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Map of California's Correctional and Rehabilitation Institutions

Facility Type Key	
★	Adult Institutions
▲	Juvenile Institutions



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EXECUTIVE SUMMARY

Overview

The California Department of Corrections and Rehabilitation (CDCR) contracted with the **SOURCECORP TEAM** to provide a high level review and summary identifying industry standards and best practices applicable to the correctional environment. These best practices standards focus on paper-based systems. Additionally, the CDCR requested this document include reference to federal regulations such as HIPAA, California healthcare regulations such as Title 22 (both acute care and correctional facilities) as well as those relevant from the following California state agencies: Department of Health Services; Department of Managed Care; Department of Mental Health, and Department of Corrections and Rehabilitation. The regulatory analysis addresses relevant standards (as they pertain to health records) established by accrediting agencies such as the JCAHO, the National Commission on Correctional Healthcare, and the American Correctional Association.

In performing this review and summary the Compliance and Regulatory members of the **SOURCECORP TEAM** encountered a vast amount of information that pointed to various regulatory standards that were being applied indiscriminately to the various Health Record functions. The Compliance and Regulatory team members felt it best to divide the findings by functional area to provide the reader with a comparison of the standards side by side where they weigh in on a particular function. In those instances where the regulatory body was silent, that column has been left blank.

The report then provides best practices which speak to a general manner in which these functions should be accomplished in a paper record world. These best practices should be modified according to affecting factors such as business rules, work flow and system needs within the CDCR. These affecting factors are currently being identified by the assessment members of the **SOURCECORP TEAM** with the intent of overlaying both the best practices and regulations in the gap analysis and remediation portions of the HIM scope of work.

This review incorporates a definition and evaluation of the functions within Health Information Management/Medical Record Services/Operations. These functions consist of the following:

- Medical Record Services/Management
- Physical Environment/Safety
- Unit Record/Master Patient Index
- Medical Record Availability/Retention
- Health Record Content/Documentation/Charting Guidelines
- Transfers/Discharges/Deaths
- Chart Order/Assembly
- Discharge Analysis/Record Completion
- Forms Control/Loose Reports
- Coding/Abstracting/Indexing/Data Collection
- Statistics
- Confidentiality/Release of Information
- Transcription

For each function described above, a review of the following elements has been incorporated into our findings:

- CDCR Operational Policies/Procedures (From the CDCR Department Operations Manual (DOM))
- Licensure Standards (Title 15, and Title 22; Division 5, Chapter 1, General Acute Care; and Title 22; Division 5, Chapter 12, Correctional Treatment Facilities) where applicable
- HIPAA Evaluation and Comparison to CDCR DOM (where applicable)
- California Hospital Association Evaluation and Comparison to CDCR DOM where applicable
- HIM Best Practices Overview and Preliminary Observations from Assessment Surveys (*These assessment findings will be further refined based on continued field assignments currently being completed. These will be incorporated into the GAP Analysis.*)

Research Findings

Upon researching all of the regulatory agencies defining Medical Record Operations within the State of California as well as Federal Regulations, the first step was to determine which regulations truly govern the Prison Facilities under the California State Department of Corrections. This evaluation was necessary to gain an understanding of the minimum requirements established for Health Record Services. The findings of this research indicated the following regulatory agencies had standards which could apply:

- Title 15 - The State Prison Facilities are licensed under Title 15 – Crime Prevention and Corrections
- Title 24 – Building Standards code. There are minimal rules relating to healthcare facilities within this section of the CCR.
- Title 22 – California State legislation; Chapter 12, Correctional Treatment Centers
- HIPAA – Health Insurance Portability and Accountability Act (1996)
- Department Operations Manual (DOM) – definition of the rules governing the Prison System Health Care System within the California Department of Corrections and Rehabilitation (CDCR) appear to be defined in the Department Operations Manual (DOM). (*Many policies within DOM reference standards defined in Title 22, Division 5 Licensing and Certification of Health Facilities, Home Health Agencies, Clinics and Referral Agencies; Chapter 1 General Acute Care Hospitals; American Correctional Association (ACA) Standards, California Penal Code, California Welfare and Institutions Code, and in some cases the HIPAA regulations.*)
- The American Correctional Association (ACA) – Private accrediting organization specializing in the correctional environment. (*The CDCR website identifies that a change in the Department Operations Manual was proposed for 2008 that defines the Department's use of the ACA Standards. The proposed revision, DOM 14090.1, states that the ACA Standards are used as resource material in developing departmental regulations, policy and operations procedures.*)
- National Commission on Correctional Healthcare (NCCH) - Private accrediting organization specializing in the correctional environment.

The Correction Standard Authority (CSA) is the entity to inspect the CDCR facilities.

Currently the CSA is mandated to inspect Local Detention Facilities bi-annually under Penal Code Section 6031. Meeting minutes of the Correctional Standards Authority, September 2006, describe a legal opinion regarding the CSA's authority as it relates to inspection of State Prison Facilities. The minutes state that the CSA is only responsible, to inspect each local detention facility in the state bi-annually and could conceivably inspect the state prison facilities in a number of different situations; **however State Correctional facilities are not included under the definition of "local detention facilities" and there was no companion provision that mandates inspection of State Prison Facilities.** ¹

In addition:

- None of the California Prison Facilities were found to be listed as Licensed by the Department of Health Services under Title 22 (reference - Office of Statewide Planning and Development – Licensed Facilities) <http://www.oshpd.ca.gov/HID/Products/Listings.html> **therefore they are not "licensed" or held accountable under Title 22 Acute Care Regulations.**
- None of the California Prison Facilities are accredited by ACA or NCCH and are **therefore not held accountable under ACA or NCCH standards.**

Recommendations

While there is opportunity to set a high bar for the management of health information and while it is recognized that this will significantly and positively impact the delivery of care, there are minimal licensure standards that specifically speak to the manner in which health information should be managed in correctional treatment facilities. ²

SOURCECORP therefore recommends the following:

- California State Legislation, Title 22, Chapter 12, Correctional Treatment Centers appears to be the minimal licensure standards that must be adopted and followed by the CDCR.
- The CDCR follow the ACA guidelines and seek future accreditation by the ACA.

¹ California Penal Code Section 6030 states the CSA was to develop minimum standards for state and local correctional facilities by January 1, 2007. A review of CSA minutes for the past two years revealed that the CSA did develop an Executive Steering Committee (ESC) and proposed preliminary recommendations to changes in Title 15 and 24 which were presented and approved by the CSA in January 2008. **Because the proposed regulations are not posted, it is still not clear if the inspection process has been clearly defined for State Prison Facilities under the Correction Standards Authority.**

² Title 22, Chapter 12, Correctional Treatment Centers. The definition under the CCR for Correctional Treatment Centers states as follows:

§ 79516. Correctional Treatment Center.

A correctional treatment center is a health facility with a specified number of beds within a state prison, county jail or California Youth Authority facility designated to provide health care to that portion of the inmate population who do not require general acute care level of services but are in need of professionally supervised health care beyond that normally provided in the community on an outpatient basis. Outpatient housing is not under the jurisdiction of this Chapter.

Plata Definitions Document, Exhibit F, (http://www.cdcr.ca.gov/Divisions_Boards/Plata/docs/DEF-0708.pdf) which states: **Correctional Treatment Center** means a health facility with a specified number of beds within a State prison, county jail or California Youth Authority facility designated to provide health care to that portion of the inmate population not requiring general acute care level of services, but who are in need of professionally supervised health care beyond that normally provided in the community on an outpatient basis (CCR, Title 22, Division 5, Chapter 12, Article 1, Section 79516).

“Regulations in corrections deal with significant life, liberty, security, safety, health, rehabilitation, and employment issues. These areas are subject to extensive public interest. California Department of Corrections and Rehabilitation (CDCR) adult regulations help support safe and effective facility operations, and the treatment of adult inmates and parolees in accordance with basic constitutional standards.

The Regulation and Policy Management Branch (RPMB) deals with regulations (Department Rules) related to Adult Operations and Programs and is responsible to ensure that the rules proposed for implementation by the CDCR that have a general application to State adult inmate and parole operations and programs meet the Rulemaking Process of the Administrative Procedure Act (APA).”

Medical Record Services/Health Information Management

Definition

Medical Record Services is an administrative responsibility for medical/health records. A medical/health record must be maintained for every individual evaluated or treated in a medical facility. The organization of the medical record service is appropriate to the scope and complexity of the services provided. The facility employs adequate personnel to ensure timely completion, filing, and retrieval of records.

Health Information Management improves the quality of healthcare by insuring that the best information is available to make any healthcare decision. Health information management professionals manage healthcare data and information resources. The profession encompasses services in planning, collecting, aggregating, analyzing, and disseminating individual patient and aggregate clinical data. It serves the healthcare industry including: patient care organizations, payers, research and policy agencies, and other healthcare-related industries.

