# Record Retention Practices among the Nation's "Most Wired" Hospitals

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## Abstract

This exploratory study examined health record retention practices among health information management professionals in acute care general hospitals in the United States. A descriptive research design was used, and data were collected using a self-reporting survey. Respondents answered questions about record retention policies, the responsibility of health information professionals in policy administration, record retention periods, factors that determine retention periods, and other information about health record retention practices.

**Key words:** Record retention, media, paper records, imaged records, electronic records, hybrid records, permanent record retention, nonpermanent record retention

## Introduction and Purpose of the Study

The importance and challenges of health record retention are inherent in the health information management (HIM) profession. Electronic health records (EHRs) or elements thereof (i.e., hybrid health records) are increasingly being used in today's healthcare environment. Further, the federal government has widely publicized its initiative to develop a functional model and standards for an EHR[1, 2] to improve patient care and increase the portability of health information. Record retention is central to these changes.

This exploratory study provides empirical data that describe health record retention practices in acute care hospitals and establishes benchmarks for future record retention practices in light of the evolving EHR. Because extensive data were obtained in this study, a portion of the findings are presented in a separate analysis and discussion.

## Background

The health record is multifaceted and demanded by diverse interests. Whether the record is paper, electronic, or a hybrid, policies and procedures are critical to the record management process and are necessary to meet an organization's needs.[3] Factors external to an organization that relate to record retention include federal and state laws, legal issues, and requirements of accrediting bodies, such as The Joint Commission and American Health Information Management Association (AHIMA) recommended retention standards.[4, 5] Internal factors include adoption of EHRs and other technologies, patient population (e.g., severity and readmission rates), institutional medical practice, research, educational needs, storage constraints or capabilities, cost, and disaster recovery plans.[6, 7] These factors require the availability of a patient's health record for varying time periods. Despite the importance of record retention and the availability of health record documentation, research has not been undertaken to

evaluate the current status of health record retention practices in hospitals throughout the United States. This study was designed to assess record retention practices of a sample of hospitals.

## Methods

A descriptive research design was used. The study population consisted of all acute care general hospitals in the United States named by the American Hospital Association to *Hospitals & Health Networks* magazine's July 2004 list of "100 most wired hospitals and health systems" (numbering 101 due to a tie), 25 "most wired small and rural" organizations, and 25 "most wireless" organizations.[8] Approximately half of the organizations were multihospital systems, resulting in approximately 700 individual facilities on the three lists (referred to cumulatively as the "most wired"). A sample population of 250 hospitals, determined statistically to be representative of the larger population, was randomly selected. To ensure uniformity outside of state laws and individual facility needs, each hospital met the criteria of offering acute medical/surgical services, having Joint Commission accreditation, and participating in Medicare.

A self-reporting survey instrument was used to collect data between August and October 2005 from HIM professionals at the randomly selected hospitals. It collected information about respondent and facility demographics and record retention policies, periods, and methods. Recipients were notified and reminded of the survey through two postcard mailers. The survey was mailed to all members of the sample population. Two follow-up mailings were sent to nonrespondents.

The survey instrument was divided into sections so respondents could answer questions specific to one or more of three health record media types (paper, imaged, electronic) used in their facilities. Imaged records were defined as records "converted to optical or other electronic images through the use of a document management/imaging system" and were distinguished from electronic records, which were defined as records "captured electronically at the point of care and maintained electronically (excluding imaged records)."

Data analysis was conducted using SPSS version 14.0. Frequencies, percentages, means, and standard deviations were calculated to determine differences in record retention policies, practices, and selected characteristics, including media types.

## Results

Of 250 surveys mailed, 84 completed surveys were returned for a 33.6 percent response rate. Thirty-nine states and the District of Columbia (DC) were represented in the sample population. Thirty-one states and DC were represented in the responses for 80 percent representation of all randomly selected states and DC. Responses ($n = 31$ states and DC) represented 62.7 percent of all 50 states and DC.

### Respondents

Among those who responded to a question about credentials, 73.5 percent ($n = 61$) held the Registered Health Information Administrator (RHIA) credential with or without another AHIMA credential (see Table 1). Another 25.3 percent ($n = 21$) held the Registered Health Information Technician (RHIT) credential with or without another AHIMA credential. HIM directors accounted for 77.1 percent ($n = 64$), and 19.3 percent ($n = 16$) were HIM assistant directors or managers/supervisors. Two respondents described their titles as "Corporate Director." Average years of professional experience in HIM were 20.8 (standard deviation of 10.5), ranging from 2 to 48 years. The most frequently occurring years of experience were 25 and 30 years, with eight respondents (9.8 percent) for each.

