Policy Statement.
This policy establishes guidelines regarding appropriate documentation in the EHR “Electronic Health Record” for physician/provider review in order to provide continuity of care and effectuate timely transfer of documents to and from outside health care facilities.

Application of Policy.
All UNT Health faculty and staff.

Definitions.
1. Application Extender: Software and data repository used to store images and indexes for UNT Health Business records.

2. ICS: The Image Control System is the software module for scanning and displaying images.

3. Abstraction: an act of withdrawing information from a paper chart and entering that information into an EHR.

4. Abstractor: one who manually withdraws information from a paper chart and enters that information into an EHR.

5. Electronic Health Record “EHR”: is a medical record in digital format.

6. Established patient: Patient who has previously received services at the Patient Care Center “PCC”.

Procedures and Responsibilities.
1.1 Patients without upcoming appointments are abstracted and scanned based upon the clinic breakdown in section 1.1.3. In regard to established patients who have scheduled appointments at the PCC, Clinical and Medical Record departments are to perform the following:

    Responsible Party: Providers, Clinical Staff, HIM Abstractors
1.1.1 At least two (2) days prior to a scheduled appointment the paper chart will be requested and sent to the appropriate clinical area. Each clinic shall have at least 1 designated abstractor. The chart is provided to the abstractor. The abstractor will perform the following:
1.1.1.1 Affix the “Patient has EMR” sticker to the front of the chart

1.1.1.2 Perform or enter the following categories of information, from the existing paper chart, into the proper corresponding EHR after performing the 5-point check:

1.1.1.2.1 Verify patient demographic information;
1.1.1.2.2 Enter PCP “Primary Care Physician” in EHR demographic screen, if needed;
1.1.1.2.3 Enter Allergies
1.1.1.2.4 Enter Immunizations (i.e. childhood, pneumovax, flu, tetanus)
1.1.1.2.5 Past Medical History (i.e. surgeries, diagnoses, chronic conditions, illnesses)
1.1.1.2.6 Family History
1.1.1.2.7 Social History (i.e. substance use, life style, abuse, occupation, exercise)
1.1.1.2.8 Medications (including dose, frequency, route)
1.1.1.2.9 Health Maintenance (i.e. colon screening, cervical screening, bone density screening, mammograms, prostate screening)
1.1.1.2.10 Indication of Advanced Directive and date

1.1.2 Once the abstractor has completed the steps in 1.1.1 of this policy, the abstractor will initial next to each category completed or write NA if no information exists in the paper chart on to the “Patient has EMR” sticker, located on the front of the chart.

Responsible Party: Clinical Staff, HIM Abstractors

1.1.3 The abstractor will next prepare the remainder of the paper chart for scanning. Refer below to respective departments for procedure. Upon completion, the chart will be forwarded to the provider for final review. The abstractor will remove, at a minimum, the following documents:

Responsible Party: Provider, Clinical Staff, HIM Abstractors

UNT SYSTEM POLICY TEMPLATE
1.1.3.1 **Surgery/Ortho** (Only abstract charts which have had an appointment going back two years). Follow the current thinning policy relating to the time frame for including relevant documents to be sent for scanning.

1.1.3.1.1 Operative notes and reports
1.1.3.1.2 Pathology Reports
1.1.3.1.3 Radiology Reports
1.1.3.1.4 History and Physical
1.1.3.1.5 Discharge and Summary
1.1.3.1.6 Lab results
1.1.3.1.7 Consults, referrals, dictations and ancillary reports
1.1.3.1.8 Progress reports
1.1.3.1.9 Advanced Directives
1.1.3.1.10 Consent forms
1.1.3.1.11 Letters from/to regarding patient
1.1.3.1.12 Advanced Beneficiary Notices

1.1.3.2 **Pediatrics** (Only abstract charts which have had appointment going back two years) Follow the current thinning policy relating to the time for including relevant documents to be sent for scanning.

1.1.3.2.1 Hospital and outside records
1.1.3.2.2 Texas Department of State Health Services form
1.1.3.2.3 Addendum to Hepatitis B vaccine
1.1.3.2.4 Addendum to Diphtheria, tetanus, Pertussis vaccine
1.1.3.2.5 Addendum to polio vaccine
1.1.3.2.6 Addendum to Haemophilus influenza B
1.1.3.2.7 Vaccine Administration record
1.1.3.2.8 THSteps Medical Checkup schedule
1.1.3.2.9 Child health history material complications
1.1.3.2.10 Growth Chart
1.1.3.2.11 13 month-2yr child history record
1.1.3.2.12 Progress notes
1.1.3.2.13 Progression of years form
1.1.3.2.14 Letters from/to or regarding patient
1.1.3.2.15 Consent forms
1.1.3.2.16 Radiology and lab reports

1.1.3.3 OMM (Only abstract charts which have had an appointment going back two years) Follow the current thinning policy relating to the time frame for including relevant documents to be sent for scanning.

1.1.3.3.1 Hospital and outside records
1.1.3.3.2 Consult, referrals, dictations and ancillary reports
1.1.3.3.3 History and Physical
1.1.3.3.4 EMG reports
1.1.3.3.5 Progress notes
1.1.3.3.6 Radiology and lab reports
1.1.3.3.7 Pain Management Agreement
1.1.3.3.8 Consent forms
1.1.3.3.9 Letters from/to or regarding patient
1.1.3.3.10 Advance Beneficiary Notices

1.1.3.4 OBGYN (Only abstract charts which have had an appointment going back two years) Follow the current thinning policy relating to the time frame for including relevant documents to be sent for scanning.