Best Practices

1. *AHIMA certified/credentialed manager (full time or consultative on minimum of quarterly basis to audit and mentor.)*

Varies. Concern regarding CDCR non-credentialed HIM Director with no direct relationship to credentialed Regional HIM Director, who has no relationship (unless use is requested) with onsite prison facility Medical Record Directors or HRT II Supervisors (who are like the director). Roles of CHSA somewhere in the middle as well.

2. *Productivity Standards are established and in place to monitor productivity in the HIM Department.*
3. *Adequate staff support planned for 7 x 24 access to records and processing (whether via on call for third watch and first watch or other resource), Adequate evidence of staff development, ongoing evaluations/discipline, accountability and education.*

Varies. There appears to be high turnover rates and high absenteeism. Physical strain of job and risk of on work injury very high due to inappropriate size and weight of the UHR. Low wage scales and treatment as 'catch all clerical' also a problem Despite this, every department has some very enthusiastic, hard working, long term staff who want to see change occur. Frequent transfer of staff amongst different prisons. Union shop typical issues.

4. *Adequate evidence of participation in and knowledge of facility wide quality improvement initiatives. Active contribution to planning for initiatives impacting health records processing and management to include paper based processes as well as electronic document management system and workflow improvement through automation and process changes.*

Quality Improvement Committee and QITs (teams) appear to be the operational vehicle for change.

CDCR – Department Operations Manual Policy(ies)/Procedure(s)

91070.1 – Policy

The medical record service shall maintain medical records that are documented accurately, in a timely manner, are readily accessible, and permit prompt retrieval of information.

91070.3 Services Defined

The medical record service shall maintain the inmate's health record in a system which allows for easy retrieval, shall assist in locating records on new arrivals, shall answer requests for medical information from other agencies, and shall transcribe various medical reports.

91070.4 Services Provided

Each departmental health care facility shall have a medical record service staffed by medical records personnel. The medical record service shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing, and filing of all medical records.

91070.7 Supervision Health Records

In departmental health care facilities with a hospital, the medical records service shall be under the supervision of a registered record administrator or accredited record technician. In all other facilities, the medical record service shall be under the supervision of either a health record technician or a medical records director. When the services of either cannot be obtained on a full-time basis, consultation services shall be obtained.

91070.7.2 Accountability

A written statement defining the accountability of the medical records service staff and administration shall be available and shall include an organizational chart.

91070.7.3 Service Evaluation

Periodically an appropriate committee of the medical staff shall evaluate the services provided and make recommendations to the medical executive committee and administration of the health care facility.

91070.20 Medical Staff Committees

The medical record service responsibilities to medical staff committees are:

- To submit statistical information as requested by the committee.
- To act as a resource.
- To obtain data at the request of the committee for their review.

Title 15	Title 22 Division 5; Chapter 1; General Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
	<p>§ 70747. Medical Records Service</p> <p>(a) The hospital shall maintain a medical record service which shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing and filing of all medical records.</p> <p>(b) The medical records service shall be under the supervision of a registered records administrator or accredited records technician. The registered record administrator or accredited record technician shall be assisted by such qualified personnel as are necessary for the conduct of the service</p>	<p>§ 79803. Health Record Service</p> <p>(a) The correctional treatment center shall maintain a health record service in accordance with accepted professional standards and practices. The health record service shall have sufficient staff, facilities, and equipment, and be conveniently located to facilitate the accurate processing, checking, indexing and filing of all health records.</p> <p>(b) The health record service shall be under the direction of a staff member with at least two years of training and experience in records administration, at a level of responsibility equivalent to a health record technician, or a medical record technician. This designated staff member shall be assisted by such qualified personnel as are necessary to conduct the service. A registered record administrator or accredited records technician shall provide consultation on at least a quarterly basis to designated staff members responsible for record administration.</p> <p>(c) If a facility, in addition to inpatient services, is providing outpatient, emergency, day treatment, or crisis intervention service, a unit health record system shall be established.</p>

		<p>(d) The facility shall have a continuing system of collecting and recording data that describe patients served in such form as to provide for continuity of care, program services, and data retrieval for program patient care evaluation and research. Health records shall be stored and systematically organized to facilitate retrieval of information. Retrievability shall be assured by the use of an acceptable coding system such as the latest version of the International Classification of Diseases (ICD-9).</p> <p>(e) Policies and procedures shall be established and implemented to ensure the confidentiality of access to patient health information, in accordance with federal, state and local laws and acceptable standards of practice.</p>
	<p>70719. Personnel Policies</p> <p>(a) Each hospital shall adopt written personnel policies concerning qualifications, responsibilities and conditions of employment for each type of personnel, which shall be available to all personnel. Such policies shall include but not be limited to:</p> <p>(1) Wage scales, hours of work and all employee benefits.</p> <p>(2) A plan for orientation of all personnel to policies and objectives of the hospital and for on-the-job training where necessary.</p>	<p>79791. Personnel Policies</p> <p>(a) Each correctional treatment center shall adopt and implement written personnel policies concerning qualifications, responsibilities, and conditions of employment for each classification employed which shall be available to all personnel. Such policies shall include but not be limited to:</p> <p>(1) Hours of work.</p> <p>(2) A plan for orientation for all new staff members that shall ensure that all new staff providing program services shall receive at least 20 hours of orientation and training within 14 days of</p>

	<p>(3) A plan for at least an annual evaluation of employee performance.</p> <p>(a) Personnel policies shall require that employees and other persons working in or for the hospital familiarize themselves with these and such other regulations as are applicable to their duties.</p> <p>(b) Hospitals shall furnish written evidence of a plan for growth and development of the hospital staff through: (1) Designation of a staff member qualified by training and experience who shall be responsible for staff education.</p> <p>(2) Reference material relevant to the services provided by the hospital which shall be readily accessible to the staff.</p>	<p>employment. Staff attendance shall be documented. Initial training shall include, but not be limited to, the following:</p> <p>(A) Orientation to all policies, procedures and objectives of the facility</p> <p>(3) A plan for at least annual evaluation of employee performance</p> <p>(b) Provision of a continuing in-service education program designed to improve patient care and employee efficiency. This training shall be in compliance with Section 79797 of this Chapter. All staff members shall attend, and attendance shall be documented.</p> <p>(c) Personnel policies shall require that employees and other persons working in or for the facility familiarize themselves with the California Code of Regulations, Title 22, pertaining to correction pertaining to correction treatment centers and such other regulations as are applicable to their duties.</p> <p>(d) The facility shall recruit qualified personnel.</p> <p>(e) If language or communication barriers exist between facility staff and patients, arrangements shall be made for interpreters or for the use of other means to ensure adequate communications between patients and personnel.</p> <p>(f) All correctional treatment center staff shall be subject to the reasonable application of security procedures necessary for the operation of the jail or prison. Written policy and procedures governing the application of security procedures to correctional treatment</p>
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		<p>center programs and staff shall be developed and adopted by the jail or prison administrator with input from the correctional treatment center administrator or director. Correctional treatment center staff shall not be primarily responsible for the enforcement of security policies or procedures.</p>
	<p>§ 70721. Employees</p> <p>(a) The hospital shall recruit qualified personnel and provide initial orientation of new employees, a continuing in-service training program and competent supervision designed to improve patient care and employee efficiency.</p> <p>(b) If language or communication barriers exist between hospital staff and a significant number of patients, arrangements shall be made for interpreters or for the use of other mechanisms to insure adequate communications between patients and personnel.</p> <p>(c) The hospital shall designate a member of the staff as a patient discharge planning coordinator.</p> <p>(d) All employees of the hospital having patient contact, including students, interns and residents, shall wear an identification tag bearing their name and vocational classification.</p>	<p>79797. Staff Development</p> <p>(a) Each correctional treatment center shall have an ongoing educational program planned and conducted for the development and improvement of necessary skills and knowledge for all facility personnel. Each program shall include but not be limited to:</p> <ol style="list-style-type: none"> (1) Orientation of all newly employed staff to all appropriate facility policies and procedures and specific job requirements. (2) Prevention and control of infections. (3) Fire prevention and safety. (4) Cardiopulmonary resuscitation. (5) All newly developed policies and procedures. (6) Internal and external disaster plans. (7) Applicable security policies and procedures of the correctional institution or detention facility. (8) Suicide prevention techniques.

