

POSITION DESCRIPTION / PERFORMANCE EVALUATION

Job Title: HIM Technician
 Prepared by: _____
 Date: _____

Supervised by: HIM Director
 Approved by: _____
 Date: _____

Job Summary: Reviews medical records after discharge for completeness in compliance with the hospital's bylaws, JCAHO standards, federal and state requirements. Assures that patient abstracts are correctly entered into the medical record deficiency system.

DUTIES AND RESPONSIBILITIES:

E = Exceeds the Standard M = Meets the Standard NI = Needs Improvement

<u>Demonstrates Competency in the Following Areas:</u>	<u>E</u>	<u>M</u>	<u>NI</u>
Collects all discharged patient medical records from the patient care units on a daily basis.	2	1	0
Collects loose filing for those discharged medical records and inserts such filing in proper medical record.	2	1	0
Combines current patient medical record with any previous patient discharges for a unit record.	2	1	0
Assembles discharged patient medical records according to assembly list.	2	1	0
Places assembled medical record in proper folder according to medical record number.	2	1	0
Analyzes medical records of discharged patients for completeness and accuracy according to department and hospital policy and procedures.	2	1	0
Enters deficiencies into computer for physician completion.	2	1	0
Forwards all analyzed medical records to the Coder.	2	1	0
Performs performance improvement audits on each medical record as directed by the director.	2	1	0
Assists in answering telephone and taking accurate messages.	2	1	0
Is familiar with pediatric and SNF medical record requirements.	2	1	0
Maintains hospital requirements, policies and standards on confidentiality.	2	1	0
Assists in retrieving medical records for physician completion.	2	1	0
Assists in filing discharged patient loose sheets when time permits.	2	1	0
Willing to accept additional assignments.	2	1	0
Must be able to keep up with workload. Be able to process a minimum of 20 medical records per day.	2	1	0
Maintains a good working relationship within the department and other departments.	2	1	0

SUBJECT: HEALTH DATA INTEGRITY	REFERENCE #6007
	PAGE: 1 OF: 3
DEPARTMENT: HEALTH INFORMATION MANAGEMENT	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

It is the policy of _____ Hospital to protect the privacy of individual identifiable health information. Believing that confidentiality is essential in developing the trust between patients and their providers of healthcare, we are committed to ensuring that patient medical information be disclosed only with informed consent or by statute.

PROCEDURE:

- The Information Management Committee is responsible for the development of organizational standards, policies and procedures concerning timeliness, accuracy, security, privacy and confidentiality, access, integrity and uniformity of data of both paper and electronic records consistent with law or regulation.
- Security/Confidentiality of Information:
 - To provide a balance between data sharing and data confidentiality, individuals/ departments have been identified with specific policies/procedures outlining the access to, and need for, data and information.
 - Health Information Management Department personnel will have access to all documentation present in the medical record in accordance with Information Management Committee approved policies and procedures.
 - Nursing personnel will have access to all pertinent patient information to allow for optimum assessment, treatment and care of the patient in accordance with general nursing policies and procedures.
 - Medical staff will have access to all pertinent patient information that will allow them to render optimum treatment to any patient for whom they are the attending, covering or consulting physician in accordance with the medical staff bylaws.
 - Clerical personnel will have access to all necessary patient information that allows for appropriate billing, insurance and financial procedures.
 - The Health Information Management Department will have access to patient information for reporting purposes in accordance with departmental policies and procedures.

SUBJECT: DISCLOSURE OF PROTECTED HEALTH INFORMATION DURING DISASTER RELIEF EFFORTS	REFERENCE #6010
	PAGE: 1
DEPARTMENT: HEALTH INFORMATION MANAGEMENT	OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- Providers and healthcare plans covered by the HIPAA Privacy Rule may share patient information to assist in disaster relief efforts and to assist patients in receiving the care they need. Information relevant to the following areas may be shared:
 - Treatment
 - Notification
 - Imminent danger
 - Facility directory

PROCEDURE:

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

SUBJECT: MEDICAL RECORD CONTENT	REFERENCE #6073
	PAGE: 1 OF: 6
DEPARTMENT: HEALTH INFORMATION MANAGEMENT	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

It is the policy of _____ Hospital that the medical record shall contain sufficient information to identify the patient, support the diagnosis, to justify the treatment and document the results accurately.

PROCEDURE:

- The Admitting Department is responsible for collecting sufficient information to identify the patient. The information is documented on the face sheet, which is a permanent part of the patient's record. Sufficient information includes, but may not be limited to:
 - Patient's name
 - Gender
 - Primary language spoken
 - Communication needs
 - Address
 - Date of birth
 - Authorized representatives (if any)
 - Legal status of patients receiving behavioral healthcare services
 - Allergies
- Emergency care, treatment and services received by the patient before his/her arrival at the hospital are documented.
- The legal status of patients who are receiving behavioral healthcare services will be documented in the patient's medical record.

SUBJECT: LEGIBILITY OF MEDICAL RECORD DOCUMENTATION	REFERENCE #6086
	PAGE: 1 OF: 2
DEPARTMENT: HEALTH INFORMATION MANAGEMENT	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- It is the policy of _____ Hospital to set legibility standards for medical record documentation and to monitor compliance with these standards as part of our performance improvement and medical error reduction activities.
- This policy is applicable to all documentation within the medical record.

PROCEDURE:

- Whenever possible, all consults, histories and physicals, interpretations of diagnostic testing, and post operative/procedure results shall be dictated.
- Only abbreviations listed in the organization’s list of approved abbreviations will be allowed for use in medical record documentation.
- Medication Orders:
 - Should include a brief notation of purpose.
 - All prescription orders are to be written in the metric system.
 - “Units” should be spelled out.
 - The order must include drug name, exact metric weight or concentration and dosage form.
 - A leading zero must precede a decimal expression of less than one.
 - A terminal zero is not to be used after a decimal.
 - Prescribers are to avoid the use of abbreviations for drug names and Latin directions for use.
 - The age and weight of the patient (especially geriatric and pediatric patients) should be included where appropriate.