### Respondent Facilities

Bed sizes of the respondent facilities were obtained from the Billian's HealthDATA Group Hospital Blue Book CD-ROM (2005 edition). (See Table 2.) Respondents indicated their facility type and checked all applicable options. There were 91 responses from 83 respondents. The most frequently identified facility types were community ($n = 32$, 38.6 percent) and rural ($n = 20$, 24.1 percent). Facility descriptors

in the "Other" category included teaching facility, health system, pediatric facility, and government teaching.

*Record Retention Policies*

Respondents were asked about health record retention policies. (See Table 3.) Regarding the existence of policies, 100 percent (*n* = 82) of the first question's respondents stated that their facilities had one or more health record retention policies. Of 81 respondents, 79 percent (*n* = 64) stated that the HIM director or another designated HIM professional was responsible for policy administration and/or oversight or, alternatively, was responsible provided that input from others was obtained. Another 17.3 percent (*n* = 14) indicated that someone other than a HIM professional was responsible, but HIM input was obtained. Finally, 3.7 percent (*n* = 3) indicated that responsibility for record retention policies resided outside HIM. Others involved in policy administration and oversight included administration, the Health Insurance Portability and Accountability Act (HIPAA) privacy officer, the legal department, and risk management.

Among 81 respondents, 87.7 percent (*n* = 71) stated that there were no separate policies based on media type. Another 11.1 percent (*n* = 9) stated that separate policies existed, while one respondent (1.2 percent) was unsure. Of those with separate policies, paper records were kept for either a specified finite period or per state and federal law; imaged and electronic records were to be permanently retained or retained for as long as the system was capable of retaining them. As for compliance with policies, 95.1 percent of facilities (*n* = 77) always or usually complied with record retention policies, while 4.9 percent (*n* = 4) stated that policies were never or usually not followed. Compliance was highest in tertiary facilities (77.8 percent), followed by urban teaching and urban nonteaching (75 percent each), rural (70 percent), community (65.7 percent), and other (62.5 percent) hospitals.

Of 80 respondents, 8.8 percent (*n* = 7) indicated that HIM professionals assumed sole responsibility for determining record retention periods, and 81.3 percent (*n* = 65) exercised varying degrees of involvement as part of a larger group. Another 10 percent (*n* = 8) indicated that HIM professionals had no involvement. Others identified as primary decision makers were administration, legal, and compliance. Group decision-making participants included legal and risk management, corporate compliance, and physicians/researchers.

HIM professionals were solely responsible for determining record retention periods in the following facility types: other (50 percent), urban teaching (47.1 percent), community (46.9 percent), rural (45 percent), tertiary (12.5 percent), and urban nonteaching (0 percent) hospitals. Record retention decisions by HIM professionals, with input from others, were most frequent in tertiary and urban nonteaching hospitals (50 percent each), followed by rural (45 percent), other (37.5 percent), community (34.4 percent), and urban teaching (29.4 percent) hospitals.

*Record Retention Periods*

A question regarding retention periods for adult records had 81 responses (see Table 4). Of those, 50.6 percent (*n* = 41) retained adult records permanently; 17.3 percent (*n* = 14) retained records at least 20 years but not permanently; and another 27.2 percent (*n* = 22) retained records less than 20 years but at least 10 years (with 10 years being AHIMA's recommended retention period). An additional 4.9 percent (*n* = 4) retained adult records for five to nine years. Factoring out respondents who retained records permanently, 49.4 percent (*n* = 40) had a mean retention period of 16.4 years (with a standard deviation of 9.9 years). Minimum and maximum retention periods were 7 and 50 years, respectively. Permanent retention of adult records was practiced most widely by urban nonteaching hospitals (100 percent), followed by urban teaching (58.8 percent), rural (50 percent), tertiary (44.4 percent), community (43.8 percent), and other (12.5 percent) hospitals.