	<p>(e) Appropriate employees shall be given training in methods of hospital infection control and cardiopulmonary resuscitation.</p> <p>(f) Uniform rules shall be established for each classification of employees concerning the conditions of employment. A written statement of all such rules shall be provided each employee upon commencing employment.</p>	<p>(b) Records shall be retained of all orientations and training and shall include date and time of training, title of presenter, summary of content and signatures of those attending.</p>
		<p>§ 79781. Required Committees (Section 1. Patient Care Policy Committee)</p> <p>(a) Each correctional treatment center shall have at least the following committees: patient care policy, infection control and pharmaceutical service.</p> <p>(b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.</p> <p>(c) In those correctional treatment centers where appropriate, these functions may be performed by a committee of the whole.</p> <p>(d) Committee composition and function shall be as follows:</p> <p>(1) Patient Care Policy Committee</p> <p>(A) A patient care policy committee shall establish policies governing the following services: Physician, psychiatrist, psychologist, dental, nursing, dietetic, pharmaceutical, health records, house-keeping and</p>

		<p>such additional services as are provided by the facility.</p> <p>(B) The committee shall be composed of at least the medical director, the administrator (if appointed), the director of nursing service, a pharmacist and a representative of each required service as appropriate.</p> <p>(C) The committee shall meet at least annually.</p> <p>D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.</p> <p>(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.</p> <p>(F) The patient care policy committee shall implement the provisions of Health and Safety Code Sections 1315, 1316, and 1316.5, by means of written policies and procedures.</p> <p>(G) Only physicians shall assume the overall medical care of patients, including performing the admitting history, and the physical examinations and the issuance of orders for medical care.</p>
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Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Physical Environment/Safety

Definition

The facility shall maintain a health record service in accordance with accepted professional standards and practices. The health record service shall have sufficient staff, facilities, and equipment, and be conveniently located to facilitate the accurate processing, checking, indexing and filing of all health records.

Best Practices

1. *Secure, well lit, well ventilated areas with fire protection (sprinklers, etc.), Appropriate use of shelving/file equipment with file guides, Retention policy in place an enforced to the minimum standards.*
2. *Adequate space, layout, lighting, ventilation, security, communications devices, desks, equipment, and access to supplies as needed.*
3. *Adequate transportation for delivery, record delivery services, and communication to drivers/runners.*

CDCR – Department Operations Manual Policy(ies)/Procedure(s)

Non identified.

Licensure Standards:

Title 15*	Title 22 Division 5; Chapter 1; Gen- eral Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
	§ 70747. Medical Records Service Section (a) The hospital shall maintain a medical record service which shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing and filing of all medical records.	§ 79803. Health Record Service Section (a) The correctional treatment center shall maintain a health record service in accordance with accepted professional standards and practices. The health record service shall have sufficient staff, facilities, and equipment, and be conveniently located to facilitate the accurate processing, checking, indexing and filing of all health records.

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Unit Health Record/Master Patient Index

Definition

Unit Health Records means a patient's health record that includes all records of care and treatment rendered to a patient. A unique identifier is assigned to a patient's unit health record which provides for an organization of the health record for retrieval and storage.

Master Patient Index (MPI) is a permanent database of every patient admitted to or treated by the facility. The MPI is also referred to as the master person index, the master population index, the master name file, the enterprise wide person or patient index (EMPI), and the master patient database. Regardless of its name, the MPI is an important key to the health record because it includes the patient's name and health record number as well as other important identifying information.

Best Practices

1. *Ability to track daily admissions, discharges, and transfers (ADT) related to 'patient' specific activity and episodes of care, daily reconciliation of records for all incoming and outgoing patients (movement of record).*

Traditional MPI number if replaced with CDCR number.
MPI equivalent = OBIS

2. *Ability to identify and reconcile duplicate patient identifying numbers and demographic data as necessary to serve as an effective index system for filing, location, and retrieval. CDC numbers are verified on a daily basis to identify duplicate numbers. A procedure is in place and being followed to perform daily CDC number validation and clean up.*
3. *A CDC number duplicate list is compiled and cleaned up on a monthly basis.*
Duplicates exists but no formal system to reconcile.
4. *Ability to collect and retrieve ADT data from a single source without redundant data entry or reporting.*

CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.16 Filing System for Inpatient/Outpatient Health Records

All inpatient/outpatient records shall be filed by the inmate's prison identification number. The records shall be filed in numerical order by the last two digits and then in order by the first three digits. The alphabetical prefix is utilized only when two numbers are identical.

91070.5 Centralized Outpatient Health Records

An outpatient health record shall be created and maintained for each inmate admitted to the Department. The outpatient health record shall contain both medical and psychiatric information. The reception centers shall initiate the record except in the case of condemned male inmates. SQ shall initiate the record on condemned male inmates.

Licensure Standards:

Title 15	Title 22 Division 5; Chapter 1; General Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
<p>Title 15, Division 3 Article 9.5; Section 3370 Case Records Section 3370 Case Records File and Unit Health Records Material – Access and Release</p>	<p>§ 70751. Medical Record Availability Section (i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.</p>	<p>§ 79803. Health Record Service (c) If a facility, in addition to inpatient services, is providing outpatient, emergency, day treatment, or crisis intervention service, a unit health record system shall be established.</p>
<p>(a) Unit health records means a patient’s health record that includes all records of care and treatment rendered to an inmate-patient.</p>		<p>§ 79579. Unit Health Records Unit health records means a patient’s health record that includes all records of care and treatment rendered to an inmate-patient.</p>

HIPAA/California Hospital Association (CHA) Considerations:

CHA:

- Psychotherapy notes are notes recorded in any medium by a mental health professional documenting or analyzing conversation, group therapy of family counseling and are separated from the rest of the patient’s record.

HIPAA:

- To meet the definition of psychotherapy notes, the information must be separated from the rest of the individual’s medical record

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Medical Record Availability/Retention

Definition

Medical Record Availability - Records are kept on all patients admitted or accepted for treatment. All health records are readily accessible upon request of persons authorized by law to have access to such records, and to those professional persons who are providing services to the patient and authorized representatives.

Record Retention – The length of time a record shall be safely preserved. This length of time is usually defined by Federal and/or State Law and Facility Policies and Procedures.

Best Practices

1. Destruction occurs in accordance with State retention policy, Records destroyed via shredding in appropriate manner to comply with HIPAA.
2. Location of patient records should be tracked and monitored on an ongoing basis. Process should include auditing and follow-up on record tracking opportunities and trends.

Record Availability – Inpatient	Unit Health Record routed to mental health or medical unit within 60 minutes of patient admission	Record Retrieval = 30 records/hour
Record Availability – Outpatient/Clinic Scheduled	<ul style="list-style-type: none"> • Record available prior to patient encounter >= 95%	Record Retrieval = 30 records/hour
Record Availability – Outpatient/Clinic Unscheduled	<ul style="list-style-type: none"> • Routine care requests available within 60 minutes of request • ASAP care requests available within 30 minutes of request • STAT care requests available within 15 minutes of request • Review requests available within 24-48 hours of request • Other request for patient care available within 4 hours • Prescription refill requests available within 24 hours of request 	Record Retrieval = 30 records/hour

Record Re-file	<p>> = 90% (includes providing reason for non-availability)</p> <p>All records returned to the HIM department are re-filed within 12-24 hours of receipt</p> <p>The location system is updated within 1 hour of record receipt</p>	Record Re-file = 45 records/hour
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CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.7.1 Health Record

The inmate’s health record, including x-ray films, shall be the property of the Department and shall be maintained for the benefit of the inmate, the medical staff, the health care facility and the Department. The health care facility shall safeguard the information in the record against loss, defacement, tampering, or use by unauthorized persons.

Note: If a hospital ceases operation, DHS shall be informed within 48 hours of the arrangements made for safe preservation of inmate patient records.

91020.10 Records

Records for each inmate housed by DMH shall be maintained by the respective “hub” institution (refer to DOM 62030). The “hub” institution and P&CSD staff shall make all contacts with the designated DMH facility to secure reports, schedule BPT hearings, and to process an inmate’s parole or discharge. Any report needed for BPT hearings, Superior Court, or other such proceeding shall be requested of DMH to prepare the report or send the departmental staff person to the hospital to complete the report.

91070.16.1 Retention of Inpatient/Outpatient Records

Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient from a departmental health care facility.

91070.18.3 Health Record Tracking

All receiving facilities shall access inmate health records to ensure that a complete medical file has been received. The facility shall track and monitor receipt of all patients’ health records. Temporary files are to be initiated only to file loose clinical reports. A complete permanent health record shall be on the file shelf within 30 days.

91070.18.4 File Audit

Each facility shall audit its file shelves quarterly to ensure that all outpatient health records have been forwarded to the inmate’s current facility. Purged files are to be forwarded immediately to the facility where the inmate currently resides with a written explanation from the medical records supervisor.

71020.5.6 Archives File Retention

Health records. Retain in hard copy for seven years after discharge, then destroy (CCR (22) 70751[c]). Fingerprint cards and photographs. Retain in hard copy for 30 years, then destroy. All other remaining case records retain in microfiche 30 years, then destroy.

