

Appendix A: Internship Plan

North End Community Health Centre

Work Schedule for Saiful Kabir, Special Projects Person

Week no.	Dates	Activities
Week 1	May 5 - 9	<ul style="list-style-type: none"> ▪ Obtain clear understanding about the organizational culture, mission, vision and goals of NECHC ▪ Understand the medical data used in NECHC ▪ Understand the flow of information within NECHC ▪ Understand the policies and requirements of NECHC about medical record managing and archiving ▪ Literature search and research on medical record managing and archiving in Canada, Nova Scotia
Week 2	May 12 - 16	<ul style="list-style-type: none"> ▪ Understand the medical data used in NECHC ▪ Understand the flow of information within NECHC ▪ Understand the policies and requirements of NECHC about medical record managing and archiving ▪ Extensive Literature search and research on medical record managing and archiving in Canada, Nova Scotia ▪ Align the policies and requirements of NECHC about medical record managing and archiving
Week 3	May 19 - 23	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical record managing and archiving ▪ Develop guidelines for NECHC to manage and archive medical records
Week 4	May 26 - 30	<ul style="list-style-type: none"> ▪ Develop policies and guidelines for NECHC to manage and archive medical records ▪ Develop business model to support the guidelines
Week 5	June 2 - 6	<ul style="list-style-type: none"> ▪ Complete the guidelines and business model for NECHC to manage and archive medical records
Week 6	June 9 - 13	<ul style="list-style-type: none"> ▪ Become familiar with the existing electronic medical records program ▪ Understand the requirements from different users' perspectives
Week 7	June 16 - 20	<ul style="list-style-type: none"> ▪ Become proficient with the existing electronic medical records program ▪ Understand the data requirements from different users' perspectives
Week 8	June 23 - 27	<ul style="list-style-type: none"> ▪ Complete developing guidelines for the efficient use of the electronic medical records program

Week no.	Dates	Activities
Week 9	June 30 - July 4	<ul style="list-style-type: none"> ▪ Research and analyze the existing data used in the chronic disease management services at NECHC ▪ Research on existing other models used in the chronic disease management services
Week 10	July 7 - 11	<ul style="list-style-type: none"> ▪ Research on existing other models used in the chronic disease management services ▪ Develop models to assist NECHC to evaluate current chronic disease program
Week 11	July 14 - 18	<ul style="list-style-type: none"> ▪ Complete developing models to evaluate current chronic disease program ▪ Develop primary healthcare programs to address the models
Week 12	July 21 - 25	<ul style="list-style-type: none"> ▪ Complete developing the primary healthcare programs ▪ Become familiar with the current shared medical appointment system ▪ Understand the current and required information flow within the system
Week 13	July 28 - Aug 1	<ul style="list-style-type: none"> ▪ Work with other staffs to evaluate the system ▪ Provide recommendations to increase the efficiency of the system

North End Community Health Centre

Work Schedule for Saiful Kabir, Special Projects Person *(updated on June 23, 2008)*

Week no.	Dates	Activities
Week 1	May 5 - 9	<ul style="list-style-type: none"> ▪ Obtain clear understanding about the organizational culture, mission, vision and goals of NECHC ▪ Understand the medical data used in NECHC ▪ Understand the flow of information within NECHC ▪ Understand the policies and requirements of NECHC about medical record managing and archiving ▪ Literature search and research on medical/dental record managing and archiving in Canada, Nova Scotia and similar healthcare facilities
Week 2	May 12 - 16	<ul style="list-style-type: none"> ▪ Understand the medical data used in NECHC ▪ Understand the flow of information within NECHC ▪ Understand the policies and requirements of NECHC about medical record managing and archiving ▪ Extensive Literature search and research on medical record managing and archiving in Canada, Nova Scotia and other healthcare facilities ▪ Align the policies and requirements of NECHC about medical/dental record managing and archiving
Week 3	May 19 - 23	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical/dental record managing and archiving ▪ Develop guidelines for NECHC to manage and archive medical/dental records
Week 4	May 26 - 30	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical record managing and archiving ▪ Develop policies and guidelines for NECHC to manage and archive medical/dental records
Week 5	June 2 - 6	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical record managing and archiving ▪ Develop policies and guidelines for NECHC to manage and archive medical/dental records
Week 6	June 9 - 13	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical record managing and archiving ▪ Develop policies and guidelines for NECHC to manage and archive medical/dental records
Week 7	June 16 - 20	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical record managing and archiving ▪ Develop policies and guidelines for NECHC to manage and archive medical/dental records

Week no.	Dates	Activities
Week 8	June 23 - 27	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical record managing and archiving ▪ Develop policies and guidelines for NECHC to manage and archive medical/dental records
Week 9	June 30 - July 4	<ul style="list-style-type: none"> ▪ Align the policies and requirements of NECHC about medical record managing and archiving ▪ Develop policies and guidelines for NECHC to manage and archive medical/dental records
Week 10	July 7 - 11	<ul style="list-style-type: none"> ▪ Complete the guidelines for NECHC to manage and archive medical/dental records ▪ Develop business model to support the guidelines
Week 11	July 14 - 18	<ul style="list-style-type: none"> ▪ Complete the business model to support the guidelines
Week 12	July 21 - 25	<ul style="list-style-type: none"> ▪ Become familiar with the current shared medical appointment system ▪ Understand the current and required information flow within the system ▪ Work with other staff to evaluate the system ▪ Provide recommendations to increase the efficiency of the system
Week 13	July 28 - Aug 1	<ul style="list-style-type: none"> ▪ Become familiar with the existing electronic medical records program (PHIM) ▪ Understand the current and required information flow within the system ▪ Understand the requirements from different users' perspectives ▪ Provide suggestions for the efficient use of the electronic medical records program

Appendix B: Sample Meeting Agenda and Minutes

Issues for meeting 1

Finalizing weekly meeting time

Duration

Focus on the project

Archiving or managing

Paper-based files or both paper-based and electronic

Standards

Local

Global

Relocation

Moving plan

Archiving vendor

File access policies

File management policies

Barriers in moving towards paperless system

Data Requirements

Components of Business Model

Preferred direction

NORX END COMMUNITY HEALTH CENTRE

Meeting 1

May 12, 2008

9:30 – 10:30 a.m.

MEETING MINUTES

Project Members Present

Sharon Lawlor, Health Team Manager
Saiful Kabir, Special Projects Person

Purpose of the Meeting

- Clarify the project scopes
- Discuss current progress
- Discuss future directions

Meeting Notes, Decisions, Issues

- Weekly meeting time
 - Tentative weekly meeting times has been set
- Focus of the project
 - Focus of the project will be on managing the paper-based files
- Scope of the project
 - Policies and guidelines for maintaining (retaining and disposing) the medical records of NECHC according the federal and provincial guidelines
- Tasks involved
 - Understanding the policies and requirements of NECHC
 - Literature search
 - Federal, provincial and organization-specific (hospital, clinic and CHC) information analysis
 - Contacting people from different organizations for suggestions and resources
 - Developing guidelines for NECHC
 - How to retain older files
 - Separate dental files
 - Ensure proper storage and access of immunization records
 - ...
- File Access policies
 - Who should have access
 - What should be accessed
 - Moving files from the office (SUBPOENA)

- Components of Business Model
 - Recommendations about what needs to be done
 - Timeline
 - Action steps
 - Cost
 - Cost comparison of keeping the medical records in NECHC and storing them in some other place
 - Risk Analysis

- Archiving concerns
 - Fire-proof Storage
 - Degrees of fire-proofing
 - Locked metal file cabinets
 - Locked doors
 - ...

- Archiving vendor concerns
 - Cost analysis
 - Identify potential service providers
 - Check their service options
 - Practicality

- Potential contact persons from QEII, IWK, Doctors NS, SWCHC has been identified and some of them are already contacted

- Tina and Dr. Glenn will be contacted after initial findings

Action Items

Action	Assigned to	Due date	Status
Contacting potential persons in different organizations for information	Saiful Sharon	ASAP	Open
Summarize findings from the reference documents	Saiful	20-05-2008	Open
Outline first draft of guidelines for NECHC	Saiful	27-05-2008	Open

Next Meeting

Tuesday, May 20, 2008 at 4:00 p.m.

Meeting Adjourned

10:20 a.m.

Issues for meeting 9

Discuss current status of the project

Discuss information received from Iron Mountain

Updates from potential contact places:

IWK

MOH

CDHA

Discuss outline of the drafts

Discuss the components of the Information Access Policy

Other issues

Notes

North End Community Health Centre
Meeting 9
June 27, 2008
11:00 a.m. – 12:00 p.m.

