Breaking with Tradition: Improving HIM Functions in Behavioral Health

by Pamela T. Haines, RRA

Operation PAR, Inc., in St. Petersburg, FL, is an integrated substance abuse/mental health delivery system that includes substance abuse programs and a recently acquired psychiatric hospital. It includes inpatient, residential, and outpatient programs for both juvenile and adult clients, as well as intervention, prevention, and research programs.

Breaking with Tradition

Prior to 1999, the medical records department role consisted of two main functions:

- storage of the often-separated clinical and medical records received from the various programs when they could no longer accommodate the records at their sites
- retrieval of records to meet internal and external customer requests

Last August, I was hired to move the department to a new level of functionality and prepare to meet the Joint Commission's standards for behavioral healthcare. The initial project: to move the department to another location and prepare more than 1000 boxes of records for secure, confidential, commercial storage. Before we began the move, we reviewed, identified, and separated the organization's HIM functions as follows.

Filing System

The move provided a good opportunity to establish an open shelf filing system, resulting in more efficient storage and retrieval of recent medical records.[1] Although the records were organized and stored in boxes in alpha order (according to program, year, and box number), the terminal digit filing system better met our needs. It was less complex and more logical because it automatically placed the unique unit record number for each client. However, we limited the new system to the boxes of records transferred to the medical records department's new location and to all subsequent admissions. This reduced the number of files. The new system demanded converting approximately 2500 records to side tab folders, then labeling and color coding them. But the process remained dynamic. After a significant number of color coded records were filed, we decided to hasten the filing process for records created before December 15, 1998 by simply writing the unit number on the side tab.[2] Subsequently, if we pulled the record, we would fully process the folder before refiling the record. Likewise, if an updated record existed in the department, and an older one in storage, we combined those records.

Analysis and Completion

After relocating the department, re-engineering the processes connected with storage and retrieval for internal and external customers, and training a new employee, the department's focus changed. We worked to identify the level of care, and the documentation requirements of each program, reviewing the organization's professional staff rules and regulations, and consulting with the management and staff of the various programs and departments. Since there was no discharge data in our computer system, we had to solicit a daily discharge list from each of the treatment programs. As the lists began to come in more regularly, we started to solicit the corresponding medical records on a timely basis. Our analyzer looked at the charts for deficiencies based on staff regulations and the Joint Commission requirements.

Deficiencies for record completion include: admit order, H&P, treatment plan, verbal orders, diagnostic test results, consultation reports, final diagnosis discharge order, and discharge/transfer summary.

Once the analysis function was operational, the record completion process was put in place. With the support of the medical director, we began to notify our physicians of their deficiencies. At this point, it also became clear that FTEs would be needed

at two of the locations where several treatment programs reside. The additional staff would facilitate the analysis and record completion processes before the records were sent to the medical records department, eliminate travel time for physicians and clinicians, and expedite our response to requests for documentation in the active records.

Release of Information

Release of information (ROI) is a more complex process for substance abuse records, since federal (CFR 42, Part 2) and state regulations specifically protect them. Without a detailed, valid consent from the client, a person's past or present enrollment may only be disclosed before a judge at a "good cause hearing." In this case, the judge must determine that specific criteria have been met before information may be disclosed. Overall, before the medical records department's overhaul, significant attention was given to ROI regulations. The new medical records department centralized and documented the process more completely. Today, all requests for information are logged, and the release of information form is filed into the medical record after the request is fulfilled. In addition, subpoenas are copied and placed in a special file.

Conclusion

Although it normally takes time to change perceptions in an organization, the clinical programs and other departments have worked hard to meet the new demands placed on them by our department. Now, with an increase in staff and all of the department's functions in place,[3] the focus has turned to improving processes to meet the needs of internal and external customers. At the same time, we continue to process a number of boxes of previously stored records.

Notes

1. The CPR was prohibitive from the budget perspective.
2. We chose this date after learning that the Joint Commission would not look at records prior to December 15, 1998.
3. Neither coding nor transcription is performed in the medical records department at Operation PAR.

***Pamela T. Haines**, RRA, is administrator of the medical records department for Operation PAR, Inc. in St. Petersburg, FL.*

Article Citation:
Haines, Pamela T. "Breaking with Tradition: Improving HIM Functions in Behavioral Health." *Journal of AHIMA* 70, no. 8 (1999): 78-79.