Licensure Standards:

<p>Title 15</p>	<p>Title 22 Division 5; Chapter 1; General Acute Care Hospitals</p>	<p>Title 22 Division 5; Chapter 12; Correctional Treatment Facilities</p>
<p>§ 3370. Case Records File and Unit Health Records Material -Access and Release</p> <p>(a) Unit health records means a patient’s health record that includes all records of care and treatment rendered to an inmate-patient.</p> <p>(b) Except by means of a valid authorization, subpoena, or court order, no inmate or parolee shall have access to another’s case records file, unit health records, or component thereof.</p> <p>(c) Inmates or parolees may review their own case records file and unit health records, subject to applicable federal and state law. This review shall be conducted in the presence of staff, and may necessitate the use of a computer.</p> <p>(d) No inmate or parolee shall access information designated confidential pursuant to section 3321 which is in or from their own case records file.</p> <p>(e) No case records file, unit health records, or component thereof shall be released to any agency or person outside the department, except for private attorneys hired to represent the department, the office of the attorney general, the Board of Prison Terms, the Inspector General, and</p>	<p>§ 70751. Medical Record Availability</p> <p>(a) Records shall be kept on all patients admitted or accepted for treatment. All required patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of:</p> <ol style="list-style-type: none"> (1) The admitting physician (2) The non physician granted privileges pursuant to Section 70706.1 (3) The hospital or its medical staff or any authorized officer, agent or employee of either (4) Authorized representatives of the Department (5) Any other person authorized by law to make such a request <p>(b) The medical record , including X-ray films, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.</p> <p>(c) Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has</p>	<p>§ 79807. Inmate-Patient Health Record Availability</p> <p>(a) Records shall be kept on all inmate-patients admitted or accepted for treatment. All required records, either as originals or as accurate reproductions of the contents of such originals, shall be maintained in a confidential manner, and be legible, and readily accessible upon request of persons authorized by law to have access to such records including, but not limited to persons authorized pursuant to Health and Safety Code, Section 1795 et seq., those professional persons who are providing services to the patient and authorized representatives of the Department.</p> <p>(b) The correctional treatment center shall safeguard the information in the record against loss, defacement, tampering, or use by unauthorized persons.</p> <p>(c) Inmate-patient health records or reproductions thereof, shall be safely preserved for a minimum of seven years following discharge of the inmate-patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.</p>

<p>as provided by applicable federal and state law. Any outside person or entity that receives case records files or unit health records is subject to all legal and departmental standards for the integrity and confidentiality of those documents.</p>	<p>reached the age of 18 years and, in any case, not less than seven years.</p> <p>(d) If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.</p> <p>(e) If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:</p> <p>(1) The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both the new and former licensee and other authorized persons; or</p> <p>(2) Arrangements have been made for the safe preservation of patient records, as above required, and that the records are available to both the new and former licensees and other authorized persons.</p> <p>(f) Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.</p> <p>(g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge.</p> <p>Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative</p>	<p>(d) If a correctional treatment center ceases operation, the Department shall be informed, within 48 hours of the arrangements made for safe preservation of inmate-patient health records.</p> <p>(e) Inmate-patient records shall be filed in an easily accessible manner in the facility or in an approved health record storage facility off the facility premises.</p> <p>(f) Inmate-patient records shall be completed within 14 days following the inmate-patient's discharge.</p>
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	<p>(offices to the effect that he is the only person who:</p> <p>1) Has possession of the stamp or</p> <p>(2) Will use the stamp or key.</p> <p>(h) Medical records shall be indexed according to patient, disease, operation and physician.</p> <p>(i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.</p> <p>(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.</p>	
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HIPAA/California Hospital Association (CHA) Considerations:

CHA:

- Records MUST be retained for: Adults – 10 years following discharge except, pregnant patients, which should be retained for at least 19 years.

HIPAA:

- Inclusion of both electronic and physical records are to be retained.

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Health Record Content/Documentation/Charting Guidelines

Definition

The content of the health record contains information to justify the admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. All entries in the health record are legible and complete and authenticated and dated promptly by the person who is responsible for ordering, providing, or evaluating the service furnished

Individual care providers are ultimately responsible for the quality of entries they make and authenticate in the health record. Documentation generally occurs at the point of care in a timely manner. Medical Record services is responsible for ensuring that providers understand the regulations and standards for proper documentation and for educating providers as changes occur.

Best Practices

1. All providers of health care services provide timely point of care documentation in the health record.
2. Nursing documentation and signatures are verified in a timely manner through 24 hour chart checks.
3. Continuously improve concurrent clinical documentation as evidenced by:
 - a. An ongoing record review process that identifies/ trends records which do not clearly, completely and accurately reflect the diagnosis.
 - b. Process improvement methods that are identified to resolve these trends on an ongoing basis.
 - c. A process to monitor the timeliness of H&Ps and Operative Reports concurrently.
 - d. A process where the aggregate results are presented, at least quarterly, to a Documentation Review/QI Committee.

CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.2.1 Documentation Principle

Each facility shall maintain health records for all patients treated by the facility. The records shall contain information to identify the patient, justify the diagnosis, to describe the patient's treatment and care, and to provide for continuity of medical care. The record shall serve as an accurate database for the evaluation of the quality of care provided, to provide documentation for business purposes, and to defend legal interests.

91070.2.3 Charting Guidelines

All entries in the medical record should be accurate, timely, objective, specific, concise, and descriptive. Only approved abbreviations shall be used. Additional information recorded on subsequent pages shall have "Continued" indicated. Entries are to be recorded consecutively, not leaving blank spaces for additions.

Error corrections are made with a single line drawn through the entry making certain not to obliterate the information. The word error is to be written with the date and

writer's initials. An asterisk (*) next to the date of the incorrect entry and another to indicate location of the correction should be used for large corrections. For small corrections continue writing. "White-out" or any other form of obliteration on hand or typewritten entries is not to be used.

All entries are to be written in permanent ink.

All pages in the health record shall contain the patient's full name, CDC inmate number, and name of the facility where treatment or care is provided.

Signatures shall consist of the writer's first initial, last name, and professional title. Countersignatures are to be used when a facility's policy and procedure require such. Initials may be used where called for on specific forms. Amendments to a record are additions that provide additional facts not available at the time the original entries were made. They provide evidence that the information originally recorded is in error or incorrectly represents the facts. Amendments also explain or clarify missing or incomplete entries. For late entries, insert (*) in the margin or between lines to correspond with observation, action, or event.

91070.21 Approved Abbreviation List

Only those abbreviations approved by the Chief of DHS or the CMO shall be used in the inpatient or outpatient health record.

91030.12 Informed Consent

A CDC Form 7203, Consent for Medical, Dental or Surgical Services--

Inmate/Guardian, is the agreement by an inmate to have a procedure performed after being told in detail of possible risks. The CDC Form 7203 shall:

- Be obtained in writing prior to treatment.
- Become part of the OPD
- Be handwritten by the person who signs it or is in typeface no smaller than 8-point type.

Licensure Standards:

Title 15	Title 22 Division 5; Chapter 1; General Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
<p>3353.1. Capacity for Informed Consent</p> <p>An inmate shall be considered capable of giving informed consent if in the opinion of health care staff the inmate is:</p> <p>(a) Aware that there is a physiological disorder for which treatment or medication is recommended.</p> <p>(b) Able to understand the nature, purpose and alternatives of the recommended treatment, medication, or health care procedures.</p> <p>(c) Able to understand and reasonably discuss the possible side effects and any hazards associated with the recommended treatment, medication, or health care procedures. An inmate shall not be deemed incapable of informed consent solely because of being diagnosed as mentally disordered, abnormal, or mentally defective.</p>	<p>§ 70749. Patient Health Record Content</p> <p>(a) Each inpatient medical record shall consist of at least the following items:</p> <p>(1) Identification sheets which include but are not limited to the following:</p> <p>(A) Name</p> <p>(B) Address on admission</p> <p>(C) Identification number (if applicable)</p> <p> 1) Medicare</p> <p> 2) Medi-Cal</p> <p>(D) Age</p> <p>(E) Sex</p> <p>(F) Martial status</p> <p>(G) Religion</p> <p>(H) Date of admission</p> <p>(I) Date of discharge</p> <p>(J) Name, address and telephone number of person or agency responsible for patient</p> <p>(K) Name of patient's admitting physician</p> <p>(L) Initial diagnostic impression</p> <p>(M) Discharge or final diagnosis</p> <p>(2) History and physical examination.</p> <p>(3) Consultation reports.</p> <p>(4) Order sheet including medication, treatment and diet orders.</p> <p>(5) Progress notes including current or working diagnosis.</p> <p>(6) Nurses' notes which shall include but not be limited to the following:</p> <p>(A) Concise and accurate record of nursing care administered</p>	<p>§ 79805. Inmate-Patient Health Record Content</p> <p>(a) Each inmate-patient's health record shall consist of at least the following items:</p> <p>(1) Admission and discharge record identification data including, but not limited to, the following:</p> <p>(A) Name</p> <p>(B) Inmate-patient identification number</p> <p>(C) Date of Birth</p> <p>(D) Sex</p> <p>(E) Martial status</p> <p>(F) Religion (optional on part of inmate-patient)</p> <p>(G) Date of admission</p> <p>(H) Date of discharge</p> <p>(I) Name, address and telephone number of person or agency responsible for the inmate-patient, or next of kin</p> <p>(J) Initial diagnostic impression</p> <p>(K) Initial diagnostic impression</p> <p>(L) Discharge or final diagnosis</p> <p>(2) Mental Status.</p> <p>(3) Admission medical history and physical within 24 hours of admission. This shall include written documentation of a Mantoux tuberculin skin test within the past year, unless a previously positive reaction can be documented or completion of adequate preventive therapy or adequate therapy for active disease can be documented. If no written documentation is available,</p>

