can be quickly located when needed
- Easily detect where charts are misfiled or missing
- Expedite daily retrieval and filing of charts
- Expansion of system can occur with minimal reorganization of files

TYPES OF FILING SYSTEMS

- Alphabetical filing
  - Uses patient's last name, first name, middle initial or name
- Alphanumeric filing
  - Combines both alphabetical and numeric filing by preceding record number with one or two letters of surname

TYPES OF FILING SYSTEMS

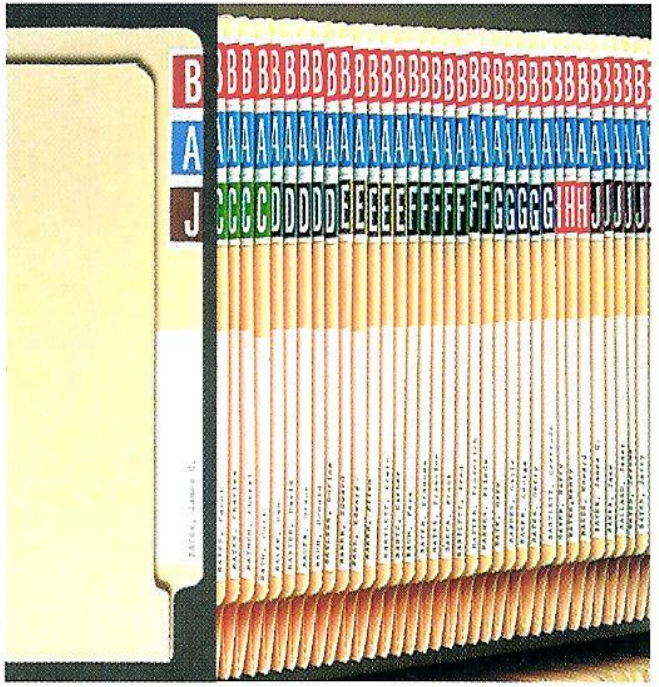
- Straight numeric filing
  - Assigns sequential medical record numbers to chart and files in ascending numeric order
- Terminal digit filing
  - Numeric system that uses last set of hyphenated record numbers (terminal digits) as primary set of numbers for filing purposes


4?-78-01 Garcia, Rosa M
45-78-01 Smith, John P
47-78-01 Marks, James T
File Room Section 01

TYPES OF FILING SYSTEMS

- Middle digit filing
  - Numeric system similar to terminal digit method but uses middle set of numbers as primary set for filing purposes

1



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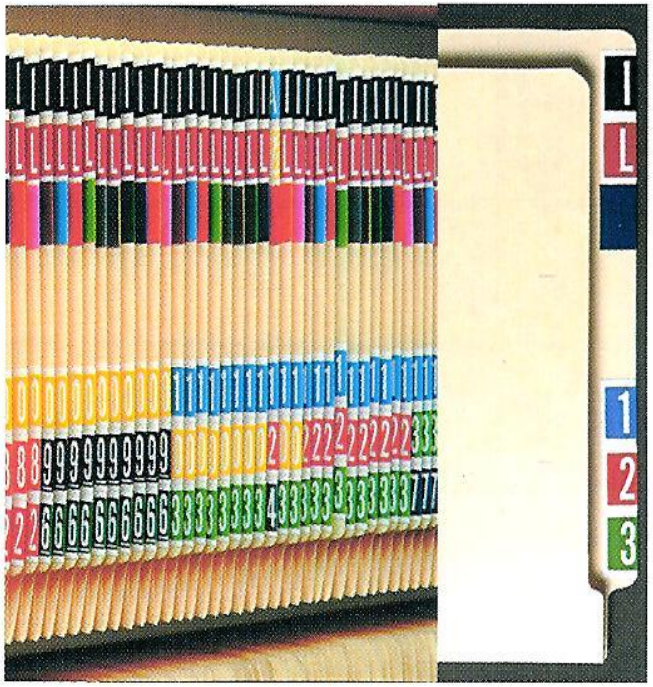