A question assessing retention periods for minors' records had 80 responses. Of those, 52.5 percent (*n* = 42) retained minors' records permanently; and 35 percent (*n* = 28) retained records at least 20 years but not permanently. Another 5.0 percent (*n* = 4) retained records a specific number of years past the age of majority, ranging from 2 to 30 years past majority (mean of 10.4 years). Two respondents provided 10 years since the last encounter as an alternative to a specific number of years past majority. Factoring out

respondents who retained records permanently or a specific number of years past the age of majority, 36.3 percent ($n = 29$) had a mean retention period of 22.3 years. Minimum and maximum retention periods were 10 and 48 years, respectively. Permanent retention of minors' records was practiced most widely by urban nonteaching hospitals (100 percent), followed by urban teaching (58.8 percent), rural (55 percent), community (45.2 percent), tertiary (44.4 percent), and other (14.3 percent) hospitals.

### Influences

Respondents identified all applicable options that influenced retention periods (see Table 5). A majority of the 81 respondents, 90.1 percent ($n = 73$), cited state record retention laws (which were cited by 100 percent of tertiary, urban nonteaching, and rural hospitals). The second most commonly selected option, Medicare Conditions of Participation, was chosen by 60.5 percent of respondents ($n = 49$) and was cited by 100 percent of urban nonteaching hospitals. The third most influential factor, facility operational needs ($n = 41$, 50.6 percent), was cited by 100 percent of urban nonteaching hospitals.

Other state and federal laws (excluding Medicare Conditions of Participation) influenced 22.2 percent of respondents. Federal laws included HIPAA, substance abuse laws, Occupational Safety and Health Administration (OSHA) regulations, and Department of Defense guidelines. Other factors included legal reasons, patient requests, medical staff compulsion, patient care, and historic reasons.

### Permanent Record Retention Practices

Permanent retention of paper records was reported by 63.1 percent of respondents ($n = 53$). Of these, 84.9 percent ($n = 45$) retained the entire record permanently and 15.1 percent ($n = 8$) retained portions permanently. In the case of imaged records, 47.6 percent of all respondents ($n = 40$) reported retaining imaged records permanently. Of these, 75 percent ($n = 30$) retained the entire record permanently and 25 percent ($n = 10$) retained portions permanently. As for electronic records, 58.3 percent of all respondents ($n = 49$) retained electronic records permanently. Of these, 55.1 percent ($n = 27$) retained the entire record permanently and 44.9 percent ($n = 22$) retained portions permanently.

Respondents who permanently retained only portions of paper records retained the following permanently: identification/demographic information; history and physicals; discharge summaries; operative, pathology, and emergency room reports; physician documentation; and test results. Respondents who permanently retained a portion or all of a patient's paper record ($n = 53$) selected all applicable options regarding paper record storage. Conversion to microfilm was most frequent, used by 56.6 percent of respondents ($n = 30$), while 35.8 percent ($n = 19$) used commercial vendors offering off-site storage. Other storage methods included imaging systems.

Respondents who permanently retained only portions of imaged records retained the following permanently: patient consents/advance directives; insurance cards; physician orders; photographs; newborn identification bracelets; emergency room reports; radiology images; transcribed reports; and test results. Respondents who permanently retained a portion or all of a patient's imaged record ($n = 40$) selected all applicable options regarding imaged record storage. For the majority ($n = 35$, 87.5 percent), information remained available rather than archived. Other methods were hard-copy storage and vendor storage.

Respondents who permanently retained only portions of electronic records retained the following permanently: radiology images and reports in picture archiving and communication systems (PACS); online nursing and ancillary documentation; labs; x-rays; transcribed reports; pastoral care; cardiopulmonary records and electrocardiograms; fetal heart monitors; medication reports; obstetric records; master patient index (MPI); and pathology reports. Respondents who permanently retained a portion or all of a patient's electronic record ($n = 49$) selected all applicable options regarding electronic record storage. For the majority ($n = 42$, 85.7 percent), information remained available rather than archived, although electronic records might be archived after a period without account activity. Other storage methods included printing of reports and placement in the paper record.

Portions of the study's results regarding permanent record retention practices for all three media types, specifically retention methods, are outlined in Table 6.

*Reasons for Permanent Record Retention, by Media Type*

Respondents selected reasons for permanent record retention, with questions specific to each media type. The number of respondents for each type was 51 (paper), 40 (imaged), and 50 (electronic). For each question, respondents selected all applicable options (Table 7) and supplied other reasons.

Other reasons for retaining paper records permanently included legal considerations, space availability, patient benefit, administrative and medical staff decisions, insufficient staff to purge, preservation of historic content, and lack of guarantee from EHR vendors that a record in the same format could be retrieved in 10 to 28 years. Analyzed by facility type, frequently cited reasons for permanent retention of paper records were cost effectiveness (tertiary: 50 percent); research and other data needs (urban teaching: 58.3 percent; urban nonteaching: 50 percent); ease of retaining rather than destroying records (urban nonteaching: 50 percent); and reluctance to destroy due to potential future need (other: 60 percent).

