SPECIAL MEDICAL RECORDS TASK FORCE

FINAL REPORT

SEPTEMBER 7, 1989

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REPORT CONTENTS

INTRODUCTION

In May, 1989, Augusta Mental Health Institute Acting Superintendent, William Thompson, invited medical record representatives from the consortium hospitals to meet with him and discuss institutional medical record concerns. Specific problems were not stated at that time and the consortium members were asked to identify a problem list and develop a plan for corrective action. As a result of that meeting, a proposal (Appendix A) was developed for Mr. Thompson which identified specific goals, processes to be followed and the individuals from the consortium hospitals who would participate and contribute.

The first step in the process was a review of all of the recommendations from previous surveyors, followed by a meeting of the medical record consortium members to discuss a tentative plan of action to identify the problems. This was followed by an on-site visit to AMHI reviewing documentation, procedures, and discussing operations with key individuals. Appendix B is a profile of the Medical Record Department, as understood by this task force. Following this meeting, the group was able to identify three major problem areas and two committees were formed to develop recommendations.

MEDICAL RECORD DEPARTMENT FUNCTION AND ORGANIZATION

The committee on Medical Record Department Function and Organization reviewed the current AMHI Medical Record Department organizational structure, qualifications for medical record management positions, as well as current procedures in place within the Medical Record Department.

ASSESSMENT

1. There is a demonstrated need for a qualified credentialed medical record professional as Manager of Medical Records. Many of the procedural and organizational problems are a direct result from the lack of direction from a qualified medical record individual.

2. The current procedure for recording and monitoring record deficiencies was found to be incomplete, fragmented, inconsistent and repetitive.

3. DSM Coding is currently being performed by personnel outside of the Medical Record Department.

4. Abstracting of statistical data from patient records is not currently being performed by the Medical Record Department.

5. The current procedure for processing admissions is duplicative in nature. Original documents are removed upon admission and an abstract of information is placed on the current record because of lack of sufficient room on the nursing units for the entire medical record.

6. No productivity measures/standards have been developed in the Medical Record Department.

7. The transcription of clinical reports that become a permanent part of the medical record is decentralized throughout the institution. In addition, the equipment utilized for transcription is antiquated.

8. The Medical Record Department has been provided sufficient space to enable personnel to function in an efficient manner and to maintain medical records on all patients so that they are easily accessible.

RECOMMENDATIONS

1. Reorganize the Department of Medical Records under the direction of a qualified Manager of Medical Records, as illustrated in the Organizational Chart in Appendix C.

a. Identify the educational and experience requirements for departmental management positions (as defined in Appendix D).

b. Upgrade a current position into a Lead Transcriptionist position.

c. Redefine several departmental roles and perform a functional job analysis (FJA) on the following positions:
Manager of Medical Records
Medical Record Technician
Lead Transcriptionist
Transcriptionists (those individuals performing transcription duties)

d. A market analysis should be conducted outside of the State structure to determine a competitive wage for the positions listed above in item #2c.

3. Establish and document a detailed procedure for analyzing medical record deficiencies utilizing deficiency slips and tags. The implementation of this procedure may result in an increase in the number of incomplete records, since a detailed analysis in not currently being performed adequately.

Once a good manual system for record deficiency monitoring has been implemented, a stand-alone PC-based deficiency and record tracking system should be evaluated to assist in this process.

4. A minimal data base with basic medical statistical information should be developed, or the institution should subscribe to an outside abstracting service.

5. All diagnosis and/or procedure coding should be performed under the auspices of the Medical Record Department. If sufficient expertise does not currently exist in the Medical Record Department, training needs to be provided.

6. Establish productivity monitors and develop standards, specific references made to transcription services.

7. Centralize all medical transcription services within the institution.

a. The Medical Record Department should be responsible for the transcription of all clinical reports that become a permanent part of the medical record.

b. Develop a policy regarding individuals authorized to utilize transcription services.

8. Contact a vendor of transcription equipment and request a review of the transcription needs of the institution.

   a. The needs should include centralized dictation equipment with the capability of management reporting.

   b. Consideration should be given to evaluating the use of the second shift to optimize utilization of expensive equipment.

9. Evaluate word processing equipment for the Medical Record Department to increase productivity and assist in the monitoring of work loads

MEDICAL RECORD CONTENT

The committee on Medical Record Content reviewed issues concerning the the quality and completeness of medical record documentation, the role of the Medical Record Committee, and the development of a non-integrated medical record.