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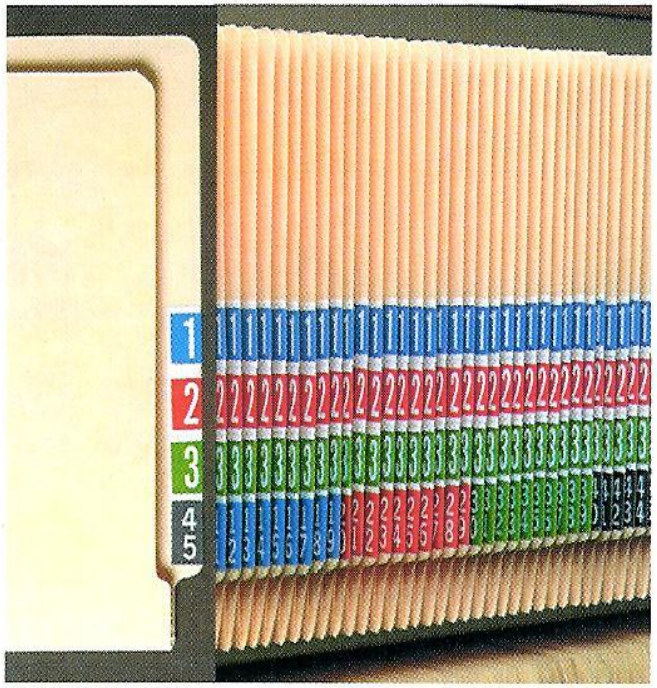

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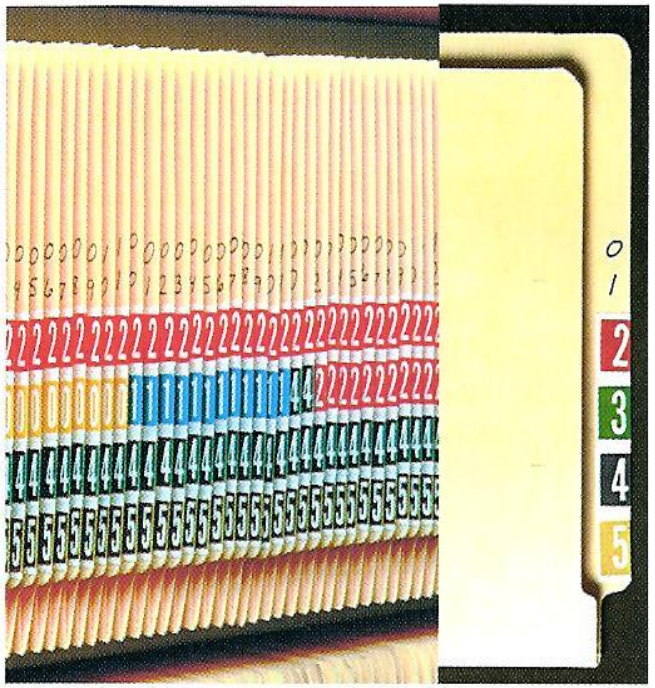

COLOR CODING OF CHART LABELS

- May be used for both alphabetical and numeric systems
- Includes different colored labels for different letters or numbers
- Helps identify incorrectly filed folder quickly

HIM RECORD CIRCULATION

- List of charts needed for day used to pull charts in advance
- Charts needed for unscheduled patients, emergency admissions, or walk-in patients requested verbally or via written form
- Paper or plastic *out guide* put in place of chart when chart is pulled


OUT
OUT
OUT
OUT
OUT

HIM RECORD CIRCULATION

- Charts batched together by provider or department, delivered to nurse or provider's staff
- New patient without chart is assigned medical record number, new folder created

HIM RECORD CIRCULATION

- Chart returned to chart room for filing when patient checks out or is discharged
  - Chart examined after patient's discharge to ensure all required documents present, complete, signed before being filed (acute care)
  - *Ambulatory care:* Chart filed immediately, then pulled and updated later as transcription, other documents arrive

CALCULATING PAPER RECORDS STORAGE

- Average inpatient stay chart contains 100 pages per AHIMA
- One hundred sheets of standard weight paper measures _ inch thick, plus 1/8 inch for manila folder
- 5/8 inch needed for each paper chart