Other reasons for retaining imaged records permanently included legal considerations, policy requirements, and ability of computer systems to retain images in compressed files. By facility type, frequently cited reasons for permanent retention of imaged records were cost effectiveness (urban teaching: 54.5 percent; other: 50 percent); research and other data needs (urban teaching: 72.7 percent; urban nonteaching: 66.7 percent; other: 50 percent); and ease of retaining rather than destroying records (urban nonteaching: 66.7 percent).

Other reasons for retaining electronic records permanently included legal considerations, patient care, policy requirements, ability of computer systems to retain data in compressed files, and maximization of accessibility. By facility type, frequently cited reasons for permanent retention of electronic records were cost effectiveness (urban teaching: 53.8 percent; urban nonteaching, community, and rural: 50 percent each; other: 60 percent); research and other data needs (urban nonteaching: 100 percent; urban teaching: 69.2 percent; other: 60 percent; tertiary: 50 percent); ease of retaining rather than destroying records (urban nonteaching: 100 percent); and reluctance to destroy due to potential future need (urban nonteaching: 50 percent; other: 60 percent).

*Nonpermanent Record Retention Practices*

Respondents who did not permanently retain a portion or all of a patient's record selected all applicable options (see Table 8). Of those with paper records ($n = 36$), 63.9 percent ($n = 23$) cited insufficient space most often, followed by retention costs and conversion of paper records to other media (44.4 percent each; $n = 16$).

Respondents who did not permanently retain a portion or all of imaged records ($n = 8$) most frequently cited ease of destruction, temporary need, and conversion to other media (75 percent each; $n = 6$). Other reasons included retention policy and reduced liability. Paper records disposed of after imaging were generally destroyed via shredding, although chemical process, incineration, and recycling were also cited.

Respondents who did not permanently retain a portion or all of electronic records ($n = 9$) most commonly cited ease of destruction and lack of need (88.9 percent each; $n = 8$). Other reasons included retention policy compliance.

## Discussion/Conclusion

The current status of record retention is important as the healthcare industry evolves toward EHRs. This study provides empirical data that illuminate the role that HIM professionals play with respect to health record retention policies as well as record retention practices in acute care general hospitals across the country.

A limitation of this study was that it relied on self-reporting and, despite definitions provided, some degree of interpretation by the respondents. A second limitation was that, because the response rate was 33.6 percent and the study was designed to elicit responses regarding retention practices of technologically advanced hospitals, it may not be representative of the larger population. This limits the generalizations that can be made.

The results show that HIM professionals exercise considerable responsibility and give a great deal of input relating to the administration and oversight of health record retention policies and the determination of record retention periods. Separate record retention policies based on media type are relatively uncommon, and the vast majority of respondents reported compliance with record retention policies.

Respondents indicated that state record retention laws and Medicare Conditions of Participation have the greatest influence on the length of time that records are retained. However, a majority of facilities retain both adults' and minors' health records permanently. This indicates that the third most frequently cited reason, facility operational needs, is important in determining that indefinite availability of health records is desirable or necessary for organizational purposes. This conclusion is supported by the finding that research and other data needs, as well as potential future needs, were cited as reasons for permanent record retention irrespective of media type. Facilities that did not retain records permanently provided different reasons based on media type. While nonpermanent retention of paper records was primarily due to insufficient space, this was—not surprisingly—much less prominent for imaged and electronic records. It is expected that facility migration toward EHRs as the industry standard will result in more frequent permanent record retention practices as storage capabilities are able to support real and perceived organizational needs.

Narrative results widely show that legal considerations, whether interpreted as requirements imposed by law, liability concerns, or legal department mandates, play a role in record retention decisions. These findings reflect the growing complexity of the legal environment in the United States. Also, as the need for individual and aggregate health information grows in order to improve healthcare and engage consumers in making decisions regarding their own treatment, the manner and length of time that health records are retained will likely change and warrant future study. Professional guidance from AHIMA, which this study shows is being used currently by facilities, will continue to be important and will merit continuous updating.

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# Notes

1. eHealth Initiative. Available at www.ehealthinitiative.org.

2. U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. "The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care." Washington, DC, July 21, 2004.