ASSESSMENT

1. Repetition of like documentation elements noted very frequently (e.g. typed "Admission Note" contains information reflected on the face sheet; a handwritten Treatment Plan and a typed Treatment Plan contain the information). Individuals from different disciplines document some of the same demographics reflected on face sheet and information contained in physician's History and Physical, and Admission Note. One of the primary purposes of the medical record is to serve as a communication tool among professionals. The very repetitious nature of the documentation encountered makes it difficult to quickly identify and follow the salient aspects of the patient's care, treatment, and reaction to treatment and progress.

2. Opportunity for 14 different disciplines to document sequentially on the Progress Notes causes difficulty in following the patient's progress from a given discipline's perspective; reaction to therapy, status regarding achieving Treatment Plan goals and progression toward discharge.

3. The separate medical and psychiatric discharge summaries create concern relative to continuity of patient care issues. This is evidenced by some medical conditions requiring follow-up at discharge which are <u>not</u> discovered until <u>after</u> discharge. In one case, the Axis I diagnosis reflected on the medical and psychiatric discharge summary, did not concur. This conflicting documentation gives rise to medicolegal concerns.

4. Organization of medical record information hinders effectiveness and usefulness of the medical record.

5. Review of "Policy 15. Patient Records," reveals this to be a good document for Medical Record Department reference; however, through the years, it appears people meet standards "by developing a form" (not assessing current forms and needs with modifications to satisfy requirements).

6. Duplication of information contained on forms was encountered.

7. Too many forms exist (there are approximately 209 forms) creating confusion regarding purpose and use.

8. The Patient Care Committee handles many significant functions and thus, it does not have sufficient time to adequately address Medical Record Committee functions.

9. Flow for the qualitative and quantitative process by Medical Record staff is handled by at least four individuals: while this provides for a "checks and balances" system, a more simplistic approach may improve efficiency. A formal mechanism is established to handle "Discharge Summary Process - Deficiencies". The Patient Care Coordinator's office performs a concurrent qualitative and quantitative analysis function which corrects many deficiencies well before the patient is discharged.

10. There is a monthly case presentation at the Clinical Case Conference; this focuses on case management issues and not peer review from a Medical Record Committee function. The Medical Record Department is required to make five copies of a record and forward these copies to appropriate parties - these copies are not returned.

11. Group consensus favors implementation of the non-integrated record.

    a. Organizational or system problems have, in the past, been addressed by development of new forms, when in reality the organizational/system issues need to be resolved.

    b. Disciplines are not departmentalized which causes lack of accountability, responsibility, and ownership when issues pertinent to medical record documentation arise (e.g. social workers, psychologists, etc. are directly accountable to the Unit Director).

    c. There appears to be "a lot of good minds with independent personalities" which has contributed to the current state of affairs. Focus should be on format, not forms (professional practice standards).

    d. Lack of Administration's delegation of authority/ responsibility/accountability has contributed to some of the medical record documentation issues.

e. Lack of proper training for ward clerks with vague job descriptions, in some instances ward clerks functioning as aids - thus, not able to perform duties associated with those of a ward clerk.

f. Team Conferences, in some areas of the hospital, are not conducted at regularly scheduled times, which affects documentation.

RECOMMENDATIONS

1. Identify and list all medical record requirements - JCAHO, Medicare's C.O.P., PRO, Medical Staff Rules and Regulations (as shown in Appendix E and F) and any other applicable regulatory agencies' standards.

2. Certain medical record documentation requirements cited in "Policy 15, Patient Records," should be incorporated into the Medical Staff Rules and Regulations. Specific reference is made regarding time-frames for completion of history & physicals, progress notes, treatment plans, orders, and discharge summaries. This would provide the necessary input from Medical Staff officers.

3. Implement documentation evaluation tools to assure required elements are documented to facilitate patient care.

4. Conversion to non-integrated record to decrease duplication of documentation and enhance the usefulness of the record.

5. Development of a formalized outpatient medical clinic record to facilitate appropriate provision of continuity of care. Concern is raised relative to ability of the medical clinic to provide adequate follow-up of patient's medical conditions, (e.g., Lab reports are difficult to locate; prior ECG's/X-Rays not readily available for comparison, interpretation capabilities).

6. Monitor adherence to regulatory agencies' documentation requirements.

7. Evaluation of each form with the goal to combine, delete and simplify information contained therein.

8. Solicit input from each user of a specific form endeavoring to consolidate information.

9. Establish a separate multi-disciplinary Medical Record Committee of the Medical Staff with representation from medical staff leadership (psychiatric and medical physicians), Medical Records Director, Administrative liaison, Nursing and Utilization Review (others, as necessary).

