Providers and healthcare plans covered by the HIPAA Privacy Rule may share patient protected health information (PHI) to assist in disaster relief efforts and to assist patients in receiving the care they need. Information relevant to the following areas may be shared:

- Treatment
- Notification
- Imminent danger
- Organization directory

**PROCEDURE:**

- **Treatment:**
  - Healthcare providers may share patient PHI as necessary to provide treatment.

  - Treatment includes:
    - Sharing information with other providers (including hospitals and clinics)
    - Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated)
    - Coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate healthcare services)
  - Providers may share patient PHI to the extent necessary to seek payment for these healthcare services.
Position Description / Performance Evaluation

Job Title: HIM Scanning Clerk
Supervised by: HIM Supervisor
Prepared by: __________________________________
Approved by: ___________________________
Date: ________________________________________
Date: _________________________________

Job Summary: Responsible for the receipt, scanning, indexing of medical record documents into the hospital’s electronic health record (EHR) in a timely and accurate manner.

DUTIES AND RESPONSIBILITIES:

3 = Exceeds Performance  2 = Expected Performance  1 = Needs Improvement

Demonstrates Competency in the Following Areas:

- Prepares medical records for scanning, matching batch header sheets, does quality review, uploads and accepts batches for completeness.
  - 3  2  1

- Scans and indexes health and administrative information into the hospital’s electronic health record system.
  - 3  2  1

- After all information is scanned and indexed, files or destroys the paper files, per policy and procedure.
  - 3  2  1

- Maintains a daily productivity log of scanning and indexing activities.
  - 3  2  1

- Scans and indexes loose medical record documents received daily.
  - 3  2  1

- Completes scanning and indexing within established timeframes.
  - 3  2  1

- Pulls ED medical records for scanning from Emergency Department and informs ED clerk of location of medical records.
  - 3  2  1

- Returns all ED medical records to Emergency Department after they are processed.
  - 3  2  1

- Prepares ED records for scanning: removes staples, places batch header sheets with appropriate medical record and organizes medical records in an orderly manner; assists in a total complete record.
  - 3  2  1

- Conducts quality audits to ensure the integrity of scanned images into the electronic health record system.
  - 3  2  1

- Accepts selected batch documents, uploads records at end of shift.
  - 3  2  1

- Interacts closely with the Health Information Management Department when discrepancies occur involving the computer system which affects the electronic health record system functions.
  - 3  2  1

- Protects the confidentiality of patient information, as well as access to computer files and access codes.
  - 3  2  1

- Supports and maintains a culture of safety and quality.
  - 3  2  1

- Maintains a good working relationship within the department and other departments.
  - 3  2  1

- Performs performance improvement functions through data collection and documentation review.
  - 3  2  1

- Willing to accept additional assignments.
  - 3  2  1

- Maintains an error rate of 5% or less in scanning medical information into the electronic health record system.
  - 3  2  1
NOTES:

- Refer to your state rules and regulations for state-specific record retention requirements.

- Healthcare organizations shall review federal regulations. Healthcare organizations shall compare State retention requirements and statute of limitations with legal counsel when developing a record retention policy. Accrediting organization standards shall also be reviewed. Follow the more restrictive requirement.

POLICY:

- Retention schedules shall meet all applicable federal and state rules and regulations.

- A retention schedule of medical information shall be established and maintained to ensure the availability of relevant data and information.
  - Medical information includes clinical and medical records, health records, and claims documentation.

- The hospital shall have a medical record system that ensures the prompt retrieval of any medical record, of any patient evaluated or treated at any location of the hospital within the past 5 years. [§482.24(b)(1)]
  - In accordance with federal and state law and regulations, certain medical records may have retention requirements that exceed five (5) years (i.e., FDA, OSHA, EPA).

- Medical records shall be retained in their original or legally reproduced form in hardcopy, microfilm, computer memory or other electronic storage media. [§482.24(b)(1)]

- The hospital shall maintain records for all radiologic services. These records shall include (at a minimum) copies of reports and printouts and any films, scans or other image records as appropriate. [§482.26(d)]
  - 21 CFR 900.12(c)(4)(i)(ii): Recordkeeping. Each facility that performs mammograms shall (except as provided in 21 CFR 900 (c)(4)(ii)) maintain mammography films and reports in a permanent medical record of the patient for a period of not less than five (5) years, or not less than 10 years if no additional mammograms of the patient are performed at the facility, or a longer period if mandated by State or local law.
POLICY:

- ____________________ (organization name) recognizes that the use of social media provides a number of benefits for employees during their own time. Within the facility, however, access to social media shall be restricted. Unauthorized employees shall not participate in social media from a network computer.

- E-mail and Internet access shall be provided to support this hospital's business purposes. This hospital understands that employees with this access may make incidental personal use of them. However, extensive personal use of these tools during work or non-work time shall be prohibited. Managers have the right and responsibility to determine extensive use and to revoke access privileges for abuse of the system.

- For the purposes of this policy, social media shall be considered to be technology and software that allows use-generated content to be shared and exchanged online (i.e., blogs, Facebook, Twitter, YouTube).

- Blogging and other social networking activities are personal and shall be done on the employee’s own time, unless said employee is assigned to perform an online activity as a part of the employee’s job responsibilities.

- Employees shall not disclose any confidential or proprietary information of or about this facility, its affiliates, vendors or suppliers, including but not limited to, business and financial information.

- All employees shall be prohibited from using social media sites to provide medical advice or medical commentary or to use the social media site to make, recommend or increase referrals to physicians who are not employed by this hospital.
PURPOSE:

To maintain an accurately written and promptly completed medical record for each inpatient and outpatient.

POLICY:

- There shall be established legibility standards for medical record documentation within this organization.
- There shall be ongoing monitoring for compliance of these legibility standards as part of the performance improvement and medical error reduction activities.
- This policy shall be applicable to all documentation within the medical record.

PROCEDURE:

- Whenever possible, all consults, histories and physicals, interpretations of diagnostic testing, and post-operative/procedure results shall be dictated.
- Only abbreviations listed in the organization’s list of approved abbreviations shall be allowed for use in medical record documentation.
- Medication Orders:
  - Shall include a brief notation of purpose.
  - All prescription orders shall be written in the metric system.
  - "Units" shall be spelled out.
  - The order must include drug name, exact strength or concentration, dose, frequency, and route.
  - A leading zero must precede a decimal expression of less than one.
<table>
<thead>
<tr>
<th>SUBJECT:</th>
<th>REFERENCE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEPARTMENT:</td>
<td>PAGE:</td>
</tr>
<tr>
<td></td>
<td>OF:</td>
</tr>
<tr>
<td>APPROVED BY:</td>
<td>EFFECTIVE:</td>
</tr>
<tr>
<td></td>
<td>REVISED:</td>
</tr>
</tbody>
</table>