3. Abdelhak, Mervat, Sara Grostick, Mary Alice Hanken, and Ellen Jacobs (Editors). Health Information: *Management of a Strategic Resource*, 3rd ed. St. Louis, MO: Saunders, 2007, p. 182.

4. The Joint Commission requires generally that "the retention time of medical record information is determined by the hospital based on law or regulation, and on its use for patient care, treatment, and services, legal, research, operational purposes, and educational activities," thus deferring in part to other requirements discussed in this review. "Comprehensive Accreditation Manual for Hospitals: The Official Handbook." IM 6.10 (January 2006).

5. Fletcher, Donna M., and Harry B. Rhodes. "Retention of Health Information" (Updated). AHIMA Practice Brief, Web extra (2002).

6. Roach, William H. *Medical Records and the Law*, 4th ed. Sudbury, MA: Jones and Bartlett, 2006.

7. McWay, Dana C. *Legal Aspects of Health Information Management*. Clifton Park, NY: Delmar, Thomson Learning, 2003.

8. Solovy, Alden. "Most Wired 2004." *Hospitals & Health Networks*, July 2004: 40–50.

**Table 1**

**Profile of Respondents**

| Respondent Profile | $f$ | % |
| --- | --- | --- |
| **Credential** ($n = 83$) | | |
| RHIA | 49 | 59.0 |
| RHIA with other AHIMA credential | 12 | 14.5 |
| RHIT | 19 | 22.9 |
| RHIT with other AHIMA credential | 2 | 2.4 |
| No AHIMA credentials | 1 | 1.2 |
| **Job Title** ($n = 83$) | | |
| HIM Director | 64 | 77.1 |
| HIM Assistant Director | 3 | 3.6 |
| HIM Manager or Supervisor | 13 | 15.7 |
| Other HIM Professional | 1 | 1.2 |
| Other | 2 | 2.4 |
| **Years of Professional Experience** ($n = 82$) | | |
| Fewer than 5 | 4 | 4.9 |
| 5–10 | 15 | 18.3 |
| 11–15 | 8 | 9.8 |
| 16–25 | 32 | 39.0 |
| Greater than 25 | 23 | 28.0 |

**Table 2**

**Profile of Respondent Facilities**

| Facility Demographics | *f* | % |
|---|---|---|
| **Licensed Beds** (*n* = 84) | | |
| Fewer than 100 | 21 | 25.0 |
| 100–249 | 28 | 33.3 |
| 250–499 | 21 | 25.0 |
| 500–999 | 13 | 15.5 |
| Greater than 1000 | 1 | 1.2 |
| **Facility Type** (91 options selected from *n* = 83) | | |
| Tertiary | 10 | 12.0 |
| Urban teaching | 17 | 20.5 |
| Urban nonteaching | 4 | 4.8 |
| Community | 32 | 38.6 |
| Rural | 20 | 24.1 |
| Other | 8 | 9.6 |

**Table 3**

**Record Retention Policies**

| Policies | f | % |
|---|---|---|
| **Policies Exist** (*n* = 82) | | |
| Yes | 82 | 100.0 |
| No | 0 | 0.0 |
| **Responsibility for Policies** (*n* = 81) | | |
| HIM director/HIM professional | 32 | 39.5 |
| HIM director/professional with input from others | 32 | 39.5 |
| Someone else, with HIM director/ HIM professional input | 14 | 17.3 |
| Someone else | 3 | 3.7 |
| **Separate Policies** (*n* = 81) | | |
| Yes | 9 | 11.1 |
| No | 71 | 87.7 |
| Unsure | 1 | 1.2 |
| **Compliance with Policies** (*n* = 81) | | |
| Always | 58 | 71.6 |
| Usually | 19 | 23.5 |
| Usually not | 3 | 3.7 |
| Never | 1 | 1.2 |
| **HIM Decision-Making Role** (*n* = 80) | | |
| Only decision maker | 7 | 8.8 |
| Primary decision maker, with input | 36 | 45.0 |
| Part of group decision making | 23 | 28.8 |
| Someone else is primary decision maker, but HIM gives input | 6 | 7.5 |
| No input | 8 | 10.0 |