MEETING MINUTES

Project Members Present

Sharon Lawlor, Health Team Manager
Saiful Kabir, Special Projects Person

Purpose of the Meeting

- Discuss current progress
- Discuss the draft policies for NECHC
- Discuss future directions

Meeting Notes, Decisions, Issues

- Progress of the work and further potential source of information were discussed
- Information received from Susan was discussed earlier
- Information received from SWCHC was discussed
- Information received from Iron Mountain was discussed. Saiful will book an appointment with Kevin to have him visit NECHC and provide initial estimates
- Sharon will send her schedule to Saiful for booking the appointment with Kevin
- Sharon is yet to hear back from Donna. Dorothy is expected to contact her
- Saiful will ask Dorothy to look for the information access policy of IWK when she contacts Donna
- Saiful is yet to reach Shawna at CDHA. He will call her again
- Glenn does not have anything for Saiful to do in PHIM at this moment
- Jessie has some work for Saiful to do with the shared medical appointment system. Saiful will work on evaluating the system. Jessie would discuss this in detail with Saiful when she has time
- Sharon will send the previous evaluation of the shared medical appointment system to Saiful
- Saiful has consulted Ronita regarding the dental files. Information received from her was discussed

- Saiful has consulted Tina once again regarding the medical records
- Saiful will look for more information from front desk about patient registers and patient index, and medical file management practice in front desk and get their feedback
- Saiful will consult some doctors and nurse practitioners about how they manage medical records in their office and get their feedback
- Saiful will add an Acknowledgement section in the draft policies and continue writing and updating them

Action Items

Action	Assigned to	Due date	Status
Contact potential persons in different organizations for information	Saiful Sharon	ASAP	Ongoing
Consult the components, integration and access policies of the medical records with required persons in NECHC	Saiful	-	Ongoing
Outline first draft of guidelines for NECHC	Saiful	-	Ongoing

Next Meeting

Monday, July 7, 2008 at 1:00 p.m.

Meeting Adjourned

12:05 p.m.

Appendix C: Developed Policies



North End Community Health Centre

HEALTH ADMINISTRATION POLICY & PROCEDURE MANUAL

TITLE: Release of Information from Health Records	Policy No:
Target Audience: All staff	Date Initiated: Review Date:
Category: Health Administration	Approved by:

POLICY

1. All information contained in the health records must be kept confidential but may be released under certain conditions as outlined in this policy.
2. The original health record is not to be removed from the facility except when required by court order and only in the custody of the Health Team Manager or his/her delegate.
3. Disclosure of confidential health information is only appropriate in the following circumstances:
 - a) With the authorization of the person or patient concerned. All authorizations expire after 6 months, unless the patient notifies NECHC in writing that he/she has withdrawn the authorization;
 - b) In the case of a person who is not capable of authorizing such disclosure, by authorization of his/her surrogate as defined in this Policy. All authorizations expire after 6 months, unless the surrogate notifies NECHC in writing that he/she has withdrawn the authorization;
 - c) To a person on the staff of NECHC for hospital or medical purposes;
 - d) To a qualified medical practitioner designated by the person as his/her physician;
 - e) From one hospital or healthcare facility to another;
 - f) To a person authorized by court order or subpoena;
 - g) To health auditors;

- h) To insurance companies;
 - i) To a person or agency otherwise authorized by law such as Workers' Compensation; or,
 - j) Various Government Departments (Including the Department of Community Services); and,
 - k) To the Minister of Health or any person or agency designated or authorized by the Minister.
4. All incoming requests for release of information from the health record (by the patient, a third party, or for the purposes of ongoing care) are to be referred to the Health Team Manager or his/her designate. If the patient/client is undergoing care at the time of the request, and if the request is for the purpose of ongoing care, the request may be processed by the health care provider.
 5. Nothing in this policy prevents NECHC or a qualified medical practitioner from refusing to release health information if there are reasonable grounds to believe it would not be in the best interest of the patient to disclose the information.
 6. If the Health Team Manager or the medical practitioner refuses to disclose the information, the person requesting records may apply for a court order. On receipt of a court order, Health Team Manager or his/her delegate must disclose the information specified in the order to the court or to the person to whom the order was granted.
 7. Third party requestors will be encouraged to use the approved NECHC Authorization for *Release of Information from Health Record* form (form no. 08-002). This will be at the discretion of the person(s) responsible for Release of Health Information in the facility where the request originated.
 - 7.1. If the approved NECHC Authorization for the *Release of Information* form is not used, Procedure section 4 on page 11 will be relied on to ensure a valid authorization exists.
 - 7.2. All authorizations expire after 6 months and must be re-obtained.

GUIDING PRINCIPLES

1. To promote proper methodologies for release of information from health records.
2. All related acts and legal guidelines are to be reviewed.
3. Appropriate consultations will occur with other federal/provincial/regional organizations and medical centers.

DEFINITIONS

Attending Physician is the medical staff member who has overall responsibility for the patient's/client's care.

Common law partners means persons who have been living together in a marriage-like relationship for at least 2 years, and includes same sex couples.

Domestic partners mean persons who have registered as domestic partners under the *Vital Statistics Act*.

Healthcare provider means the professionals who are providing care to the patients.

Health/medical record/information consists of patient related information those are required for the healthcare of the patients. These are legal documents which include both paper-based and electronic information.

Next-of-kin means the spouse or blood relative named on the health record.

Staff: the employees of NECHC (including work placements) whose job or portion of job includes providing healthcare and related services.

Spouse means legally married spouse, common law partner or domestic partner.

Surrogate means the person authorized by law to act on behalf of a patient who does not have capacity to make his/her own health decisions and includes:

- the person who has been appointed by the court to be the patient's/client's legal guardian (the executor/administrator of the estate, if one exists, will be the surrogate in case of a deceased patient);
- but if none exists, the patient's/client's spouse;
- but if none exists, the patient's/client's next of kin;
- but if none exists, the Public Trustee;

Third party request means a request for information from the health record other than a request for the purpose of ongoing care.

PROCEDURE

1. INTERNAL RELEASE

- 1.1. Health information is available to the NECHC healthcare team members as required in the performance of their duties relating to patient care and on a “need to know” basis.
- 1.2. The patient’s/client’s authorization is not required for release of health information to a staff of NECHC for medical purposes or to a qualified medical practitioner designated by the person as his/her physician.
- 1.3. The healthcare provider, unless otherwise stated, may review the health record of a family member of his/her patient to enable management of the ongoing care of his/her patient. In this instance, the consent of the family member is not required, but the information on the health record of the family member must not be shared with the patient.

2. EXTERNAL RELEASE

2.1. Record of Release

- 2.1.1. A record of all information released externally is filed on the patient’s/client’s health record. Such record will include:
 - a) The request and authorization;
 - b) A list of specific documents sent/shown;
 - c) A list of parties to whom documents were sent/shown;
 - d) The signature of the person who filled the request; and,
 - e) The date the information was released.
- 2.1.2. The *Release of Information from Health Record* form (form no. 08-002) or *Request to Access / Review Medical Information* form (form no. 08-003) should be used to record all the release of information from health records.

2.2. Release for the Purpose of Ongoing Care

- 2.2.1. Requests for information required for patient care from the qualified medical practitioner designated by the patient as his/her physician or from a hospital where the patient is currently being treated do not require authorization from the patient. All other requests for health information require the patient/client’s authorization. Verbal authorization is sufficient, but must be documented on the health record.

2.2.2. Written requests for release of information for ongoing patient care are accepted in person, through the mail or via facsimile.

2.2.2.1. Written requests must be on the letterhead of the physician, facility, organization or program. A facsimile form is acceptable if information relating to the practice, facility, organization or program is noted on the form (i.e. medical practice or hospital name, requesting physician's full name, address, telephone and facsimile numbers). Requests received via facsimile will be considered an original document and filed on the patient's health record.

2.2.2.2. The request must contain the following information in order to allow Staff or health care providers to process the request and to prioritize all requests according to need:

- a) Full name of the patient;
- b) Date of birth;
- c) Health care number and province;
- d) Specific information required; and,
- e) Purpose of the request.

2.2.2.3. Transmission of the record via fax is only permitted when the health record is required on an urgent basis for ongoing care.

2.2.2.4. To ensure the security of the information sent via fax, the transmittal is prefaced with a completed, approved fax transmittal form. Confirmation of the completed transmission is obtained via the fax transmission report produced automatically by the fax machine or by placing a follow-up telephone call to the intended recipient. Senders are required to take the utmost care to ensure the accuracy of the fax number dialed.

2.2.2.5. In all non-urgent cases, copies of the health record are transmitted via sealed envelope following routine mailing procedures. The envelope should be marked as "confidential." To ensure that the mail has been received by the intended receiver or his/her delegate, the sender should validate the receipt.

2.2.3. Telephone requests for release of information to a physician, facility, organization or program for the purposes of ongoing patient care may be accepted only when required on an urgent basis for ongoing care.

2.2.3.1. Any Staff or health care provider receiving a telephone request for release of information must continue with the telephone conversation in presence of at least one more staff (who will be the witness of the request), complete the verbal request for *Release of Information from*

Health Record form (form no. 08-002), and forward the complete form to the appropriate Staff for processing the request immediately.