10. In order to comply with regulatory /accrediting agencies th Medical Record Committee should assume at least the following functions:

    a. Determine format of complete medical record, forms to be utilized in the record, data processing use (lab slips).
    Form analysis should include:
        Need for the form
        Who will use the form
        Place form will be used in (in the record proper or flow sheet on clipboard)
        When will the form be used
        Design to facilitate use

    b. Review records for timely completion, clinical pertinence, adequacy from a quality assessment perspective, and adequacy as a medicolegal document.

    c. Review of records to assure record contains results of all tests/therapies given and reflects patient's condition and progress during hospitalization.

    d. Monitor medical record compliance to all pertinent regulatory agencies' requirements.

    e. Monitor outpatient records for all above functions.

    f. Initiate monthly Medical Record Committee quantitative and qualitative analysis functions on a representative sample.

11. Medical Record Department staff should be given the authority and responsibility to conduct orientation for new members of Medical and Ancillary Staff and provide ongoing continuing education regarding documentation practices and requirements.

12. Develop policies and procedures to accomplish the functions of qualitative and quantitative analyses in a more streamlined fashion. Specific emphasis should be placed on medical record practice standards.

13 Recommend the current practice of providing copies of records for monthly Clinical Case Conference cease immediately for medicolegal implications; this practice also represents a costly one in terms of effective employee utilization and copying costs.

14. Recommend conversion to the non-integrated record to facilitate communication among staff and enhance patient care.

    a. Conversion to the non-integrated record with the Treatment Plan being the focal point supplemented by the required Team Meetings which would create one area in the record in which to view the patient holistically - supporting segregated portions of the record would support treatment at a given point.

    b. Development of a process of conversion with target dates for completion to accompany each phase.

    c. Once departmentalization of the disciplines is accomplished, assignment of responsibility regarding acceptable documentation guidelines/professional practice standards with monitoring by the Department Manager and the Medical Record Committee will be necessary.

    d. Establishment of strong educational programs to facilitate the conversion process.

    e. Medical Record Department should have input for training of ward clerks and unit secretaries, as well as input regarding these individuals' job descriptions as they relate to medical record functions.

    f. Ward clerks should be trained to perform concurrent medical record quantitative analysis.

FLOW OF ACTIVE MEDICAL RECORDS

The committee reviewing the Flow of Active Medical Records evaluated current procedures in place to assure the timely receipt of discharged medical records following discharge, daily census reconciliation procedures, and the movement of medical records throughout the facility.

ASSESSMENT

1. Definition of authority and accountability for all record maintenance functions on inhouse patients is lacking or absent.

    a. Daily census reconciliation is handled differently by all of the nursing units. This procedure is not perceived by unit personnel as being a critical function. Staff are not sufficiently trained/oriented on census reconciliation and ward clerks are not present on all shifts/units.

    b. Medical records of discharged patients are not routinely forwarded to Medical Records upon discharge or notification of convalescent status (C.S.) termination.

    c. Reports are not filed promptly on the record or consistently in the same location within the inhouse record.

2. The medical records of inhouse patients are not consistently accompanying patients as they move throughout the facility.

    a. Patients are seen in the medical clinic and returned back to their unit while the record remains in the clinic for documentation by clinic staff.

    b. Records are removed from nursing units and taken to private offices for review/charting.

RECOMMENDATIONS

1. Develop a consistent manual census reconciliation procedure.

    Since all discharges require a physician's order, incorporate the use of the multi-copy order sheet into the discharge procedure. Forward all copies of discharge

orders to one central location responsible for processing the discharge and update the manual census. This central location should be an area that is staffed 24 hours per day. This will eliminate the inconsistency among nursing units and will allow Medical Records to be aware of all discharges the day after they occur.

2. Incorporate the use of a clinic record to document treatment performed in the medical clinic. A multi-part form (or photocopies) is suggested, with the original document filed on the patient's inhouse record and the duplicate maintained by the medical clinic. This would eliminate the need for making progress note entries regarding all lab results as clinic lab copies would be maintained in the clinic record. This would also eliminate the need for the clinic to request the medical record from the unit whenever laboratory results are received.

APPENDIX A

AMHI
Proposed Plan for Addressing Medical Record Issues

Three primary areas of concern have been identified that demand immediate attention and resolution in order for Medical Record activities to improve. The absence of any strong effective leadership for the Medical Record Department Staff and for the medical record functions in the organization has resulted in many of the current departmental problems. The lack of any accurate daily census reconciliation activities hinders work flow and accountability within the Department. Also, the record content is duplicative, difficult to follow, thus is unable to serve its main purpose for being a communication tool for patient care.