	<p>(B) Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient</p> <p>(C) Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration</p> <p>(D) Record of type of restraint and time of application and removal</p> <p>(8) Reports of all laboratory tests performed.</p> <p>(9) Reports of all X-ray examinations performed.</p> <p>(10) Consent forms, when applicable.</p> <p>(11) Anesthesia record including preoperative diagnosis, if anesthesia has been administered.</p> <p>(12) Operative report including preoperative and postoperative diagnosis, description of findings, technique used, tissue removed or altered, if surgery was performed.</p> <p>(13) Pathological report, if tissue or body fluid was removed.</p> <p>(14) Labor record, if applicable.</p> <p>(15) Delivery record, if applicable.</p> <p>(16) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, his condition on discharge and the</p>	<p>the Mantoux tuberculin skin test shall be administered within 24 hours of admission, and recorded in millimeters of in duration in the medical history.</p> <p>(4) Dated and signed observations and progress notes recorded as often as the inmate-patient's condition warrants by the person responsible for the care of the inmate-patient.</p> <p>(5) Consultation reports.</p> <p>(6) Medication, treatment and diet orders.</p> <p>(7) Social service evaluation, if applicable.</p> <p>(8) Psychological evaluation, if applicable.</p> <p>(9) Dated and signed health care notes including, but not limited to, the following:</p> <p>(A) Patient care plan</p> <p>(B) Concise and accurate records of nursing care provided</p> <p>(C) Records of pertinent nursing</p> <p>(D) The reasons for the use of and the response of the inmate-patient to PRN medication administered and justification for withholding scheduled medications</p> <p>(E) Record of type of restraint, including time of application and removal</p> <p>(F) Rehabilitation evaluation, if applicable.</p> <p>(G) Interdisciplinary treatment plan, if applicable</p> <p>(H) Progress notes including the patient's response to medication and treatment rendered and observation(s) of patient by all members of treatment team providing services to the patient</p>
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	<p>recommendations and arrangements for future care.</p>	<p>(I) Medication records including name, dosage, and time of administration of medications, and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration</p> <p>(J) Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided</p> <p>(K) Vital sign record sheet.</p> <p>(L) Consent forms as required, signed by the inmate-patient or the appropriate surrogate decision maker</p> <p>(M) All dental records, if applicable</p> <p>(N) Records of all laboratory tests ordered</p> <p>(O) Reports of all cardiographic or encephalographic tests performed</p> <p>(P) Reports of all X-ray examinations ordered</p> <p>(Q) All reports of special studies ordered</p> <p>(R) A discharge summary prepared by the admitting or primary care practitioner which shall recapitulate the significant findings and events of the inmate patient's treatment, his/her condition on discharge and the recommendation (and arrangements for future care.</p> <p>(S) Discharge or transfer information and continue care instructions</p>
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Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Transfers/Discharges/Deaths

Definition

The disposition of a patient when provision of the health care services the patient received is terminating, and there is a formal release of a patient from the facility. This can either be a discharge, transfer, or death.

Best Practices

1. *Location of patient records should be tracked and monitored on an ongoing basis. Process should include auditing and follow-up on record tracking opportunities and trends.*
2. *Ensure the record follows the patient upon transfer for continuity of patient care in a timely manner.*
3. *Standard chart tracking across the system to support timely record movement.*

CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.15 Transfer of Inpatients to Different Levels of Care Within the Same Facility

The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital that has a distinct partially skilled nursing or intermediate care service.

91070.15.1 Transfer to Outside Facilities

A transfer summary shall accompany the patient upon transfer to another health facility. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan. The transfer summary shall be signed by a physician. A copy of the transfer summary shall be retained in the inpatient record.

Note: Patients transferred to an outside community health facility shall be considered discharged from the CDC health care facility. The inpatient record shall be closed and a discharge summary completed. Upon return of the patient, a new record shall be established. The history and physical from the outside community health facility may be used if the attending physician makes a notation that the history and physical has been reviewed.

91070.15.2 Transfers to Other Facilities

A narrative discharge summary or transfer summary shall accompany inmates who transfer from one acute care service in one health care facility to another within the Department.

91070.18 Transfer of Inmates

An inmate shall not be transferred to another facility unless accompanied by the outpatient health record.

91070.18.1 Paroles and Discharges

Outpatient health records of inmates who parole shall be forwarded to the appropriate regional parole office. Outpatient health records on inmates who have been discharged shall be forwarded to Archives.

91070.18.2 Deaths

Outpatient health records on inmates who expire shall be retained at the facility in which the death occurred. These records shall be maintained for a minimum of seven years. Health records on parolees who expire shall be forwarded to Archives.

Licensure Standards:

Title 15	Title 22 Division 5; Chapter 1; General Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
<p>§ 3355. Health Care Examinations</p> <p>Section</p> <p>(b) Transfers. Inmates received on transfer from other facilities shall be interviewed by health care staff at the receiving facility within 24 hours of arrival. The health record of each new arrival shall be reviewed to determine the need for previously prescribed medications or continuing treatment for unusual or chronic health problems. Sending facility health care staff shall notify the receiving facility and any anticipated layover facilities regarding any inmate's need, as in the case of diabetics, for maintenance medications while en route and after arrival.</p>	<p>70717. Admission, Transfer and Discharge Policies</p> <p>(a) Each hospital shall have written admission transfer and discharge policies which encompass the types of clinical diagnoses for which patients may be admitted, limitations imposed by law or licensure, staffing limitations, rules governing emergency admissions, advance deposits, rates of charge for care, charges for extra services, terminations of services, refund policies, insurance agreements and other financial considerations, discharge of patients and other related functions.</p> <p>(b) Hospitals offering emergency and/or outpatient services shall make available, upon request of a patient, a schedule of hospital charges.</p> <p>(c) Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall</p>	<p>§ 79809. Transfer Summary</p> <p>A transfer summary shall accompany or precede the inmate-patient upon transfer to another facility where continuing care will be provided. The transfer summary shall include essential information relative to the inmate-patient's diagnosis, treatment course, medications, dietary requirements, known allergies and treatment plan.</p>

	<p>be established at time of admission by the member of the medical staff who admits the patient, subject to the rules and regulations of the hospital, and the provisions of Section 70705(a).</p> <p>(1) Patients admitted to the hospital for podiatric services shall receive the same basic medical appraisal as patients admitted for other services. This shall include the performance and recording of the findings in the health record of an admission history and physical examination which shall be performed by persons lawfully authorized to do so by their respective practice acts.</p> <p>(d) Within 24 hours after admission, or immediately before, every patient shall have a complete history and physical examination performed providing the condition of the patient permits.</p> <p>(e) No mentally competent adults shall be detained in a hospital against their will. Emancipated minors shall not be detained in a hospital against their will. Unemancipated minors shall not be detained against the will of their parents or legal guardians. In those cases where law permits unemancipated minors to contract for medical care without the consent of their parents or legal guardians, the minors shall not be detained in the hospital against their will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the hospital in the</p>	
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	<p>patient's own interest nor the detention of mentally disordered patients for the protection of themselves or others under the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000, et seq.) if the hospital has been designated by the county as a treatment facility pursuant to said act nor to prohibit minors legally capable of contracting for medical care from assuming responsibility for their discharge.</p>	
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Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Chart Order/Assembly

Definition

Chart Order/Assembly is the process for organizing the forms in a medical record in a systematic fashion. This means that all records have an established chart order of filing that is followed. In addition, this process ensures that the documents in the record belong to one individual and those documents are properly labeled and identified. Chart Order/Assembly also ensures that all records are received and accounted for.