2.2.3.2. Responses to urgent requests may be released by facsimile. Release of information from patients' health records should be recorded in their charts.

2.2.4. If a patient is referred to a specialist or some other healthcare facilities, the reason for referral should be clearly stated while sharing only the information required for the treatment of the patient.

2.3. Release to Patient/client or surrogate

2.3.1. Patients/clients must put their requests in writing using the *Request to Access / Review Medical Information* form (form no. 08-003), indicating whether an on-site review of the record or a copy of the record is desired. The request will be on an Authorization for Release of Health Information form.

2.3.2. Where the patient is not capable to make his/her own health care decisions, the patient's/client's surrogate may request access.

2.3.3. Prior to releasing any information to the patient/client or surrogate, staff will notify the attending physician / nurse practitioner and the Health Team Manager.

2.3.4. If the physician has not objected in writing to the release within 7 days, it will be assumed that he/she has no objection to the release and the release will be processed. The attending physician / nurse practitioner may discuss the matter with the Health Team Manager.

Exception: Written authorization for release of a mental health record must be obtained from the attending psychiatrist, the psychiatrist who most recently provided care, or the Health Team Manager if the psychiatrist who most recently provided care is no longer with NECHC, before the psychiatry record will be released.

2.3.5. If the attending physician / nurse practitioner, or the Health Team Manager, feels there is a risk to the patient/client or a third party that would arise from the release of the information contained in the health record, he/she must provide a written declaration to that effect, which is to be kept in the patient's file. The staff, who has received the request for release of information, will notify the patient/client or surrogate about the status of the request. If the patient/client or surrogate still wants to access the health record, he/she may apply for a court order to grant access.

2.3.6. If there is no objection to the patient/client or surrogate accessing the information in the health record, staff will arrange an appointment for the patient/client or surrogate to view the record or make copies as requested.

2.3.7. If the request is for an on-site review of the record, it will be under the supervision of a medical staff. If the request is for a copy of the record, fees may be charged.

2.4. Release to Family Members, Person with Enduring Power of Attorney or the Executor of a Deceased's Estate

2.4.1. A family member (including a physician who is related to the patient) may only access the patient's/client's health record after obtaining the patient's/client's/surrogate's written authorization to do so. The *Request to Access / Review Medical Information* form (form no. 08-003) should be filled out by the requesting person.

2.4.2. If the appropriate authorization is granted (dated not more than 6 months prior to the request for the information) and the request is for an on-site review of the record, the review will be under the supervision of a medical staff, and if the request is for a copy of the record, fees may be charged.

2.4.3. Executors of an estate must provide a probated will or enduring power of attorney as proof of their authority to have access to any information from the patient record.

2.5. Release to Law Enforcement Agencies

2.5.1. With the exception of the office of the Medical Examiner, a signed authorization for release of information of the patient/client or surrogate (dated not more than 6 months prior to the request for information) must be produced before information will be released.

2.5.1.1. Requests received via facsimile will be considered an original document and filed on the patient's health record.

2.5.1.2. The Medical Examiner is entitled to a copy of the health record under the *Fatal Investigations Act*. The authorization of the patient/client or surrogate is not required.

2.5.2. In the absence of patient/client or surrogate authorization, a search warrant is required to obtain information from the health record (see Procedure Section 2.6 for more information).

- 2.5.3. Requests from law enforcement officers for non-medical patient information (e.g. contact information, addresses) may be referred to / discussed with the Health Team Manager. In both the cases, the request for information (including the information of the requesting person and the rationale of the request) and result of the request (i.e., if information was revealed or not, and if yes, then what information was revealed) is filed with the patient's medical record.
- 2.5.4. Only information designated on the authorization form or search warrant will be copied and released to the law enforcement officer.
- 2.5.5. In the case of a sexual assault, the police provide a Forensic Report form to the attending healthcare provider. The completed original is returned to the police and a copy is kept for filing.
- 2.5.5.1. For a law enforcement officer to obtain any further medical records related to the sexual assault, he/she must provide written patient authorization or, a subpoena, or a search warrant.
- 2.5.6. A processing and/or photocopying fee may be applied.

2.6. Release Arising from a Search Warrant

- 2.6.1. In the absence of a written authorization from the patient/client or surrogate, (see Procedure section 2.5) a law enforcement officer must provide a search warrant to obtain information from the health record.
- 2.6.2. A search warrant is an order authorizing the search and seizure of the items specified on the warrant. The search warrant must be addressed to and served on the attending healthcare practitioner. The healthcare practitioner may notify and review the matter with the Health Team Manager.
- 2.6.2.1. Only documents specifically mentioned in the search warrant will be copied and, depending on the wording of the search warrant, either the copy or the original will be released to the person named on the warrant.
- 2.6.2.2. The information on the search warrant must be carefully checked to ensure validity (date, time etc.). If there is any doubt as to the validity, the Health Team Manager should be contacted.
- 2.6.3. A processing and/or photocopying fee may be applied.

2.7. Release Arising from a Court Order

2.7.1. Subpoena/Summons

2.7.1.1. Subpoenas/Summons are documents requiring an appearance in court. They often require the person named on the document to take the health record to court with him/her.

2.7.1.2. Under the Nova Scotia Rules of Court, only the custodian of the record can appear in court with the record. For NECHC, the custodian of the record is the Health Team Manager or his/her delegate. Therefore, all subpoenas/summons requiring an appearance in court with a health record must be addressed to and served on the Health Team Manager or his/her delegate.

2.7.1.2.1. If the person named on the document is not the custodian of the record, he/she must notify the Health Team Manager immediately.

2.7.1.3. The subpoenaed or summoned record will be photocopied in its entirety to the date specified in the subpoena/summons.

2.7.1.4. An administrative and/or processing and/or photocopying fee may be applied.

2.7.2. Order for Production

2.7.2.1. The Order for Production must be addressed to and served on the Health Team Manager or his/her delegate. She/he will consult with the attending physician / nurse practitioner / psychiatrist or anybody else relevant to the patient's health care, as necessary.

2.7.2.2. The record that is the subject of the Order for Production will be photocopied in its entirety, to the date specified in the Order. Third party information will be removed from the copy before forwarding to the person/agency named on the Order.

2.7.2.3. An administrative and/or processing and/or photocopying fee may be applied.

2.8. Release Arising from a Notice of Examination/Discovery

- 2.8.1. The Health Team Manager should be notified immediately upon receipt of Notice for Examination or a Notice of Discovery. As this Notice is not an Order of the Court, release of the health record without patient authorization or a court order is not permitted. The Health Team Manager will communicate this to the requestor.
- 2.8.2. The person named on the Notice shall attend the Discovery, but shall not release any health information without the written authorization of the patient.
- 2.8.3. An administrative and/or processing and/or photocopying fee may be applied.

2.9. Release to Law Offices

- 2.9.1. Law offices must request information in writing on their letterhead. The Authorization for *Release of Information* form must accompany the request.
- 2.9.3. A lawyer is permitted to view records for which authorization has been received, with an appointment and under the supervision of a NECHC staff.
- 2.9.4. When such information is shared with a lawyer, consultation should take place with the Health Team Manager or his/her delegate.
- 2.9.5. An administrative and/or processing and/or photocopying fee may be applied.

2.10. Release to Insurance Companies

- 2.10.1. When a client indicates that he or she is a subscriber to a Health Insurance Plan, NECHC furnish information (receipt) to support client receiving reimbursement to that visit for the purpose of obtaining payment for the medical services received.
- 2.10.2. By authority of the Minister of Health, the insurer of NECHC shall have access to any and all patient records relating to legal cases.
- 2.10.3. All other insurance companies, and physicians representing insurance companies, must forward an acceptable authorization along with a written request for information from the health record on their letterhead. See Procedure Section 4 for requirements for authorization.

- 2.10.4. Only information for the specific dates specified in the request and authorization is released.
- 2.10.5. If a specific report(s) is/are not identified in the request, only a copy of the Discharge Summary is sent.
- 2.10.6. Insurance companies requesting proof of death are required to provide an acceptable authorization signed by the executor/administrator or, if there is no executor/administrator, the deceased patient's/client's spouse or next of kin. A Discharge Summary will be sent to the requesting insurance company, or, if a specific form is required, it will be forwarded to the appropriate Attending Physician for completion.
- 2.10.7. An administrative and/or processing and/or photocopying fee may be applied.

2.11. Release to the Workers' Compensation Board

- 2.11.1. Information is released by Staff to the WCB upon receipt of a valid WCB Claim Number, or other proof of a valid WCB claim.
 - 2.11.1.1. Verbal, telephone, written and faxed requests may be accepted from the WCB.
 - 2.11.1.2. Copies of documents from the health record may be transmitted to the WCB by mail or fax. See Procedure Section 2.2.2.4 and/or 2.2.2.5 for process of sending information in mail and/or fax.