The short term goals for each problem, suggestions for process, and the medical record practitioners who have agreed to assist are noted in the following summaries.

I. Medical Record Department Function and Organization

A. Goals

1. Recommend organizational restructure and management requirements for the Medical Record Department.

2. Review the following procedures and evaluate the potential for productivity standards:
   a. Record Deficiency Monitoring
   b. Record Location/Tracking
   c. Coding/Statistical Reporting
   d. Medical Record Department Admissions Processing

3. Review transcription services in terms of the following issues:
   a. Productivity Standards
   b. Centralized versus Decentralized Transcription Services
   c. Equipment Needs

B. Process

1. Redefine job description of Medical Record Director and Medical Record Technician by 8/1/89.

2. Review and recommend appropriate changes to Department procedures and work flow by 9/1/89.

3. Review and recommend appropriate changes to Transcription procedures and work flow by 9/21/89.

C. Consortium Team Members

1. Robert Bidwell, B.S., M.A., R.R.A., Director of Medical Record Services, Central Maine Medical Center.

2. Jennifer Lohnes, B.S., R.R.A., Manager of Medical Record Department, Mercy Hospital

3. Mary Ellen Mahoney, B.S., M.S., R.R.A., Director of Medical Record Services, Maine Medical Center

4. Susan Ouellette, B.S., R.R.A., Director of Medical Records, Kennebec Valley Medical Center

II. Record Content
(Issues concerning the medical records to be addressed: Completeness, Quality, Medical Record Committee, and Development of a non-integrated medical record)

A. Goals:

1. Recommend record content assessment to determine compliance with JCAHO standards, Medicare's COP, and Medical Staff Standards by July 19, 1989.

2. Recommend assessment of all forms contained in the record:
   a) Purpose
   b) Format (for efficiency and effectiveness)
   c) Duplication of information and forms by 7/19/89.

3. Recommend Medical Record Committee be an independent committee by 8/19/89.

4. Recommend assessment of current Medical Record Committee functions by 8/16/89.
   a) Qualitative analysis functions
   b) Quantitative analysis function

5. Recommend assessment of current Medical Record Staff procedures by 8/16/89.
   a) Qualitative analysis procedures
   b) Quantitative analysis procedures

6. Recommend conversion to non-integrated records to facilitate communication among staff by 10/19/89.

B. Process:

1. List JCAHO and Medical Staff Bylaws standards and review 10 records for compliance (this will identify the problematic areas) by 7/19/89.

2. Gather all forms presently utilized in the medical record and correlate with the Medical Record Manual by 7/12/89.

3. Identify core group of individuals to serve on an independent Medical Record Committee. Representation should include: Medical Staff leadership (psychiatric and medical physicians), Medical Record Director, Administrative Liaison, Nursing Liaison, PA, Nurse Practitioner and utilization review personnel, others as the need arises by 8/19/89.

4. Develop policies and procedures and forms to satisfy the qualitative and quantitative analysis functions and implement education sessions for committee by 8/19/89.

5. Develop procedures, policies and forms to satisfy the qualitative and quantitative analyses functions and implement educational sessions for medical record staff by 8/19/89. (NOTE: Meeting with Medical Record Staff to evaluate present evaluation process.)

6. Interview each professional discipline for feedback regarding conversion to non-integrated record by 9/16/89.

C. Consortium Team Members

1. Sharon E. King, A.A., A.R.T., C.P.Q.A., Director, Medical Review Services, Central Maine Medical Center

2. Linda Libby, A.R.T., Director of Medical Information Services Department, Mid-Maine Medical Center

III. Flow of Active Medical Records

A. Goals

1. Evaluate the timeliness of the receipt of discharged medical records in the Medical Record Department following discharge.

2. Investigate the movement/availability of medical records on patients throughout their hospitalization.

B. Process

1. Recommend changes to insure compliance of the current policy to deliver discharged records to Medical Records within 48 hours of discharge and/or death by 9/1/89.

2. Meet with key individuals within the institution to investigate and discuss daily reconciliation procedures currently in place and recommend appropriate changes by 8/1/89.