CALCULATING PAPER RECORDS STORAGE

- Shelving unit for medical records that is 36 inches wide will have 34 inches of filing space per shelf
- Standard shelf depth 12 inches; shelving units usually have 6, 7, or 8 shelves spaced 10 inches apart

CALCULATING PAPER RECORDS STORAGE

- Therefore, based on this example, 36-inch-wide unit with 7 shelves can store 378 patient charts approximately
  - 200 units needed to store paper records for 75,000 patients

PAPER CHARTS WEIGHT

- 1 inch of charts weighs approximately 2.5 pounds
- For 34-inch shelves times 7 shelves, weight is 590 pounds
- Shelving unit with lockable doors weighs 210 pounds

PAPER CHARTS WEIGHT

- Total weight of each filled unit is 800 pounds
- Combined weight for 200 filled units is 80 tons

DOCUMENT IMAGING SYSTEMS

- Computer systems that scan and store images of paper documents
- Facilities use to complement EHR systems and replace/eliminate paper charts
- Scanned documents require cataloging, or entering data in computer about document

DOCUMENT IMAGING QUALITY CONTROL

- Necessary because original may be stored at remote location or shredded
- Lack of quality controls may cause improper batching, or document being cataloged as wrong type
  - May be missed by a provider or for billing purposes

ROLE OF HIM PROFESSIONAL

- Prep chart by examining pages, removing staples and paper clips, removing duplicate pages, replacing or manually scanning torn or damaged pages, ensuring documents assembled in correct order
- Check scanned images for quality

ROLE OF HIM PROFESSIONAL

- Verify cataloged information or enter it manually
- Return pages to chart, archive, or shred (depending on HIM department policy)

LEGAL MANAGEMENT OF HEALTH RECORDS

- Follows three-step process by HIM professional:
  - *Step 1:* Ensure all required information present; all required signatures obtained or authorized
  - *Step 2:* Prepare deficiency report and notify affected provider about missing, incomplete items
  - *Step 3:* Review file for completeness and file (paper chart)

RECORD RETENTION

- Patient health records must be retained by provider to meet regulatory and accreditation requirements
- Length of time varies by state law, contractual obligations, age of patient
- Facility's HIM policy determines

Sample Health Record Retention Schedule	
Hospital Health Information	**Recommended Retention Period**
Adult Patients' health records	10 years after the most recent encounter
Children's health records	10 years after child reaches the age of majority (or longer if required by state law)
Fetal heart monitor records	10 years after child reaches the age of majority (or longer if required by state law)
Registers of births and deaths	Permanently
Register of surgical procedures	Permanently
Master patient/person index	Permanently
Disease index	10 years
Comprehensive outpatient rehabilitation facilities (CORF)	5 years after patient discharge
Laboratory Pathology tests	10 years after date of results report
Diagnostic images (such as x-ray film)	5 years
Mammography	5 years if subsequent mammograms are performed on the patient at the facility 10 years if no additional mammograms are performed

RECORD DESTRUCTION

- May occur if healthcare organization has policy in place for records that have passed scheduled retention period or been converted to digital images or microfilm
- Usually done via shredding and/or incinerating
- Falls under purview of HIM department
- Also includes computers or disks that once held EPHI upon their disposal

OTHER HIM TASKS

- Managing release of information contained in health record:
  - Patient's authorization required, except for authorized government agencies
  - HIM professional ensures proper authorization documents signed, portions to disclose, track disclosures for at least 6 years

OTHER HIM TASKS

- Producing legal health records:
  - HIM departments should have written policy listing types of documents that constitute legal record, how copies are to be prepared when copies of patient's chart requested for use in legal matter

HIM ETHICS

- Professional standards by which HIM professionals conduct themselves called ethics
- Healthcare facilities create policies and procedures to provide guidance in care and handling of confidential records
- Code of ethics provides guidance in how to act in professional capacity, helps to guide those who create policies and procedures for facilities
- Review AHIMA Code of Ethics

Thank you