2.12. Release to Government Departments (Including the Department of Community Services)

- 2.12.1. The Government department requesting health information must provide a valid, acceptable authorization (see Procedure Section 4 for requirements) and a written request on its letterhead prior to the release of any information from a health record.
- 2.12.2. If the request for information release / audit (e.g., audit by MSI) is addressed to a physician / nurse practitioner, he/she must inform the Health Team Manager about the request.
- 2.12.3. The Health Team Manager or his/her delegate will arrange or assist as necessary the audit / release of information upon receiving appropriate request.
- 2.12.4. An administrative and/or processing and/or photocopying fee may be applied.

2.13. Release of Vital Statistics

2.13.1. Only non-identifiable information shall be released to Vital Statistics without patient authorization, pursuant to the *Vital Statistics Act*.

2.13.2. The physician's name shall be provided to Vital Statistics when required.

3. SPECIAL PRECAUTION

3.1. Mental Health Records

3.1.1. Mental Health records are to be treated with utmost respect and sensitivity. They are to be filed within the general file but within its own plastic sleeve labeled "Mental Health / Forensic / Addiction" and "Confidential."

3.1.2. Except in the case of a subpoena or release for direct patient care, requests for release of mental health records must be authorized by the attending psychiatrist / community mental health practitioners, or in his/her absence, by the Health Team Manager.

3.1.3. An administrative and/or processing and/or photocopying fee may be applied.

3.2. Forensic Reports and Addiction Treatment & Prevention Services Records

3.2.1. Forensic Reports completed in the case of a sexual assault are to be treated with utmost respect and sensitivity. They are to be filed within the general file but within its own plastic sleeve labeled "Mental Health / Forensic / Addiction" and "Confidential."

3.2.2. Access by a clinical staff to Forensic Reports of sexual assaults and Addiction Treatment & Prevention Services records is limited to situations: presenting problems, treatment of a long-standing illness, and/or to refresh their memory in preparation for a trial.

4. REQUIREMENTS FOR A VALID AUTHORIZATION

4.1. To meet all requirements of a valid authorization, the following information must be included:

- a) Name of individual or facility authorized to release the information;
- b) Name of the individual, agency or facility to receive the information;
- c) Patient's/client's full legal name, address, and date of birth;
- d) Particulars of information requested (specific range of dates);
- e) Original signature in ink of the patient or his/her surrogate;
- f) Date of signature (no more than 6 months prior to receipt of the request by the NECHC); and,
- g) Signature of the witness.

4.2. The form must be completed by the patient, or if the patient is incapable of making his/her own health care decisions by his/her surrogate.

5. RELEASE OF INFORMATION AUTHORIZED BY THE MINISTER OF HEALTH

5.1. The Health Team Manager or his/her delegate will, upon receipt of a letter from the Minister of Health or an agency authorized by the Minister requesting specific patient information under the *Hospitals Act*, direct NECHC to comply with the request.

5.1.1. If the request for release of information is specific to an identifiable individual(s), the individual(s) will be notified of the Minister's request and any objection to the release will be brought to the attention of the Minister's office by the Health Team Manager or his/her delegate.

5.1.2. Under the circumstances outlined in 5.1.1, the release of information will not be processed until the matter of the patient's/client's objection has been resolved.

5.2. A copy of the request will be filed on the patient's/client's record, if specific to one patient, or in the office of the Health Team Manager, if a general release.

5.3. When a request from an agency designated by the Minister is granted, NECHC will release the minimum amount of information required to satisfy the stated request. If the Minister or designated agency will be making subsequent use of the patient information, NECHC will encourage the Minister or agency to omit, where possible, any identifying information (including the patient's/client's name and any factual description relating to, but not limited to, the condition, care, and location of the patient).

5.4. An administrative and/or processing and/or photocopying fee may be applied.

ACKNOWLEDGEMENTS

1. Kitty Grant, Risk Management Consultant, Capital District Health Authority.
2. Susan Jakeman, Privacy Officer, Capital District Health Authority.
3. Donna Gallivan, Manager, Special Projects, Health Records and Admitting, IWK Health Center.
4. Dorothy R. Barnard, MD, FRCPC, Clinical Laboratory Accreditation Consultant, IWK Health Center.
5. Merry Cardinal, Program Coordinator, Health Services, Somerset West Community Health Centre, Ontario.

REFERENCES

ADAPTED FROM:

1. Capital Health. (2004). Administrative Manual - Policy & Procedure: Release of Information from the Health Records.

OTHER REFERENCES:

1. Personal Information Protection and Electronic Documents Act (PIPEDA) (2000, c. 5). Department of Justice Canada. Current to April 18th, 2008.
2. Freedom of Information and Protection of Privacy Act (FIPPA) (1993, c. 5, s. 1). Last updated in 2007.
3. Privacy Act (R.S., 1985, c. P-21). Department of Justice Canada. Current to April 18th, 2008.
4. Access to Information Act (R.S., 1985, c. A-1). Department of Justice Canada. Current to June 17th, 2008.
5. Chapter 10 - Nova Scotia Medical Act. (1995-96). College of Physicians and Surgeons of Nova Scotia (CPSNS).
6. Health Protection Act (2004, c. 4, s. 1), Office of the Legislative Counsel.
7. Chapter 208 – Hospitals Act (1989, c. 208, s. 1). Office of the Legislative Counsel. Last amended in 2001.
8. Chapter 197 – Health Services and Insurance Act (1989, c. 197, s. 1). Office of the Legislative Counsel. Last amended in 2004.
9. Privacy Policy. (2006). Canadian Medical Protective Association (CMPA).
10. CMA Code of Ethics. (2004). Canadian Medical Association (CMA).
11. Statutory Reporting Requirements: A Guide for Nova Scotia Physicians. (2003). College of Physicians and Surgeons of Nova Scotia (CPSNS).



North End Community Health Centre

HEALTH ADMINISTRATION POLICY & PROCEDURE MANUAL

TITLE: Retention/Management of Medical/Dental Records	Policy No:
Target Audience: All staff	Date Initiated: Review Date:
Category: Health Administration	Approved by:

POLICY

1. All NECHC-generated medical information is the property of NECHC. This includes all information as defined above and specified in the *Retention Schedule* and includes all documents and records not specifically mentioned which contain information and/or data gathered from NECHC sources.
2. Original information or master records are to be archived or retained in accordance with the *Retention Schedule*.
3. NECHC makes no distinction between primary or secondary medical records as described by the Nova Scotia Department of Health's Guidelines on Retention of Health Records. All medical records are considered as primary records.
4. The custodian and authority for disposal in NECHC is the Health Team Manager.
5. All medical/dental records should be retained in a secure area free from extreme fluctuations in temperature, humidity and other environmental conditions that might cause the records to deteriorate. When not in use, client files should be kept in a secure place.
6. Transitory records may be disposed of through appropriate means as per this policy.

GUIDING PRINCIPLES

1. Promote proper methodologies for retention of medical and dental records.
2. All related acts and legal guidelines are to be reviewed.
3. Appropriate consultations will occur with other federal/provincial/regional organizations and medical centers.

DEFINITIONS

Archive: retention and storage of business and patient-related records in hardcopy or electronic format to meet legislated or recommended record retention guidelines or requirements.

Backup: a copy of system files or data that substitutes for the original files for the purposes of restoring network or personal data systems in the event of failure.

NECHC-generated information: records or documents containing data or information in any form or medium, created, received and maintained by NECHC in the conduct of business. This is further defined as paper copies of documents and records, and digital and electronic information, but does not include computer software.

Master Records: original records that are held as the official file copies.

Medical Records: patient related information that is required for the healthcare of the patient, and several legal and official procedures. It comprises of, but not limited to the followings:

- Medical history
- Demographic information
- Summary sheets
- Caution sheets
- Social and psychological assessment
- Consultation records
- Operation records
- Doctor's orders
- Diagnostic and therapeutic reports
- Diagnostic imaging reports
- Progress notes
- Out-patient department and clinic notes
- Emergency records
- Psychiatric records
- Nursing assessments and notes

Referral sheets
Flow sheets
Medication records
Diet sheets
Dietician notes
Physiotherapy notes
Occupational therapy notes
Community service notes
Consent forms
Authorization forms
Appointment information
Correspondence

Transitory Records: documents or information that have a temporary period of usefulness and are not generally part of the official or master record. Transitory records are not subject to a legislated retention period and are not generally required for any operational reasons after their immediate purpose has passed. Transitory records are further defined as:

- Temporary notes such as: phone messages not part of a progress note, routing slips, rebooking slips and opened envelopes;
- Duplicate documents when nothing has been added, changed or deleted to the content of the document and the copy was created for convenience and the original is maintained on the master record. Examples include copies of minutes, correspondence, and reference materials and publications;
- Draft documents and working papers which were used to prepare a final or master record and are no longer required except when the draft or working documents provide substantiating or background data for the master record, such as an audit; and,
- External publications and unsolicited materials such as books, magazines, brochures, catalogues, newspapers, and advertising circulars.