Best Practices

1. Record reconciliation is completed on a daily basis to ensure the receipt of all appropriate records.
2. A universal chart order has been implemented and is being followed to reflect an order similar to concurrent inpatient records to assist providers in accessing information in the medical record.
3. Records are assembled in a timely manner. The monthly average number of days from the date of discharge/visit to the date the record is received and assembled is less than or equal to 24 hours.
4. Centralized record processing staff should be in place with full cross-training amongst staff for various types of records.
5. Standardized Assembly (chart order) List, Standardized Deficiencies (minimal based on key reports/signatures -- not all documents - Less is Better Approach), Automated deficiency tracking, access to transcription (dictated reports at time of analysis, Universal chart order (chronologic preferred), Keep chart dividers and folders to a minimum and in standard order.

CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.11 Standardized Health Services Forms

All forms filed in the inpatient or the outpatient health record shall be approved departmental forms.

91070.12 Inpatient Health Record

The inpatient record shall be in the following order:

- Patient identification
- Face sheet/admitting form/patient identification
- Narrative discharge and transfer summary
- Death reports
- Report of death
- Coroner's report (autopsy)
- Medical reports
- Refusal of examination and treatment
- Emergency room reports (also known as ER reports)
- Medical history
- Physical examination

- Consultant reports
- Informed consent
- Human Immunodeficiency Virus (HIV) consent
- Notice of transfer/transfer summary
- Operative reports
- Consent of surgical operation
- Preop check list
- Preanesthesia check list
- Anesthesia report
- Postanesthesia report
- Report of operation
- Pathology report
- Physician's reports
- Physician's progress notes
- Doctor's orders
- Psychiatric treatment plan
- Material from outside facilities (same order):
- Staff reports
- Laboratory reports
- X-ray reports
- Electrocardiograms (also known as EKGs)
- Other diagnostic reports
- Physical therapy reports
- Respiratory therapy reports
- Social services
- Occupational therapy
- Dietary assessment
- Nursing reports
- Medication records
- Graphic charts
- Intake & output records
- Intravenous flow charts (also known as IV flow charts)
- Diabetic record
- Weight record
- Nursing assessment
- Bedside records (nursing notes)
- Patient care plan
- Record of daily activities
- Medical report of injury or unusual occurrence
- Telegram
- Suicide watch

- Chronos
- Miscellaneous

91070.17 Outpatient Health Record

Documents are to be filed behind appropriate divider in reverse chronological order (most recent on top). The outpatient record shall be maintained in the following order:

Left Side of Folder

Outpatient medication record:

- Daily diabetic record
- Consultation/inpatient reports section (yellow)
- Consultation reports-most recent on top
- Inpatient reports
- Consent to operate-outpatient surgery
- Operative reports-outpatient surgery
- Refusal of treatment

Miscellaneous section (blue):

- Reports from other (non-department) facilities
- Medical report of injury or unusual occurrence
- Requests for medical information from Department to outside facilities
- Receipts from inmate for receiving copies of records
- Memos
- Correspondence

Laboratory/pathology section (orange):

- Laboratory reports
- Laboratory reports
- Pathology reports

X-ray section (brown):

- X-ray reports
- X-ray reports from nondepartment facilities
- Computerized Axial Tomography Scans (also known as CAT Scans)

Other diagnostic section (pink):

- Electrocardiograms
- Electroencephalograms
- Hearing tests
- Eye refractions
- Physical therapy

Right Side of Folder

Outpatient medical record:

Physician orders for outpatient services.

Chronos section (green):

- CDC Form 128-C, Medical/Psychiatric/Dental Chronos
- CDC Form 128-C-1, Medical Clearance and Special Instructions Chronos

Physical exam section (red):

- Periodic health reviews
- Prenatal records
- Immunization records
- Entry medical history
- Entry physical examination
- Record of original dental exam

Psychiatric section (purple):

- Progress notes by psychologist and psychiatrists
- Psychiatric arrival screening forms
- Psychiatric chronos
- Board reports
- Psychiatric evaluations
- Psychiatric test results (multiphysical exam)
- DMH outpatient partial day-care treatment reports

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Discharge Analysis/Record Completion

Definition

Discharge analysis consists of checking the presence of reports and signatures in the medical record. These requirements are typically defined in Facility Policies/Procedures, Medical Staff Rules and Regulations, State/Federal Regulations, and/or Accrediting Agencies.

Record Completion is the process of ensuring all required documentation components are completed in a timely manner in conjunction with Regulatory/Accrediting agencies.

Best Practices

1. Records are assembled and analyzed in a timely manner. The average turnaround time for assembly/analysis is less than 48 hours post discharge.
2. Emphasis on concurrent/point of care documentation completion and signatures. Formal communication process and expectations with clinicians, presence of clinician orientation and standardized completion guidelines are established.
3. A process to measure HIM policy and/or regulatory compliance for incomplete/delinquent records is in place. This process captures and reports incomplete/delinquent record statistics, as defined by HIM policy and/or regulatory agencies (following most stringent guidelines) on a monthly basis is in place.
4. Monthly measures do not exceed HIM policy and/or regulatory agencies.

Assembly/Analysis	<ul style="list-style-type: none">• Performed as one process• Completed within 24-48 hours of discharge or encounter	Inpatient = 5-8 records/hour Outpatient (SDS) = 10 records/hour
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CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.13 Discharge Analysis

Qualitative analysis shall be performed on all inpatient records. Each inpatient medical record shall consist of at least the following items:

Identification sheets shall include, but are not limited to, the following:

- Name
- Address on admission
- Identification number
- Age
- Sex
- Marital status
- Religion
- Date of admission
- Date of discharge

- Name, address, and telephone number of person or agency responsible for patient
- Name of patient's admitting physician
- Initial diagnostic impression
- Discharge or final diagnosis
- History and physical examination
- Consultation reports
- Physician Order to Admit/Discharge including medication, treatment, and diet orders
- Progress notes including current or working diagnosis
- A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, the condition on discharge, and the recommendations and arrangements for future care

Nurses' Notes

Nurses' notes shall include, but not be limited to, the following:

- Concise and accurate record of nursing care administered
- Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual
- Occurrences and relevant nursing interpretation of such observations
- Name, dosage, and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.
- Record of type of physician-ordered restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient or required for seclusion for custody reasons.
- Vital sign sheet
- Reports of all X-ray examinations performed
- Consent forms when applicable
- Anesthesia record including preoperative diagnosis if anesthesia has been administered
- Operative report including preoperative and postoperative diagnosis, description of findings, technique used, tissue removed or altered if surgery was performed
- Pathological report or laboratory report if tissue or body fluid was removed
- Labor record if applicable
- Delivery record if applicable
- Nursing care plan
- Psychiatric treatment plan if applicable

91070.2.2 Record Completion

Records shall be complete, legible, typed or in ink, signed, dated, and in compliance with licensing requirements in CCR (22). Correctable deficiencies are those that can be completed by the individual responsible for the entry or in the absence of the responsible person by another member of the clinical staff with knowledge of the recorded events. Non-correctable deficiencies are entries where it is not possible to

determine if the staff member responsible provided care and treatment.

91070.14 Incomplete Inpatient/Outpatient Medical Records

Medical records shall be completed promptly and authenticated or signed by a physician, dentist, or podiatrist within two weeks following the patient’s discharge.

Licensure Standards:

Title 15	Title 22 Division 5; Chapter 1; General Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
	<p>§ 70751. Medical Record Availability Section(s)</p> <p>(g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient’s discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician’s signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the</p> <p>(1) Has possession of the stamp or key only person who:</p> <p>(2) Will use the stamp or key.</p> <p>(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service</p>	<p>§ 79807. Inmate-Patient Health Record Availability Section</p> <p>(f) Inmate-patient records shall be completed within 14 days following the inmate-patient’s discharge</p>

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Forms Control/Forms Design/Loose Reports

Definition

Forms Control/Forms Design establishes standards for all forms within the medical record. Any new form is approved through standard protocols established within the organization. Forms control is extremely important to ensure a standardized health care document. Standardization and control of forms will transition a healthcare organization from a paper based to an electronic health record.

Loose Reports are those documents that are not filed with the patient's medical record in a timely manner and are received in the Medical Records area to be interfiled in the patient's health record.

Best Practices

1. *Standard forms guidelines are adhered to in forms development/design. Placement of inmate patient identification and location is consistent.*
2. *On a concurrent basis, medical record documentation including diagnostic tests are filed in the health record the day the result is made available.*
3. *A process includes filing/processing loose reports within 24 - 48 hours of receipt in the HIM Department.*
 - a. *The process includes filing/processing loose reports within 24-48 hours of receipt in the HIM Department.*
 - b. *Process improvement methods are in place to identify and resolve opportunities with timely report receipt from other ancillary departments.*

CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.11 Standardized Health Services Forms

All forms filed in the inpatient or the outpatient health record shall be approved departmental forms.