C. Consortium Team Members

1. Robert Bidwell, B.S., M.A., R.R.A., Director of Medical Record Services, Central Maine Medical Center.

2. Jennifer Lohnes, B.S., R.R.A., Manager of Medical Record Department, Mercy Hospital

3. Mary Ellen Mahoney, B.S., M.S., R.R.A., Director of Medical Record Services, Maine Medical Center

4. Susan Ouellette, B.S., R.R.A., Director of Medical Records, Kennebec Valley Medical Center

APPENDIX B

Augusta Mental Health Institute
Medical Records Department Profile

Facility Profile

AMHI is a 398 bed State psychiatric facility. The average daily census is approximately 370 with an average of approximately 100 discharges per month.

Medical Record Department Staffing

The Department is open to the public from 7:30 a.m. to 4:00 p.m., Monday through Friday and is directed by Lois Frost. Lois Frost is currently on medical leave and the Acting Director is Joan Moore. Neither the Director or Acting Director possess medical record credentials through the American Medical Record Association. There is one RRA within the Department functioning as a Medical Record Technician. The Medical Record Director reports to Richard Besson, Director of Hospital Services. The staffing in the Department is comprised of 8 FTEs performing transcription (in addition to handling court transcripts), 2 FTEs performing clerical functions, and 1 FTE coding. Two clerks in the Admission Office also report to the Director of Medical Records.

Numbering/Filing System

AMHI utilizes a dual numbering system. A unit number is assigned and utilized for billing; however, a unique new number is assigned with each subsequent hospitalization. The Department does utilize a serial unit filing system and medical record numbers are assigned by the Admitting Office (next sequential number). Since AMHI is a State institution, inactive medical records are forwarded to the State Archives and become the responsibility of the State Archivist. Within the Medical Record Department, thinned out portions of the inpatient record are maintained alphabetically until the patient is discharged. Following discharge they are processed and filed in open-shelf filing units, by the medical record number, in straight serial order. No color-coding is currently utilized.

Master Patient Index (MPI)

A new MPI card is generated with each admission. The basic information plus all past visits are recorded on the new admission/MPI card and the old card is placed in the old medical record. The MPI is maintained manually and includes inpatient visits only.

Admission/Discharge Procedure

Documents from previous admissions are pulled upon readmission and forwarded to the appropriate nursing unit. The old medical records are brought forward and assigned the new serial unit number. As patients are discharged from the facility, the Department of Evaluation is notified. Medical Records does not know that patients have been discharged unless they receive the record from the floor. Patients are routinely discharged and no one is notifying Medical Records.

Record Flow

Upon receipt of the medical record following discharge, the record is first forwarded to the Discharge Clerk. At that time, the thinned portions are merged with the discharge record and a brief analysis for missing documents is completed. The record is then forwarded to the Patient Care Coordinator (UR) and the record is reviewed by the PCC and Axis III of DSM is coded. The record is then forwarded back to the Medical Record Department and assigned to the physician extender, who is responsible for dictating a medical summary. Following completion of the Discharge Summary, the record is then forwarded to Admitting where the MPI cards are completed and the Office of Statistics is notified. The record then moves to the Discharge Clerk, followed by coding and finally back to the Patient Care Coordinator so that assigned ICD-9 codes can be entered into the computer for the billing system. The final step is the completion of the face sheet by the Medical Record Department .

Record Completion

Record deficiencies are maintained in the Department manually. Incomplete records are filed by nursing unit and a physician is given 30 days before a medical record is considered delinquent. No disciplinary action is taken for delinquent medical records. Pre-printed deficiency slips are not utilized in the Department and memos are sent to physicians notifying them of any missing signatures or incomplete documents. The Department maintains a tickler file that is a log by discharge date. The log is utilized to identify records that are incomplete for a particular physician. Incomplete/delinquent records are counted once a month and delinquency is based on 30 days from the day of discharge. It was very difficult to clearly identify the incomplete records for a given physician as a result of their tickler file being sequenced by discharge date.

Discharge analysis is performed in two steps. The initial analysis is done by the Discharge Clerk and the individual looks for the presence of certain forms and sends notices to physicians if those forms are missing. A second cursory analysis is performed again at the time that the record is coded.

Record Tracking

Record tracking is done manually through the use of a sign-out card system. Old records for all readmissions are routinely sent to the nursing units upon notification. As patients are transferred from one unit to another, the Medical Record Department is not notified of these changes and has no idea where the patients and/or the old medical records are currently located. Likewise, the Department is not notified of discharges, therefore, does not have the ability and knowledge to follow-up on records of discharged patients that are not received within the Department in a timely fashion.