PROCEDURE

1. Calculate the minimum retention period from the end of the fiscal accounting year, unless otherwise noted.
2. For medical records not specifically covered under the *Retention Schedule*, develop and maintain an information retention process in accordance with professional standards, this policy and the Nova Scotia *Limitation of Actions Act*.
3. All active medical records should be kept in a secure place when not in use. They should not be left in open mail box or unattended on desk.

4. All information, documents and/or other medical records which have exceeded retention time frames may be disposed of upon written approval of the Health Team Manager.
 - 3.1. All confidential paper-based medical/dental records should be shredded as per the vendor's (Shred-it) procedures. In case of shredding large volume of medical/dental records, confidential shredding services will be used.
 - 3.2. All electronic records should be deleted from the hard drive and other electronic storage media (e.g., floppy drive, pen drive etc.). It may not be possible to permanently delete medical records from hard drives and other electronic storages. In most cases, it is preferable to destroy the hard drives and other electronic storages along with the electronic medical records.
5. Information regarding the disposal of medical/dental records will be recorded in a file and maintained by the Health Team Manager.
6. The decision to dispose should also include the assessment of any need to preserve records that may have historical significance to future generations. The Health Team Manager may act as a consultant to this process and may consult with other persons as deemed appropriate.

RETENTION SCHEDULE

ORIGINAL DOCUMENTS	MINIMUM RETENTION PERIOD
1. Health Care Records (in general) <ol style="list-style-type: none"> a) 19 years of age or older b) Under 19 years of age c) Expired (at any age) 	a) 15 years following last visit b) 15 years after last visit or 7 years after age 19, whichever occurs last c) 10 years after death
2. Patient Care Records known to be involved in litigation of any type	2 years past closure of litigation
3. Dental Records <ol style="list-style-type: none"> a) 19 years of age or older b) Under 19 years of age c) Person of unsound mind 	a) 6 years following last visit b) 6 years after age 19 c) Retain until the person is certified to be of a sound mind

ACKNOWLEDGEMENTS

1. Shirley Miller, Manager, Physician Patient Relations, Doctors Nova Scotia.
2. Kitty Grant, Risk Management Consultant, Capital District Health Authority.
3. Susan Jakeman, Privacy Officer, Capital District Health Authority.
4. Donna Gallivan, Manager, Special Projects, Health Records and Admitting, IWK Health Center.
5. Dorothy R. Barnard, MD, FRCPC, Clinical Laboratory Accreditation Consultant, IWK Health Center.
6. Merry Cardinal, Program Coordinator, Health Services, Somerset West Community Health Centre, Ontario.
7. Barry Johnston, Director, Security and Real Property Services, Corporate Services Division, Veteran Affairs Canada.

REFERENCES

ADAPTED FROM:

1. Capital Health. (2004). Administrative Manual - Policy & Procedure: Retention of Records.

OTHER REFERENCES:

1. Revised Guidelines on Retention of Administrative, Operational and Health Records of Hospitals. (1995). Department of Health, Nova Scotia.
2. Guidelines for Medical Record-Keeping. (2006). College of Physicians and Surgeons of Nova Scotia (CPSNS).
3. Guidelines for Physicians when Closing a Medical Practice. (2007). Canadian Medical Association (CMA) Legal Department.
4. Record Keeping Guidelines. (2006). Provincial Dental Board of Nova Scotia.
5. CMA Code of Ethics. (2004). Canadian Medical Association (CMA).
6. Statutory Reporting Requirements: A Guide for Nova Scotia Physicians. (2003). College of Physicians and Surgeons of Nova Scotia (CPSNS).
7. Chapter 10 - Nova Scotia Medical Act. (1995-96). College of Physicians and Surgeons of Nova Scotia (CPSNS).
8. Chapter 3 – The Dental Act. (1992). Provincial Dental Board of Nova Scotia. Current to 2006.
9. Personal Information Protection and Electronic Documents Act (PIPEDA) (2000, c. 5). Department of Justice Canada. Current to April 18th, 2008.
10. Freedom of Information and Protection of Privacy Act (FIPPA) (1993, c. 5, s. 1). Last updated in 2007.
11. Limitation of Action Act. (1989, R.S., c. 258, s. 1). Office of the Legislative Counsel. Last amended in 2003.



North End Community Health Centre

HEALTH ADMINISTRATION POLICY & PROCEDURE MANUAL

TITLE: Access of Information from Health Records	Policy No:
Target Audience: All staff	Date Initiated: Review Date:
Category: Health Administration	Approved by:

POLICY

1. All information contained in the health records must be kept confidential and may be released under certain conditions on a 'need to know' basis as outlined in this policy.
2. Appropriate Information from health records can be internally shared with / accessed by:
 - a. the healthcare practitioners and clerical staff to provide their professional services to the clients;
 - b. NECHC staff / students doing research or statistical analysis;
 - c. other healthcare professionals, who occasionally visit NECHC and participates in client management and/or consultations; and,
 - d. IT administrator and staff who install and maintain the software used.
 - e. Business Manager in relation to supervision and support to IT and clerical staff.
3. Appropriate Information from health records can be externally shared with / accessed by:
 - a. a client/patient, and his/her family member and/or surrogate
 - b. a qualified medical practitioner designated by the person as his/her physician;
 - c. other hospital or health care facility;
 - d. law enforcement agencies;
 - e. a person authorized by court order or subpoena;
 - f. health auditors;

- g. insurance companies;
- h. a person or agency otherwise authorized by law such as Workers' Compensation;
- i. various Government Departments (Including the Department of Community Services); and,
- j. the Minister of Health or any person or agency designated or authorized by the Minister.

For additional information regarding the external release of information from health records, refer to the *Release of Information from Health Records* policy of NECHC.

- 4. All persons intending to access information externally from the health records under any criteria above must sign the *Release of Information from Health Record* form (form no. 08-002) or *Request to Access / Review Medical Information* form (form no. 08-003) before accessing any information from the health records.

GUIDING PRINCIPLES

- 1. Promote proper methodologies for accessing information from health records by the NECHC staff to promote and protect clients' confidentiality.
- 2. All related acts and legal guidelines are to be reviewed.
- 3. Appropriate consultations will occur with other federal/provincial/regional organizations and medical centers.

DEFINITIONS

Health/Medical Records: patient related information (both paper-based and electronic) which is required for the healthcare of the patients. These are legal documents.

Healthcare provider: the healthcare professionals who are providing care to the patients.

Staff: the employees of NECHC (including work placements) whose job or portion of job includes providing healthcare and related services.

Surrogate: the person authorized by law to act on behalf of a patient who does not have capacity to make his/her own health decisions and includes:

- the person who has been appointed by the court to be the patient's/client's legal guardian (the executor/administrator of the estate, if one exists, will be the surrogate in case of a deceased patient);
- but if none exists, the patient's/client's spouse;
- but if none exists, the patient's/client's next of kin;
- but if none exists, the Public Trustee;

PROCEDURES

1. Health information is available to the NECHC healthcare team members as required in the performance of their duties relating to patient care and on a “need to know” basis.
2. The patient’s/client’s authorization is not required for release of health information to a staff of NECHC for medical purposes.
3. The clerical staff has access to only the demographic and scheduling information of the patients/clients, unless otherwise required for performance of duties (e.g., transcription, referrals etc.).
4. Staff/students can do research or statistical analysis using the information from the health records provided the ethical approval of their work/research is documented. Their work will not reveal any particular patient’s health information. Only aggregated information can be released in these cases.
5. IT administrator and IT staff are allowed to access health records to ensure proper functionality of the medical record management system/software used.
 - 5.1. IT administrator and the Business Manager should ensure that all the users of the medical records management system/software have access to the system according to their authority on a “need to know” basis and to provide support to staff.
 - 5.2. IT administrator and IT staff should not intentionally access any client’s medical/personal information except where required for support.
 - 5.3. IT administrator and IT staff may develop and retract reports as required.
 - 5.4. IT administrator and IT staff may input and delete test data as required for testing and troubleshooting purpose. But, when their work is done, they should make sure that no valid data is deleted and no invalid data remains in the system.

ACKNOWLEDGEMENTS

1. Kitty Grant, Risk Management Consultant, Capital District Health Authority.
2. Susan Jakeman, Privacy Officer, Capital District Health Authority.

REFERENCES

1. North End Community Health Centre. (2008). Health Administration Policy & Procedure Manual - Release of Information from Health Records.
2. North End Community Health Centre. (2008). Health Administration Policy & Procedure Manual - Retention/Management of Medical/Dental Records.
3. Capital Health. (2004). Administrative Manual - Policy & Procedure: Release of Information from the Health Records.
4. Personal Information Protection and Electronic Documents Act (PIPEDA) (2000, c. 5). Department of Justice Canada. Current to April 18th, 2008.
5. Freedom of Information and Protection of Privacy Act (FIPPA) (1993, c. 5, s. 1). Last updated in 2007.
6. Privacy Act (R.S., 1985, c. P-21). Department of Justice Canada. Current to April 18th, 2008.
7. Access to Information Act (R.S., 1985, c. A-1). Department of Justice Canada. Current to June 17th, 2008.
8. Chapter 10 - Nova Scotia Medical Act. (1995-96). College of Physicians and Surgeons of Nova Scotia (CPSNS).
9. Health Protection Act (2004, c. 4, s. 1), Office of the Legislative Counsel.
10. Chapter 208 – Hospitals Act (1989, c. 208, s. 1). Office of the Legislative Counsel. Last amended in 2001.