91070.18.3 Health Record Tracking

All receiving facilities shall access inmate health records to ensure that a complete medical file has been received. The facility shall track and monitor receipt of all patients' health records. Temporary files are to be initiated only to file loose clinical reports. A complete permanent health record shall be on the file shelf within 30 days.

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Coding/Abstracting/Indexing/Data Collection

Definition

Coding is the process of translating a diagnosis into a numerical assignment that provides an organized approach to data retrieval. Codes are symbolic abbreviations that allow information to be categorized into succinct forms for ease of storage and use.

Abstracting is the process of extracting information from a document to create a brief summary of a patient's illness, treatment, and outcome and entering that data into an automated system for easy retrieval and aggregation of data..

Best Practices

1. Final coding/abstracting for all patient types is completed within 3-5 days of a patient's discharge/visit. The monthly average number of days from the date of discharge/visit to the date the abstract is finalized is less than or equal to 3-5 days.
2. Use of appropriate software support for encoding, grouping (if needed), and data collection and reporting.
3. Use of appropriate AHIMA credentialed/certified staff, provision of appropriate ongoing education.
4. Follows Central Cooperating Parties national coding guidelines, Should have annual (minimum) external and internal education per coder as well as focused audits, HIM responsible for coding all types of care (diagnoses and procedures - ICD, CPT/HCPCS, DSM) , Cross trained staff for multiple patient types.
5. Coding quality reviews are completed at least semi-annually (or more frequently as directed by company initiative or facility leadership) by each facility.
6. Standard data collection and validation of entries.
7. Ability to report on all aspects of patient related statistical data (Inpatient and Outpatient) as well as other core indices (patient, disease, death , procedures), Use of standard nomenclature for capture of indices.

Coding (excludes abstracting)	Records are coded within the 4 days of discharge	Hospital/Facility Inpatient = 3-4 records/hour Outpatient Surgery/Observation = 6-8 records/hour ERs =15-20 records/hour (E&M level assignment or verification) Professional & Outpatient Diagnostics =20+ records/hour (dependent on resource documents)
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CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.9 Coding

The most recent edition of the International Classification of Diseases shall be used for coding. In those facilities with psychiatric units, the most recent edition of the Diagnostic Statistical Manual shall be used for psychiatric Operations Manual DEPARTMENT OF CORRECTIONS AND REHABILITATION Operations Manual 731 diagnostic coding. Coders shall have completed an approved basic coding course.

91070.10 Indexing

Medical records shall be cross-indexed according to patient by:

- Disease
- Operation
- Physician

Licensure Standards:

Title 15	Title 22 Division 5; Chapter 1; General Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
	<p>§ 70751. Medical Record Availability Section</p> <p>(h) Medical records shall be indexed according to patient, disease, operation and physician.</p>	<p>§ 79803. Health Record Service Section</p> <p>(d) The facility shall have a continuing system of collecting and recording data that describe patients served in such form as to provide for continuity of care, program services, and data retrieval for program patient care evaluation and research. Health records shall be stored and systematically organized to facilitate retrieval of information. Retrievability shall be assured by the use of an acceptable coding system such as the latest version of the International Classification of Diseases (ICD-9).</p>

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Statistics

Definition

Medical record services generally maintains a central, comprehensive, system of data collection, statistical analysis, indexes, registers and reports. Statistical information is compiled based on consistent definitions, units of measure, and uniform methods of data collections. Statistical reports may be prepared as needed for use by medical and administrative staffs and accrediting and regulatory agencies.

Best Practices

1. *As required by state agency or law - provide data to registries (i.e. Cancer, Trauma, Birth, etc.) and insure ability to report on such data is available.*
2. *Statistical definitions are consistent with the Uniform Hospital Discharge Data Set definitions.*
3. *Statistics may be used to support budgeting, planning, or other administrative needs.*

CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.19 Statistics Admission and Discharge List

All admissions to the health care facility shall be listed by day. All discharges from the health care facility shall be listed by day. The admission/discharge list shall contain at least the following information:

- Inmate's name
- Inmate's number
- Previous housing
- New housing

91070.19.1 Daily Census Report

The following information shall be maintained on a daily basis:

- Number of admissions
- Number of discharges
- Transfers to community hospitals
- Beginning census
- Ending census
- Inpatient daily census
- Length of stay for patients discharged
- Inter-wing/unit transfers

91070.19.2 Monthly Statistics

The following statistics shall be maintained monthly and forwarded to the HCSD:

For inpatient acute and infirmary hospitalizations:

- Total admissions
- Total discharges
- Average daily census

These statistics shall be maintained for all health care facility patients, all patients at outside hospitals, and all non-medical personnel housed in a health care facility.

91070.19.3 Death Log

The following information shall be maintained on all deaths:

- Inmate's full name
- Inmate's number
- Date of death
- Cause of death
- Place of death

This log shall also include inmates who expire outside the facility.

91070.19.4 Master Patient Index

A master patient index shall be maintained on all patients. For patients previously hospitalized, current information shall be added to the master index. The following information shall be maintained on each master patient index:

- Full name of inmate (last name, first name, middle initial)
- Inmate prison identification number
- Social security number
- CI&I fingerprint identification number
- Race. AKA
- Date of birth
- Age
- Comments
- Date of admission
- Date of discharge
- Physician
- Final diagnosis on discharge

This is a permanent file and shall never be destroyed.

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Confidentiality/Release of Information

Definition

Release of Information is the process of ensuring that patient records are treated as confidential and information from or copies of records may be released only to authorized individuals, and the facility must ensure that authorized individuals cannot gain access to or alter health records. Original medical records must be released by the hospital only in accordance with federal or state laws, court orders or subpoenas.

Best Practices

1. Requests for Information are completed within 3-5 working days of request receipt.
2. Requests are traced in a centralized database to permit management, timeliness and reporting.
3. Confidentiality policies in place, Authorized provider access only to information when active practitioner of record, Centralized Release of Information process.
4. Legal health record definition in place which covers release authorizations fax and in person access policies, printing and access control to be addressed.

Release of Information	Completed within 5 days of request	4-6 requests/hour dependent on storage locations, etc. Compliance with HIPAA entry for disclosure management.
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CDCR – Department Operations Manual Policy(ies)/Procedure(s):

91070.8 Confidentiality and Release of Information

All health records, either as originals or accurate reproductions of the content of such originals, shall be maintained in such form as to be legible and readily available upon the request of admitting physician; the non-physician granted privileges pursuant to CCR (22) 70706.1; the hospital, its medical staff, or any authorized officer, agent, or employee of either authorized representatives of DHS; or any other person authorized by law to make such a request.

91070.8.1 Valid Authorization

A valid authorization for the release of an inmate's health care record shall follow these guidelines:

- Be handwritten by the person who signs it or is in typeface no smaller than 8-point type.
- Be clearly separate from any other language present on the same page and be executed by a signature which serves no other purpose than to execute the authorization.
- Be signed and dated by the inmate. If the inmate is deceased or incompetent, the legal representative, spouse of inmate or person responsible for the inmate, or the beneficiary or personal representative of the deceased inmate may sign the authorization.

- State the specific uses and limitation on the types of medical information to be disclosed.
- State the name or functions of the provider of health care that may disclose the medical information.
- State the name or functions of the persons or entities authorized to receive the medical information.
- State a specific date after which the provider of health care is no longer authorized to disclose the medical information.
- Advise the person signing the authorization of the right to receive a copy of the authorization.
- Statement of revocation.

91070.8.2 Requests From Outside Agency/Facility

Verbal Requests

Upon receipt of a valid written authorization, health information shall be copied and sent to the requesting hospital, physician, or other agency. Verbal requests for health information shall be referred to the medical records director, medical records supervisor, correctional health services administrator, CMO, or chief psychiatric officer if the request is for psychiatric information.

Within Department

It is not necessary to have a valid authorization when releasing health information to another facility within the Department or when releasing information to consulting health care personnel within the Department.

91070.8.3 Requests From State AG's Office

Copies of health records shall be made available for review at each facility at the request of the State AG's Office.

91070.8.4 Inmate's Request

Inmates have the right to review and receive copies of their own health record. This review shall take place in the presence of a health services staff member. A charge shall be made for all pages copied at rates specified in the DOM 13030. Inmates totally without funds and/or a pay number shall be provided copy service without charge. An inmate shall not review or be given access to another inmate's health record.

91070.8.5 Requests From Inmate's Attorney

Upon receipt of a valid authorization from the inmate's attorney, health information can be copied and sent to the attorney. Representatives of the attorney shall have the same degree of access as the attorney providing the attorney designates so in writing. Designated representatives of an attorney are limited to licensed investigators, attorney-sponsored law students, a State Bar certified paraprofessional, or a full-time employee of the attorney. No charge shall be made to the attorney. (See DOM 71020 for more details.)