Transcription

Transcription services are provided by the Medical Record Department utilizing desktop cassette units. An Admission Summary is dictated and completed within 24 hours of admission and subsequent 72 hour progress notes are also transcribed. The Medical Record Department is responsible for typing most of the transcribed reports that are found as a permanent part of the record including social assessments, physician extender notes, nursing notes, as well as typing for a patient advocate program. The Department maintains an extra copy of all dictations in the patient's record in case the original document is lost.

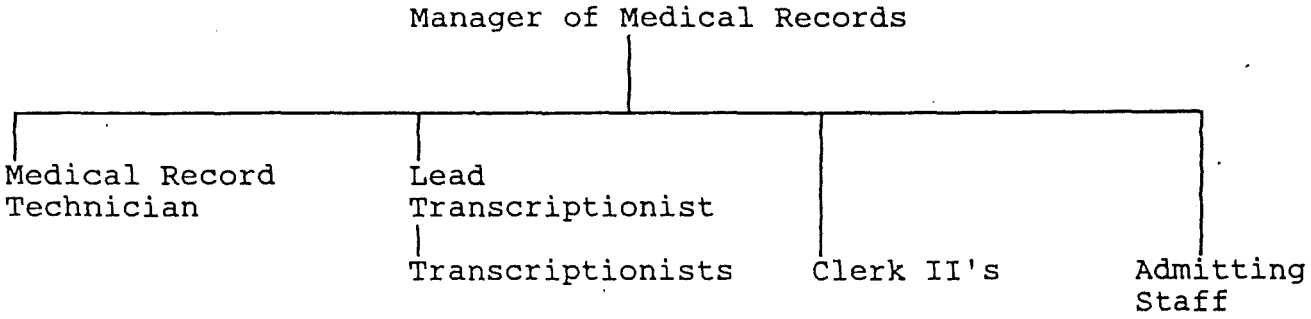
Abstracting/Coding

The Medical Record Department is responsible for coding inpatient discharges; however, no abstracting is performed. The Patient Care Coordinator (UR) also performs some of the coding, specifically Axis III of DSM coding. The Patient Care Coordinator is also responsible for entering codes into the billing system. The Billing Office requires codes within 15 days of discharge; however, the coding is not performed until the record has been completed by the appropriate physicians. Information is taken from the diagnostic sheet for the coding of medical problems.

APPENDIX C

AUGUSTA MENTAL HEALTH INSTITUTE
MEDICAL RECORDS

ORGANIZATIONAL CHART



APPENDIX D

JOB TITLE: Manager

DATE REVIEWED:_____

JOB DEFINITION

The manager of Medical Record Services will direct and maintain the operations of both the Medical Record Department and the Admission's Office. This position will manage the human, financial and material resources available in a manner that provides comprehensive, accurate and timely information on Augusta Mental Health Institute patients and the care they receive in conformity with accreditation, licensing and legal standards.

The Manager will work under the direct supervision of the Chief of Hospital Services.

QUALIFICATIONS: Certification from the American Medical Record Association as a Registered Record Administrator or an Accredited Record Technician. Must have three to five years of supervisory experience in a Medical Records Department. Strong communication and organizational skills required.

TASKS

1. Supervises daily operations of the Medical Record Department and the Admission's Office. Consistently monitors and documents staff performance to include annual performance appraisals.

2. Arranges for the hiring, training, and counseling of departmental employees. Conducts monthly meetings.

3. Demonstrates the ability to identify and resolve interpersonal conflicts constructively when dealing with department staff, medical staff and other institute personnel.

4. Insures timely and accurate provision of services through the operation of a departmental quality assurance program.

5. Sets and meets goals and objectives for the department.

6. Initiates policies and procedures for the department. Reviews and updates these at least annually.

7. Maintains ongoing fiscal awareness and budgetary limitations in the daily functioning of the departments.

8. Serves as a member of the Patient Care Evaluation and Record Committee. Participates in other committee/special task force functions, as assigned, relative to medical records and patient information systems.

9. Assures that records are reviewed for completeness and accuracy in conformance to standards as set forth by the Joint Commission on Accreditation for Healthcare Organizations, regulations associated with participation in the Medicare program and any applicable state licensing regulations.

10. Supervises the release of information from patient's medical records.

11. Teaches the Medical Record section of the basic nursing course.

12. Maintains an accurate clinical data base for use in research, reimbursement, and other statistical compilations.

13. Demonstrates current knowledge and practices in the Medical Record Profession. Assumes personal responsibility for professional development.

