AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines

Practice Guidelines for LTC Health Information and Record Systems

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Record Systems, Organization and Maintenance

- Maintaining a Unit Record
- Assigning a Medical Record Number
- Maintaining Records in a Continuum of Care
- Defining What is Part of the Medical Record
- Maintenance of the Medical Record
- Identification (Name and Number) on Pages of the Medical Record Number
- Common Forms and Thinning Guidelines
  - Integrating Hospital Records into the Long Term Care Record
  - Thinning the Medical Record
- Maintaining the Overflow Record of Thinned Documents
- Maintaining a "Soft Chart" or "Shadow Record" and Other Types of Records
- Forms Control Processes

Audits and Quality Monitoring

- Internal Qualitative vs. Quantitative Audits and Monitoring
- Assessing the Quality of Documentation
- Routine Audits/Monitoring (Criteria and Timeframes)
- Focus Audits and Monitoring Systems
- Integrating Audits/Monitoring into the QA/QI Program
- Retention of Audits, Checklists, and Monitoring Record
- Auditing the Electronic Health Record

Discharge Record Processing

- Discharge Record Assembly
- Discharge Record Analysis
- Timely Completion of a Discharge Record
- Incomplete and Delinquent Records
- Maintaining a Control Log for Discharge Records
- When to Close a Record on Temporary Absence
  - Closing Records with a Change in Level of Care
  - Closing Records with a Payer Change

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Filing and Retrieval

- Separate Location for Incomplete Records
- Typical Filing Systems
- Retrieval
- Filing

Storage Systems

- Storage System Options
- Security Issues: Locking Office and Storage Areas
- Alternative Storage Areas

Retention

- Retention Guidelines

Destruction

- Acceptable Methods of Destruction
- Abstracting Documents Prior to Discharge
- Destruction Logs and Witnesses

Physical Security of Manual/Paper Records

- Security Measures for Record Check Out — Manual
- Maintaining Security of Electronic Record Access
- What To Do If a Record Is Lost, Destroyed or Stolen
- Disaster Plans

Confidentiality and Release of Information

- Identification of Confidential vs. Non-confidential Information
- Resident Access to Their Records
- Confidentiality, Training and Agreements with Employees and Volunteers
- Resident Identification Boards at Nursing Stations and other Facility Locations
- Maintaining an Access/Disclosure Grid for Employees, Contractors and Outside Parties
- Handling a Request for Health Information Contained in the Designated Record Set
  - Consent for Use and Disclosure of Protected Health Information
  - Redisclosure Upon Transfer to Another Healthcare Facility
- Handling Telephone Requests for Information
- Transmitting Resident Information via Facsimile
- Responding to a Subpoena or Court Order
- Removing Original Records from the Facility
- Notice of Information Practices
- Designation of a Privacy Officer

Coding and Reimbursement

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- Training and Resources
- Frequency of ICD-9-CM Coding
- Coding and Billing Relationships
- Investigation of Claim Rejection/Denials Due to Coding
- Coding Issues Under Consolidated Billing

Indexes and Registries

- Master Patient Index
  - Maintaining an MPI
  - Minimum Content
- Admission/Discharge Register
- Disease Index

Minimum Statistical Reporting

- Total Admissions
- Total Discharges
- Average Daily Census
- Total Census Days
- Length of Stay
- Percentage of Occupancy
- Electronic Patient Records (on hold)

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