91070.8.6 Subpoenas

The "Protocol for Subpoenas" published by the California Medical Record Association shall be followed in preparing the records in response to a subpoena.

91070.8.7 Drug Abuse

Health records containing information of drug abuse subsequent to March 21, 1972

and alcohol abuse subsequent to May 14, 1974 are covered by federal laws, 42 CFR C and D. Valid authorization shall indicate that the patient knows that drug and/or alcohol abuse information shall be released if there is any in the record.

91070.8.8 Psychiatric Records

Valid written authorization shall indicate that the patient knows that psychiatric information shall be released if there is any record. Records shall be released by subpoena only if it directs the release of the information to the judge of the court and a subsequent court order is obtained when information is admitted as evidence. Records shall be released by court order. (W&I 5328 and 5328.I9.)

91070.8.9 AIDS and AIDS-Related Condition (ARC) Information

Valid authorization shall indicate that the patient knows that AIDS and/or ARC information shall be released if there is any in the record.

Licensure Standards:

Title 15	Title 22 Division 5; Chapter 1; General Acute Care Hospitals	Title 22 Division 5; Chapter 12; Correctional Treatment Facilities
<p>§ 3370. Case Records File and Unit Health Records Material-Access and Release Sections</p> <p>(b) Except by means of a valid authorization, subpoena, or court order, no inmate or parolee shall have access to another’s case records file, unit health records, or component thereof.</p> <p>(c) Inmates or parolees may review their own case records file and unit health records, subject to applicable federal and state law. This review shall be conducted in the presence of staff, and may necessitate the use of a computer.</p> <p>(d) No inmate or parolee shall access information designated confidential pursuant to section 3321 which is in or from their own case records file. designated by the institution head shall inform the media regarding a facility incident or newsworthy event.</p>	<p>§ 70751. Medical Record Availability Section</p> <p>(a) Records shall be kept on all patients admitted or accepted for treatment. All required patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of:</p> <ol style="list-style-type: none"> (1) The admitting physician. (2) The nonphysician granted privileges pursuant to Section 70706.1. (3) The hospital or its medical staff or any authorized officer, agent or employee of either. (4) Authorized representatives of the Department. (5) Any other person authorized by law to make such a request. 	<p>§ 79803. Health Record Service Section</p> <p>(e) Policies and procedures shall be established and implemented to ensure the confidentiality of access to patient health information, in accordance with federal, state and local laws and acceptable standards of practice administration.</p>

(e) No case records file, unit health records, or component thereof shall be released to any agency or person outside the department, except for private attorneys hired to represent the department, the office of the attorney general, the Board of Prison Terms, the Inspector General, and as provided by applicable federal and state law. Any outside person or entity that receives case records files or unit health records is subject to all legal and departmental standards for the integrity and confidentiality of those documents.

3261.2. Authorized Release of Information.

(a) Only an employee designated by the institution head shall inform the media regarding a facility incident or newsworthy event.

(b) No person without written authorization of the affected individual shall disclose the name of other identifying information of any person as having Acquired Immune Deficiency Syndrome (AIDS) nor shall they disclose any person's blood test results to detect AIDS related antibodies.

(c) Information pertaining to a CYA ward shall not be released to the media or the public, except as provided in section 3261.7(c)(3).

(d) Information derived from a person's Criminal Identification and Investigations Report shall not be provided to the media.

<p>(e) Including the limitations of (c) and (d) above, the only inmate or parolee data, which may be released to the media, includes the inmate's or parolee's:</p> <ol style="list-style-type: none"> (1) Name (2) Age (3) Birthplace (4) Place of previous residence (5) Commitment information obtained from their adult probation officer's report (6) Facility assignments and behavior (7) General state of health (8) Cause of death (9) Nature of injury or critical illness (unless the condition is related to the Acquired Immune Deficiency Syndrome) (10) Sentencing and release actions <p>(f) The only employee data which may be released to the media by other than the employee concerning their involvement in a facility incident or newsworthy event includes:</p> <ol style="list-style-type: none"> (1) Name (2) Civil service classification (3) Age (4) Work assignment (5) Length of service with the department and/or current division or unit (6) Past work assignments (7) Role or function in a newsworthy event <p>(g) Information endangering an employee or concerning an employee who is a crime victim shall not be released to the media.</p>		
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HIPAA/California Hospital Association (CHA) Considerations:

HIPAA:

- The covered entity to make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure (§ 164.506(b)).
- An individual has a right to request restrictions on uses or disclosures for treatment, payment or health care operations.
- However, The Privacy Rule does not require accounting for disclosures:
 - (a) for treatment, payment, or health care operations;
 - (b) to the individual or the individual's personal representative;
 - (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories;
 - (d) pursuant to an authorization;
 - (e) of a limited data set;
 - (f) for national security or intelligence purposes;
 - (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or
 - (h) incident to otherwise permitted or required uses or disclosures
- De-identified information is created in accordance with procedures (§ 164.514).
- The protection of protected health information about deceased individuals exists for as long as the covered entity maintains the information.
- Covered entities may disclose protected health information to a funeral director, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. Such disclosures are permitted both after death and in reasonable anticipation of death.
- Persons are authorized to act on behalf of the person who is the subject of the protected health information. For adults and emancipated minors, that "individual" includes a legal representative to the extent to which applicable law permits such legal representative to exercise the individual's rights in such contexts.
- An inmate does not have the right to receive a Notice of Privacy Practices.
- Covered health care providers that create or receive protected health information in the course of providing health care to inmates of a correctional institution are not required to obtain the inmate's consent prior to using or disclosing protected health information about the inmate to carry out **treatment, payment, and health care operations.**
- Individuals may revoke an authorization at any time, in writing, except to the extent that the covered entity had taken action in reliance on the authorization.
- A covered entity must document and retain any signed authorization as required by § 164.530(j).
- Usually authorization has to be given for disclosure of PHI. Section 164.512(k)(5) of the HIPAA privacy rule has made exceptions for the following six situations:
 - a) the provision of health care to such individuals;

- b) *the health and safety of such individuals or other inmates;*
 - c) *the health and safety of the officers or employees or others at the correctional institution;*
 - d) *the health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility or setting to another;*
 - e) *law enforcement on the premises of the correctional institution; and*
 - f) *the administration and maintenance of the safety, security and good order of the correctional institution.*
- § 164.512(f)(1) permits a covered entity to make disclosures that are required by other laws, such as state mandatory reporting laws, abuse/negligence, or are required by legal process such as court orders or grand jury subpoena.

CHA:

- California law is stricter, and thus must be followed. A provider must permit record inspection within 5 days, and a summary within 10 days or within 30 days if the provider has notified the requestor of a difficulty. Copies must be mailed within 15 days. (HIPAA states request must be honored within 30 days of receipt of request).
- AIDS/ARC - California law is the stricter of federal and state, so must therefore be followed, pursuant to Health and Safety Code. With several law enforcement exceptions, HIV status is not released without a separate authorization. May be released without authorization to Chief officer of a correctional institution if an inmate has been exposed to HIV or enters the institution with such a diagnosis.

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished

Medical Transcription

Definition

Medical Transcription is the process of converting voice-recorded reports, such as those dictated by a physician or other healthcare professional, into text format.

Best Practices

1. Adequate clerical support is in place to support the medical transcriptionist's dedication to the transcription function only.
2. Digital dictation *,appropriate word processing system (application specific, not generic Word), Quality checks, standard measurement 65 printed character output per line recommended.
3. A quality assessment program, consistent with the Association for Healthcare Documentation (AHDII/AAMT), is in place to ensure the transcribed document from voice to text is clear, consistent, accurate and complete.
3. Transcribed reports are filed in the record the same calendar day as transcribed.
4. Copies of reports are distributed within 24 hours of transcription.
5. Use of overflow agency to be managed by central HIM office, in-house medical transcriptionists for better quality, control, and turnaround time, incentive plans typically improve morale, retention, and productivity, use of certified (CMT) staff whenever possible.

Transcription	Reports have turnaround within the following time frame: H&P – 12 hours Operative Report/Consults – 24 hours Discharge Summary – 24 hours TTA Report – 12-24 hours Diagnostic Report – 6-12 hours Clinic Notes – 48 hours A quality program that includes a 10% volume sampling of all reports monthly. 98% Accuracy/Quality	15-18 minutes of dictation / transcribed in one hour or 150 lines/hr
Transcription Clerical	Reports are charted within 4-6 hours of receipt unless available electronically	Reports should be incorporated into the record. Duplicate copies of reports are to be avoided.

CDCR – Department Operations Manual Policy(ies)/Procedure(s):

None identified.

Current Practice

To be completed after assessments are finished

Gap Analysis Summary

To be completed after assessments are finished

Remediation Summary

To be completed after gap analysis is finished