Appendix D: Developed Forms



North End Community Health Centre

2165 Gottingen Street
Halifax, Nova Scotia B3K 3B5
Canada

Tel: (902) 420-0303, Fax: (902) 422-0859
email: northend@nechc.com
website: www.nechc.com

RELEASE OF INFORMATION FROM HEALTH RECORD

Date Requested: _____

Chart No: _____

Full name of Patient: _____

Address: _____

Date of Birth: _____

Health Ins. No: _____

I hereby authorize the release of the following information or copies of records concerning my health or previous treatment from North End Community Health Centre to the following physician / agency / healthcare facility:

To share with: _____

Information requested: _____

Signature of the Patient / Surrogate: _____

Signature of the Witness: _____

In case of verbal request, Staff Signatures: _____



North End Community Health Centre

2165 Gottingen Street
Halifax, Nova Scotia B3K 3B5
Canada

Tel: (902) 420-0303, Fax: (902) 422-0859
email: northend@nechc.com
website: www.nechc.com

REQUEST TO ACCESS / REVIEW MEDICAL INFORMATION

Date Requested: _____

Chart No: _____

Full name of Patient: _____

Address: _____

Date of Birth: _____

Health Ins. No: _____

I request to access the following information or copies of records concerning my health or previous treatment from my health record at North End Community Health Centre due to the following reasons:

- Request for: On-site review
 Copy from health record

Information requested: _____

Reason for request: _____

Signature of the Patient: _____

Signature of the Witness: _____

Appendix E: Vendor Concerns

Concerns regarding managing the health records and using the service of Iron Mountain

Currently, NECHC has nearly 365 cft. inactive medical records and 35 cft. dental records, which altogether becomes about 400 cft. If NECHC chooses to dispose the medical and dental records whose retention period has exceeded, the total volume is expected to be around 200-225 cft.

All the estimates in this document assume that the medical files kept in the reception area are all of active patients. If we need to transfer files from the active to inactive status, the expenses will increase accordingly.

Cost of managing the health records within NECHC

If NECHC wishes to manage the files itself, the followings can be the one-time probable costs:

Cost of cabinets (10 standard file cabinets at the rate of \$500)	= \$5000
Cost of identifying the files to be disposed (salary of the personnel)	= \$3000
Cost of purging (payable to shredding vendor)	= \$1000
Cost of space arrangements and renovation (moving furniture, building walls and doors, ensuring better security etc.)	= \$6000
Total:	= \$15000

Once the files to be disposed are shredded and there is a well-managed system to track the files to be disposed every year, the yearly cost of identifying and purging medical records then on are expected to be \$500-1500.

Cost of managing the health records with the service of Iron Mountain

Assuming NECHC will dispose the disposable files first and then transfer the inactive files to Iron Mountain, the cost for identifying the disposable health records and purging them (\$5000) in the first year is still applicable.

Iron Mountain charges 33 cents per cft. of medical/dental records per month for storage. Their minimum charge for storage per month is \$100, which would be the case for NECHC. It provides 15"x12"x10" boxes at a cost of \$2.25 per box while storing the documents, if clients need any. In addition, it charges \$3 per file to deliver to client from their storage along with a \$15 delivery charge.

Draft as of July 16, 2008

If NECHC chooses to use the services from Iron Mountain, the approximate yearly expenditures is given below:

Yearly fees for storage: $\$100 \times 12 = \1200

Assuming NECHC needs 15 files from Iron Mountain's
Off-site storage every week in 2 deliveries per week: $(\$3 \times 15 + \$15 \times 2) \times 52 = \3900

Miscellaneous (unforeseen service charges, increase in service rate,
cost of yearly shredding etc.) = \$900

Total: = **\$6000**

There might be some other hidden costs, which are not known at this moment. Otherwise, depending on the no. of files to be delivered and no. of times the files need to be delivered, we can estimate an expenditure of \$4000-\$7000 per year for the off-site storage services provided by Iron Mountain.

Besides, there might be a one-time cost of buying boxes for the health records to be stored. Currently, we have 70 boxes of medical records and 9 boxes of dental records, which comprise about 108 cft. in total. If we choose to dispose the medical and dental records which have passed the retention period before sending the rest of inactive records to storage, we may need about 80 more boxes. In that case, we will have to pay another $80 \times \$2.25 = \180 . If we choose to store all the files in new identical boxes provided by Iron Mountain, we will need around 160 boxes and have to pay about \$360.

If we choose not to dispose any records and send all of them to Iron Mountain for storage, the expenditure would be nearly double. But in that case, we might be able to use Iron Mountain's secure shredding service if the files to be disposed are already identified. Detailed information including the cost of Iron Mountain's shredding services is not available yet.

Cost Benefit Analysis

Whether NECHC decides to use the service of Iron Mountain or not, the cost for identifying the disposable health records and purging them (\$5000) in the first year is a common cost for both the cases.

If Iron Mountains service is used,

The cost in 1 year is expected to be = $\$4000 + \$6000 = \$10000$

The cost in 2 years (cumulative) is expected to be = $\$10000 + \$6000 = \$16000$

The cost in 3 years (cumulative) is expected to be = $\$16000 + \$6000 = \$22000$

If NECHC decided to manage the health records itself,

The cost in 1 year is expected to be = \$15000

The cost in 2 years (cumulative) is expected to be = \$15000 + \$1500 = \$16500

The cost in 3 years (cumulative) is expected to be = \$16500 + \$1500 = \$18000

From the discussion above, it seems to be financially beneficial for NECHC in the long run, if it decides to manage the health records in-house rather than using the service of Iron Mountain.

The equations are represented in the following chart, where the break-even point is little after 2 years.

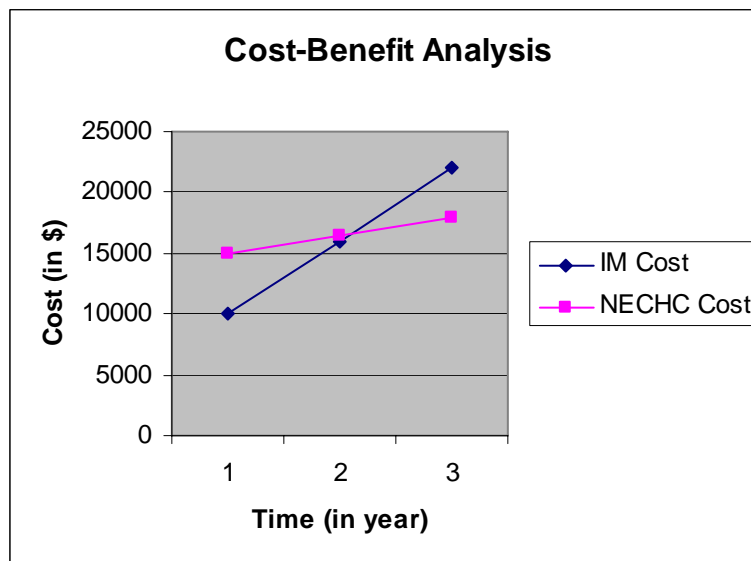


Figure: Cost-Benefit Analysis of using the service of Iron Mountain

Concerns for NECHC

1. At first NECHC needs to have all the policies regarding retention and access of health records in place.
2. NECHC needs a good medical record tracking system to track the files to be disposed every year. To do that, NECHC may wish to receive consultations from Iron Mountain. While implementing the system, NECHC also needs to identify the medical and dental records that currently qualify for disposal.
3. NECHC needs to identify the cost of managing the health record internally more accurately. Once this information is known and Iron Mountain's business proposal is received, another cost-benefit analysis can be performed.

4. NECHC may also choose to scan the paper charts and then destroy them or send them to the off-site storage. In this way all or most of the cost for off-site storage and delivery of the files can be saved. But there will be one time investment in scanning all the paper charts and there has to be a proper system in place to track and maintain the scanned paper charts.
5. Once ADM is introduced, all the medical records are expected to be electronic in 2-5 years. NECHC needs to evaluate the health practitioners' readiness and willingness to use paperless system. They may have to see fewer patients in first few months to adapt with the system.
6. If NECHC chooses to manage the health records internally,
 - a. There might be some one-time expenditure to provide better in house storage facilities, which may include space planning, designing/buying furniture and shelves, providing better security etc.
 - b. New guidelines may be developed to efficiently manage the health records.
7. If NECHC chooses to manage the health records with the help of Iron Mountain,
 - a. It needs to determine what services it needs to receive from them.
 - b. It needs to be aware of some unforeseen costs and make sure that there is none.
 - c. NECHC needs to find out an efficient way to manage the (probable) walk-in clients' health records.