**Table 4**

**Record Retention Periods for Adult and Minor Records**

| Record Retention Periods | *f* | % |
|---|---|---|
| **Adult Records** (*n* = 81) | | |
| Permanent retention | 41 | 50.6 |
| 30–50 years | 7 | 8.6 |
| 20–29 years | 7 | 8.6 |
| 10–19 years | 22 | 27.2 |
| 5–9 years | 4 | 4.9 |
| Less than 5 years | 0 | 0.0 |
| **Minor Records** (*n* = 80) | | |
| Permanent retention | 42 | 52.5 |
| 30–50 years | 4 | 5.0 |
| 20–29 years | 24 | 30.0 |
| 13–19 years | 0 | 0.0 |
| 12 years or less | 6 | 7.5 |
| Specified no. of years past age of majority | 4 | 5.0 |

**Table 5**

**Factors Influencing Record Retention Practices**

| Factor | *f* | % |
|---|---|---|
| (*n* = 81, respondents selected all applicable options) | | |
| State record retention laws | 73 | 90.1 |
| Medicare Conditions of Participation | 49 | 60.5 |
| Facility operational needs | 41 | 50.6 |
| Research | 20 | 24.7 |
| Costs of retaining records | 19 | 23.5 |
| Education | 12 | 14.8 |
| More convenient not to purge | 10 | 12.3 |
| Other needs or reasons | 7 | 8.6 |
| AHIMA recommended retention standards | 40 | 49.4 |
| Statute of limitations for lawsuits | 38 | 46.9 |
| Joint Commission or other accrediting bodies | 37 | 45.7 |
| Other federal laws | 12 | 14.8 |
| Other state laws | 6 | 7.4 |

**Table 6**

**Permanent Record Retention Methods by Media Type**

| Retention Methods | *f* | % |
| --- | --- | --- |
| **Paper** (*n* = 53) | | |
| Microfilm or other similar medium | 30 | 56.6 |
| In-house by staff | 4 | 7.5 |
| In-house by vendor | 3 | 5.7 |
| Off-site by vendor | 26 | 49.1 |
| Commercial vendor/off-site storage | 19 | 35.8 |
| In hospital building(s) | 14 | 26.4 |
| Hospital off-site storage facilities | 11 | 20.8 |
| Other | 11 | 20.8 |
| On grounds, but outside hospital building(s) | 9 | 17.0 |
| **Imaged** (*n* = 40) | | |
| Available online, accessible to user | 35 | 87.5 |
| Available online for predetermined period of time, then archived | 4 | 10.0 |
| Other | 2 | 5.0 |
| **Electronic** (*n* = 49) | | |
| Available online, accessible to user | 42 | 85.7 |
| Available online for predetermined period of time, then archived | 6 | 12.2 |
| Other | 3 | 6.1 |

**Table 7**

**Reasons for Permanent Record Retention, by Media Type**

| | Paper (of 51) | | Imaged (of 40) | | Electronic (of 50) | |
|---|---|---|---|---|---|---|
| Factor | *f* | % | *f* | % | *f* | % |
| More cost effective | 12 | 23.5 | 16 | 40.0 | 25 | 50.0 |
| Reluctant to destroy; may need in future | 17 | 33.3 | 13 | 32.5 | 15 | 30.0 |
| Easier to retain than to destroy | 7 | 13.7 | 10 | 25.0 | 5 | 10.0 |
| Need for research or other data needs | 15 | 29.4 | 18 | 45.0 | 25 | 50.0 |
| Other reasons | 20 | 39.2 | 15 | 37.5 | 19 | 38.0 |

## Table 8

### Reasons for Nonpermanent Retention of Records, by Media Type

| Reason Not to Permanently Retain | *f* | % |
|---|---|---|
| **Paper** (*n* = 36) | | |
| Too costly to retain | 16 | 44.4 |
| Insufficient space | 23 | 63.9 |
| Easier to destroy | 3 | 8.3 |
| Records not needed | 11 | 30.6 |
| Convert to other medium | 16 | 44.4 |
| Other | 5 | 13.9 |
| **Imaged** (*n* = 8) | | |
| Too costly to retain | 2 | 25.0 |
| Insufficient space | 2 | 25.0 |
| Easier to destroy | 6 | 75.0 |
| Records not needed | 3 | 37.5 |
| Imaged records needed only temporarily | 6 | 75.0 |
| Convert to other medium | 6 | 75.0 |
| Other | 2 | 25.0 |
| **Electronic** (*n* = 9) | | |
| Too costly to retain | 5 | 55.5 |
| Insufficient space | 2 | 22.2 |
| Easier to destroy | 8 | 88.9 |
| Records not needed | 8 | 88.9 |
| Electronic records needed only temporarily | 8 | 88.9 |
| Convert to other medium | 2 | 22.2 |
| Other | 4 | 44.4 |