JOB TITLE: Medical Record Technician

JOB DEFINITION

The Medical Record Technician will assist in the management of the department. This position will maintain the statistical data base for the Institute, release patient information as authorized, serve on committees as assigned, and performs quality assurance reviews within the department.

This position will report to the Manager, Medical Record Services.

QUALIFICATIONS: Accredited Technician preferred. High school graduate plus two years Business, College, Nursing or Medical secretarial Department. Extensive knowledge of medical terminology, anatomy and physiology required.

TASKS

1. Maintains an accurate statistical data base for the institute by accurately coding and abstracting patient medical records. Keeps current on ICD-9-CM and DSM coding classification changes.

2. Insure timely and accurate completion and retrieval of patient records and information through performance of reviews as part of the departmental Quality Assurance program.

3. Releases information from patient's medical records and conformance with legal standards. Prepares abstracts of records as requested.

4. Serves as a member to the Patient Care Evaluation and Record Committee, and other committees as requested.

5. Reports cancer follow-up to the primary care provider and retrieves cancer research information.

6. Verifies discharges with charts received on a daily basis.

7. Assumes personal responsibility for professional development.

JOB TITLE: Lead Transcriptionist

DATE REVIEWED:_____

JOB DEFINITION

The Lead Transcriptionist of Medical Record Services will supervise the accurate and timely provision of transcribed reports as directed by members of the medical and ancillary staff.

The Lead Transcriptionist will work under the direct supervision of the Manager of Medical Record Services.

QUALIFICATIONS: High school graduate with 3 to 5 years experience as a medical transcriptionist

TASKS

1. Supervises the daily operations of the transcription function.
2. Assists in the selection and hiring of transcription staff.
3. Monitors the quality of transcribed reports routinely.
4. Assists in the development and monitoring of productivity standards.
5. Prepares staff schedule.
6. Acts as liaison between Medical Record Department and users of transcription services.
7. Transcribes dictated reports as necessary.

APPENDIX E

MEDICAL RECORD TEAM CONSORTIUM
AMHI REVIEW - 07/07/89

JCAHO CONTENT STANDARDS

Course of patient's medical evaluation treatment/changes during stay.

		Yes/No/Comments
I.	(MR 1.4) - Detailed and Organized to Enable:	
	A. Continuing care to be rendered.	
	B. Physician to determine patient's condition at any given specific time.	
	C. Review diagnostic/therapeutic procedures and patient's response to treatment.	
	D. Consultant to render opinion to exam of patient and record.	
	E. Another physician to assume care of patient at any time.	
	F. Retrieval of pertinent information required Utilization Review.	
	G. Retrieval of pertinent information required Quality Assurance.	
II.	(MR 1.5) - Unit Record is used.	
III.	(MR 1.6 - Information From Outside Sources Available to Reference.	
IV.	MR 1.7 - Standardized Format Utilized:	
	A. Approved by Medical Staff.	
	B. Quality Assurance (see Quality Assurance Section).	
V.	MR 2.1 - Medical Record Contains Following:	
	A. Identification Data:	
	Patient's Name	
	Address	
	Date of Birth	
	Next of Kin	
	Medical Record #	
	When not obtainable, reason recorded on MR	

B. Medical History:

Chief Complaint _____
Details of present illness _____
When appropriate, patient's emotional status _____
behavioral " _____
social " _____

Relevant past history _____
" social history _____
" family history _____
Inventory by body system _____
When possible, medical history obtainable from patient _____
Programs for children/adolescents:
Evaluation of developmental age factors _____
Consideration of educational needs (included as appropriate) _____
History should not include interviewer's opinion _____
Medical history done within 24 hours of admission _____
If complete history is done within 1 week PTA, durable copy may be in record if no subsequent changes or changes have been recorded with admissions. _____

C. Physical Examination:

Comprehensive current physical assessment _____
Done within 24 hours of admission _____
If complete history is done within 1 week PTA, durable copy may be in record if no subsequent changes have been recorded with admissions. _____
Signed by physician _____
For readmission within 30 days for same or related problem interval and physical exam reflecting subsequent changes may be used _____
Physical exam before surgery done _____
Statement of conclusions or impression drawn from admission history and physical exam. _____
Statement of course of action planned for patient _____

D. Physicians Orders:

Written by physician/or others with authority to do so _____
Verbal Order accepted and transcribed by qualified personnel _____
Above individuals identified by title or category _____
Medical Staff defines any category of diagnostic or therapeutic V.O. associated with any potential hazard to patient _____
Authentication within 24 hours _____