Appendix F: File Checking Summary

File Checking Summary

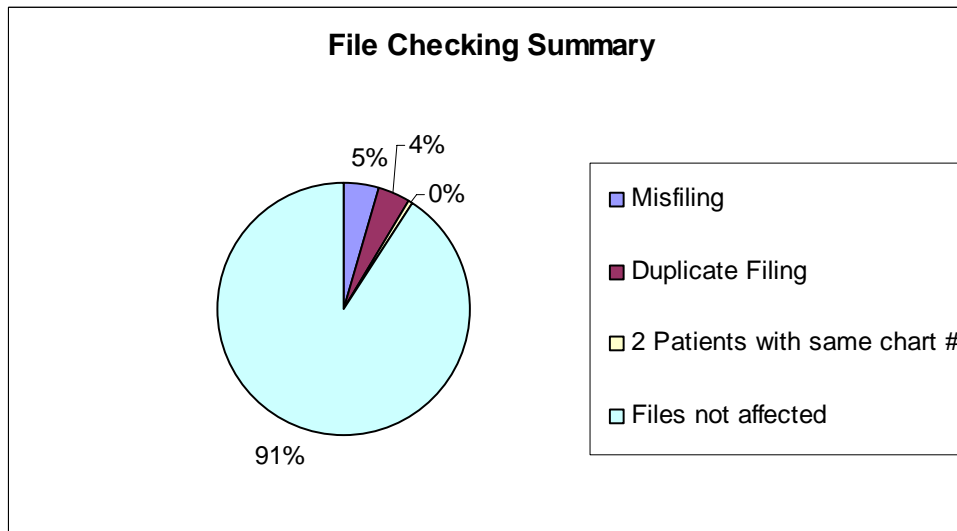
Summary from the files checked from the boxes

Statistics

Total files checked 526

	Incidences	No. of Files affected
Misfiling	12	24
Duplicate Filing	11	22
2 Patients with same chart #	1	2
Total	24	48

Files not affected 478



Latest last visit found: in year 2006 (chart no. 1110)
Number of patients with last visit on or after 1991: 24 (4.6%)

Concerns

A good number of misfiling and duplicate filing has been discovered.

The file checking was not aimed at finding misfiling, as the person checking the files was not looking for patients' medical information. So, there might be a lot more misfiling issues if the files are thoroughly checked.

Duplicate filing issues were discovered only if one of the files exists in either PHIM or RISE. There can be a significant number of duplicate files if none of the files exists in either system.

Suggestions

Though the findings might not look very significant as most of the files will be disposed, it is suggested that all the charts be checked manually before disposing them.

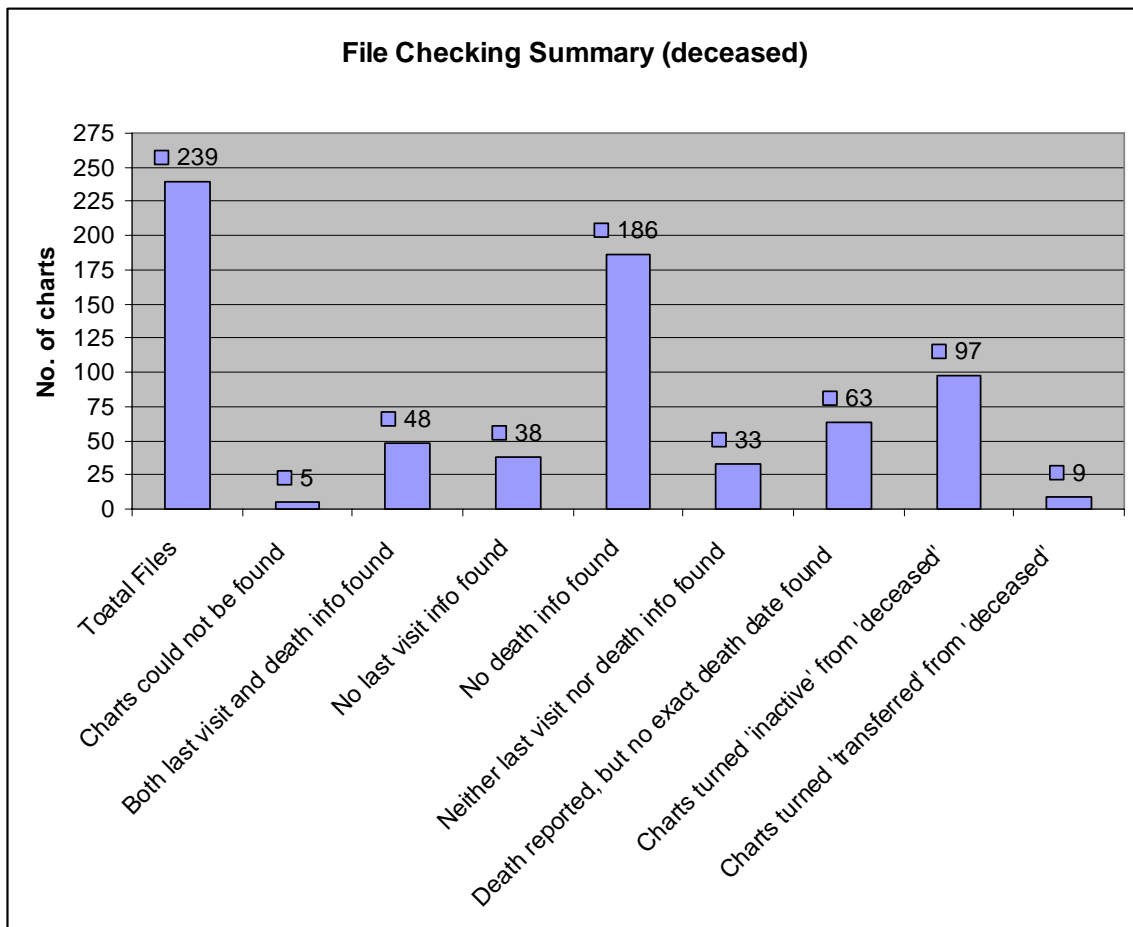
Summary from the files checked from the deceased list

Statistics

Total Files

239

Findings	No. of Files	% of Total Files
Charts could not be found	5	2.09%
Both last visit and death info found	48	20.08%
No last visit info found	38	15.90%
No death info found	186	77.82%
Neither last visit nor death info found	33	13.81%
Death reported, but no exact death date found	63	26.36%
Charts turned 'inactive' from 'deceased'	97	40.59%
Charts turned 'transferred' from 'deceased'	9	3.77%



Concerns

For a good number of patients, last visit date and death date/information was not found. It is highly suspected that there were data entry errors while inserting data in RISE and PHIM. It is observed that a lot of data has been inserted in PHIM on November 29 at 1:58 a.m. It is very common to have data entry errors if someone works so fast at late night (assuming the date and time of the computer was set correctly).

Data entry errors were concentrated in a certain range of files numbers (24000-28000). It is suspected that since in the drop down menu the 'inactive' and 'deceased' status are adjacent in both RISE and PHIM, an effort to speed up the data entry process has caused mouse slips, which had resulted the wrong data entries.

Exact death date could not be found for a lot of patients who are reported as deceased. In these cases, patients' status was updated as 'deceased,' but rather than inserting patients' death date in the system, either the field 'inactive/deceased' was left blank or filled with the date of the status update, not the date of death of the patient.

Sincere efforts were given to double check and collect more information about the patients whose files were being checked. A good number of death incidents of the patients could be confirmed. For the patients whose death information could not be found, their statuses were changed as 'inactive' from 'deceased.'

Suggestions

In this project, patients' files were checked only if the patients were reported as 'deceased' in PHIM. But to generate the accurate list of deceased patients, all files are needed to be checked manually. Also, accuracy in data entry and data retrieval is very crucial.

Appendix G: Final Recommendations

Final Recommendations

Concerns for NECHC regarding medical (and dental) records management

1. At first NECHC needs to have all the policies regarding retention and access of health records in place. The policies are already developed.
2. NECHC needs a good medical record tracking system to track the files to be disposed every year. Suggestions have been provided to do so (e.g., writing down the year of patient's last visit, writing 'M' on the minor patient's charts, filling up the field 'Deceased on' in PHIM, entering required information in the newly developed database etc.).
3. While implementing the system, NECHC also needs to identify the medical and dental records that currently qualify for disposal. From the sample file checking done in this project, it is recommended that all files be checked manually once to capture all the required information. This information is essential for tracking the files properly in different purposes both in present and in future.
4. It is estimated that the checking files manually (both electronic and paper-based) may take about 4000 human hours. From the sample project done, it was identified that for each boxes of files (which is about 1.1 cft. in volume), 7 human hour work is required to check the information from files and insert them in the system. NECHC has about 400 cft. inactive medical and dental files and about 250 cft. active medical files. In total it becomes $(650 \times 7) / 1.1 = 4136$ human hours. The time can widely vary with the expertise of the person checking the files and information found on the files. Incomplete, inconsistent and wrong information found can significantly prolong the file checking process.
5. The simple database developed can be used to store all the required information. It can be expanded as and when required.
6. Consistency and accuracy of information stored is extremely important. Verifying information from patient's files is a very crucial and time-consuming process. Data entry errors should be minimized to get the benefit of the systems.
7. NECHC needs to identify the cost of managing the health record internally more accurately. The later part of this document includes the updated cost-benefit analysis of managing health records with or without vendor. Additional analysis can be performed by a business professional.
8. NECHC may also choose to scan the paper charts and then destroy them or send them to the off-site storage. In this way all or most of the cost for off-site storage and delivery of the files can be saved. But there will be one time investment in scanning all the paper charts and there has to be a proper system in place to track and maintain the scanned paper charts.

9. Once Advanced Document Management (ADM) system is completely implemented, all the medical records are expected to be electronic in 2-5 years. NECHC needs to evaluate the health practitioners' readiness and willingness to use this paperless system. They may have to see fewer patients in first few months to adapt with the system.
10. If NECHC chooses to manage the health records internally,
 - a. There might be some one-time expenditure to provide better in house storage facilities, which may include space planning, designing/buying furniture and shelves, providing better security etc.
 - b. More new guidelines may be required and developed to efficiently manage the health records.
11. If NECHC chooses to manage the health records with the help of Iron Mountain,
 - a. It needs to determine what services it needs to receive from them.
 - b. It needs to be aware of some unforeseen costs and make sure that there is none.
 - c. NECHC needs to find out an efficient way to manage the (probable) walk-in clients' health records.

Concerns and Cost-Benefit Analysis of managing health records with or without vendor

Currently, NECHC has nearly 365 cft. inactive medical records and 35 cft. dental records, which altogether becomes about 400 cft. If NECHC chooses to dispose the medical and dental records whose retention period has exceeded, the total volume is expected to be around 230-240 cft.

All the estimates in this document assume that the medical files kept in the reception area are all of active patients. If NECHC needs to transfer files from the active to inactive status, the expenses will increase accordingly.

Cost of managing the health records within NECHC

If NECHC wishes to manage the files itself, the followings can be the one-time probable costs:

Cost of cabinets (10 standard file cabinets at the rate of \$500)	= \$5000
Cost of purging (payable to shredding vendor)	= \$600
Cost of space arrangements and renovation (moving furniture, building walls and doors, ensuring better security etc.)	= \$6000
Miscellaneous	= \$900
Total:	= \$12500

Assuming NECHC would assign its regular staff for manually checking the files for required information, no monetary cost is shown in this regard.

Once the files to be disposed are shredded and there is a well-managed system to track the files to be disposed every year, the yearly cost of identifying and purging medical records then on are expected to be about \$250 (excluding the cost of manual labor).

Cost of managing the health records with the service of Iron Mountain

Assuming NECHC will dispose the disposable files first and then transfer the inactive files to Iron Mountain, the cost for identifying the disposable health records and purging them in the first year is still applicable.

Iron Mountain charges 33 cents per cft. of medical/dental records per month for storage. Their minimum charge for storage per month is \$100, which would be the case for NECHC. It provides 15"x12"x10" boxes at a cost of \$2.75 per box while storing the documents, if clients need any. In addition, it charges \$1.05 per cft. file to deliver to client from their storage along with a \$14-\$82 delivery charge depending on the time and urgency of the delivery.

There is a one-time program start-up charge of moving the boxes at the rate of \$2 per cft. Assuming that NECHC is going to dispose the files that have passed the retention period before sending the rest of inactive records to storage, it would be about $240 \times \$2 = \480 . If it chooses to store all the files without disposing, it would cost around $400 \times \$2 = \800 .

Besides, there might be a one-time cost of buying boxes for the health records to be stored. Currently, NECHC has 70 boxes of medical records and 9 boxes of dental records, which comprise about 108 cft. in total. If NECHC chooses to dispose the medical and dental records which have passed the retention period before sending the rest of inactive records to

storage, it may need about 80 more boxes. In that case, it will have to pay another $80 \times \$2.75 = \220 . If NECHC chooses to store all the files in new identical boxes provided by Iron Mountain, it will need around 160 boxes and have to pay about \$440.

If NECHC chooses to use the services from Iron Mountain, the approximate yearly expenditures is given below:

Yearly fees for storage: $\$100 \times 12 = \1200

Assuming NECHC needs 15 files (1 cft. in each delivery) from Iron Mountain's Off-site storage every week in 2 regular non-urgent deliveries per week: $(\$2 \times 14 + \$1.05 \times 2) \times 52 = \1565

Miscellaneous (unforeseen service charges, increase in service rate, labor charge, fuel surcharge, regular retrieval charge for archival, cost of yearly shredding etc.) = \$1000

Total: = **\$3765**

The above calculation assumes the file deliveries as regular and non-urgent, where the delivery charge is \$14 per delivery. In case of urgent delivery, the delivery charge may go high up to \$82 per delivery. All the deliveries have an additional fee (\$1.05 per cft.) depending on the volume of the files to be delivered.

There might be some other hidden costs, which are not known at this moment (e.g., increase in service rate, labor charge, fuel surcharge, regular retrieval charge for archival, service withdrawal fee etc.). Otherwise, depending on the no. of files to be delivered and no. of times the files need to be delivered, NECHC can estimate an expenditure of \$3500-\$5000 per year for the off-site storage services provided by Iron Mountain. Additional services received from Iron Mountain would increase the fees accordingly. If NECHC chooses not to dispose any records and send all of them to Iron Mountain for storage, the expenditure would be nearly double.

Labor charge in Iron Mountain is quite high (\$45 per hour). It is recommended that all possible official procedure be done in NECHC (e.g., manually identifying the files to be disposed, checking information for correctness etc.) rather than seeking service from Iron Mountain.

Cost Benefit Analysis

Whether NECHC decides to use the service of Iron Mountain or not, the cost for identifying the disposable health records and purging them in the first year is a common cost for both the cases. Assuming NECHC would assign its regular staff for doing this job, no monetary cost is shown in the cost benefit analysis.

If Iron Mountains service is used, assuming every year the charge is \$4000, and additional cost for the first year is \$1000 (start up cost, cost for buying boxes and other hidden costs),

The cost in 1 year is expected to be = $\$1000 + \$4000 = \$5000$

The cost in 2 years (cumulative) is expected to be = $\$5000 + \$4000 = \$9000$

The cost in 3 years (cumulative) is expected to be = $\$9000 + \$4000 = \$13000$

The cost in 4 years (cumulative) is expected to be = $\$13000 + \$4000 = \$17000$

If NECHC decided to manage the health records itself,

The cost in 1 year is expected to be = $\$12500$

The cost in 2 years (cumulative) is expected to be = $\$12500 + \$250 = \$12750$

The cost in 3 years (cumulative) is expected to be = $\$12750 + \$250 = \$13000$

The cost in 4 years (cumulative) is expected to be = $\$13000 + \$250 = \$13250$

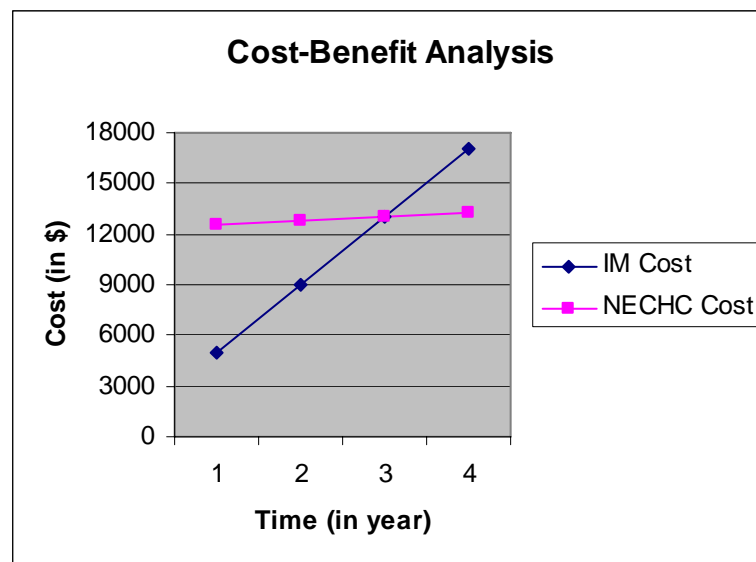


Figure: Cost-Benefit Analysis of using the service of Iron Mountain

From the discussion above, it seems to be financially beneficial for NECHC in the long run if it decides to manage the health records in-house rather than using the service of Iron Mountain. The equations are represented in the following chart, where the break-even point is in 3 years.