E. Evidence of appropriate informed consent:

When not obtainable, reason recorded in M.R. _____
Policy and Procedure re: informed consent _____
M.R. has informed consents for procedures/ treatments (per P & P) _____

F. Clinical observations:

Results of therapy _____
Pertinent chronological report of patient's course _____
Reflect change in condition _____
Results of treatment _____
Progress Notes made by those with clinical privileges _____

G. Reports of procedures, tests, results:

Recorded in the record and are signed _____
Reports from outside hospital may be included - Source identified _____
(Pg. 92) OR - pre-op diagnosis recorded prior to surgery _____
- OP report copy/signed _____
(Pg. 92) Path & Lab - (see Manual) _____

H. Consultations (exam of patient and M.R.): _____

I. Nursing Notes and entries by non-physicians contain:

Pertinent, meaningful observations _____

J. Autopsy done:

Provisional anatomic diagnosis recorded within 3 days _____
Complete protocol in record in 60 days _____

K. Sensitive portions of record kept elsewhere - note in record to alert authorized personnel _____

L. Conclusions at:

Termination of hospitalization _____
OR
Evaluation/Treatment _____
Provisional diagnosis or reason for admission _____
Principle and all other associates' relevant diagnosis _____

Clinical Resume _____
Significant findings _____
Treatment rendered _____
Condition of patient at discharge _____
(specific-measurable comparison with condition at admission) ("No - condition improved")
Instructions given to patient/family _____
Physical activity _____
Medication _____
Diet _____
Follow-up care _____
For pre-printed instructions given, record so indicates _____
Sample of above on file in M.R. Dept. at the time of its use _____
When appropriate, autopsy _____
Operative procedures performed _____
Final progress note for those less than 48 hours length of stay _____
Instructions to patient _____
For deaths - notes reason for admission _____
findings _____
course in hospital _____
events leading to death _____

Quality of Medical Record (timeliness, meaningfulness, authentication, legibility.

I. Entries authorized personnel: _____

Dated _____
Signed with professional discipline _____
(Use of rubber stamp) _____

II. PA's performing History and Physical Exam, signed by PA: _____

Authenticated by responsible physician _____

III. House staff/non physicians' notes, countersigned responsible physician _____

IV. Use of abbreviations (approved listing) _____

V. Typed entries _____

VI. Discharged records complete in 30 days _____

General observations regarding the content and quality of the medical records.

APPENDIX F

MEDICAL RECORD TEAM CONSORTIUM
AMHI REVIEW - 07/07/89

MEDICARE COP STANDARDS - PSYCHIATRIC RECORDS

	Yes/No/Comments
482.61 - Record must document degree and intensity of treatment provided.	
(a) Record contains assessment/diagnostic data - stressing psychiatric components -	
- History of findings	
- Treatment provided	
- Patient's legal status documented	
- Admitting diagnosis and inter-current diagnosis documented	
- Reason(s) for admission documented	
- Social Service notes include interviews with patient/family members/others	
- Assessment of home plans	
- Assessment of family attitudes	
- Assessment of community resources	
- Assessment of social history	
- When indicated, complete neurological exam done	
(b) Psychiatric evaluation done on each patient	
- Completed within 60 hours of admission	
- Includes medical history	
- Documents mental status	
- Notes onset of illness and circumstances leading to admission	
- Describes attitude and behavior	
- Estimates intellectual functioning,	
- Estimates intellectual memory	
- Estimates intellectual orientation	
- Inventory of patient's assets in description not interpretive	

Yes/No/Comments

(c) Treatment Plan (T.P.) _____

- Each patient has T.P. highlights strengths and weaknesses _____
- Includes substantiated diagnosis _____
- Short Term and Long Term goals _____
- Contains specific treatment modalities _____
- Identifies responsibilities of each member of treatment team _____
- Contains documentation to justify:
  * Diagnosis _____
  * Treatment _____
  * Rehabilitation activities carried out _____
- Treatment received by patient documented to reflect that all active therapeutic efforts are included _____

(d) Progress Notes (includes):

- By M.D./D.O., Nurse, Social Worker, Psychologist, etc.) _____
- At least weekly X 1st 2 months _____
- Monthly thereafter _____
- Contain recommendations for revisions in treatment plan _____
- Reflect precise assessment of patient's proper per treatment plan and revisions thereof _____

(e) Discharge Planning and Discharge Summary

- Above must be done on each patient _____
- Reflects recapitulation of patient's hospitalization _____
- Reflects recommendations re: follow-up or after care _____
- Reflects brief summary of patient's condition on discharge _____