1.1.3.4.1 Prenatal records
1.1.3.4.2 Health Department reports
1.1.3.4.3 Hospital or outside records
1.1.3.4.4 OB or GYN discharge summary
1.1.3.4.5 Prenatal and Post-partum counseling
1.1.3.4.6 Prenatal flow chart
1.1.3.4.7 Progress notes
1.1.3.4.8 Informed consent to test for HIV form
1.1.3.4.9 Sterilization consent
1.1.3.4.10 Medicaid Community Care Drug & Substance Abuse questionnaire form
1.1.3.4.11 Consults and referrals
1.1.3.4.12 GYN history
1.1.3.4.13 Sonogram report
1.1.3.4.14 Lab and radiology reports
1.1.3.4.15 EKG strips/halter monitor reports
1.1.3.4.16 Advance Beneficiary Notices
1.1.3.4.17 Letters from/to or regarding patient

1.1.3.5 Internal Medicine (Only abstract charts which have an appointment going back two years) follow the current thinning policy relating to the time frame for including relevant documents to be sent for scanning.

1.1.3.5.1 Hospital and outside records, discharge summary
1.1.3.5.2 Radiology and lab reports
1.1.3.5.3 EKG, nuclear medicine reports (i.e. stress tests, PFTs, Echo’s)
1.1.3.5.4 DEXA scan reports
1.1.3.5.5 Geriatric Assessment reports
1.1.3.5.6 History and Physical
1.1.3.5.7 Family Conferences
1.1.3.5.8 Diabetic flow sheets
1.1.3.5.9 Remicade flow sheets
1.1.3.5.10 Progress Notes
1.1.3.5.11 Consults, referrals, dictations and ancillary reports
1.1.3.5.12 Advance Beneficiary Notices
1.1.3.5.13 Advanced Directives
1.1.3.5.14 Pathology reports
1.1.3.5.15 Pain Management Agreements
1.1.3.5.16 Consent forms
1.1.3.5.17 Letters from/to or regarding patient

1.1.3.6 Family Medicine (Only abstract charts which have an appointment dating back two years) follow the current thinning policy relating to the time frame for including relevant documents to be sent for scanning.
1.1.3.6.1 Hospital and outside records, discharge summary
1.1.3.6.2 Radiology and lab reports
1.1.3.6.3 EKG reports
1.1.3.6.4 DEXA scan reports
1.1.3.6.5 History and Physical
1.1.3.6.6 Diabetic flow sheets
1.1.3.6.7 Progress notes
1.1.3.6.8 Consults, referrals, dictations and ancillary reports
1.1.3.6.9 Advanced Directives
1.1.3.6.10 Pain Management Agreements
1.1.3.6.11 Advance Beneficiary Notices
1.1.3.6.12 Pathology reports
1.1.3.6.13 Consent forms
1.1.3.6.14 Letters from/to or regarding patient

1.1.4 The abstracted documents are assigned to designated ICS document types. The process for placing abstracted documents within the correct document type is as follows:

**Responsible Party:** Clinical Staff, HIM Abstractors

1.1.4.1 Make a copy of the patient’s MRN bar code sheet. Print only to a laser printer. The MRN bar code sheet is accessed by opening the patient’s EHR, clicking on the demographics template. The MRN will be near the upper right hand corner of the template.

1.1.4.2 Make a copy of the appropriate ICS document type bar code sheet. Print only to a laser printer.

1.1.4.3 Place the MRN bar code sheet on top, followed by the ICS document type sheet and followed by the pertinent document. The ICS documents type sheets are accessible in the EHR under the “utilities” icon on the top tool bar.

1.1.4.4 Once all documents have been abstracted, place a large clip over all documents, to be held together.

1.1.5 The ICS document types which are available for use are defined in the Document Identification Classification Grid for ICS. The document types listed below describe generally what documents are placed within these areas as follows:
Responsible Party: Clinical Staff, HIM Abstractors

1.1.5.1 Other Records: Medical records of non-UNTHealth Providers either brought in by the patient or requested by the physician and not otherwise specifically described under one of the other categories, including records from a patient’s prior PCP or other providers.

1.1.5.2 Historical Radiology: Documents from the existing paper record which are radiology reports should be placed in this category. This does not include reports received after the initial paper record has been abstracted. Refer to section 1.1.3 to determine date range for this records category.

1.1.5.3 Historical Laboratory/Pathology: Documents from the existing paper record which are laboratory or pathology reports should be placed in this category. This does not include reports received after the initial paper record has been abstracted. Refer for section 1.1.3 to determine date range for this records category.

1.1.5.4 Historical Diagnostics: Documents from the existing paper record which are diagnostics reports (i.e. EKG’s, EEG’s, EMG’s, PFT’s, Nuclear Medicine Scans, Ultrasounds, Allergy Testing, etc.) should be placed in this category. This does not include reports received after the initial paper record has been abstracted. Refer to section 1.1.3 to determine date range for this records category.

1.1.5.5 H & P/Encounters: Documents from the existing paper record which are progress notes or encounters. These documents contain the clinical visit information where the providers have documented their clinical findings. Do not place encounters created within the EHR in this category. Encounters documented in the EHR are already a part of the EHR.

1.1.5.6 Laboratory/Pathology: Laboratory/Pathology documents received after the existing paper record has been abstracted are to be placed in this category.

1.1.5.7 Radiology: Radiology reports/documents received after the existing paper record has been abstracted are to be placed in this category.

1.1.5.8 Diagnostics Cardiovascular: Diagnostic reports/documents/images received after the existing paper record has been abstracted are to be placed in this category.
1.1.5.9 **Diagnostics GI/GU:** Diagnostic reports/documents/images received after the existing paper record has been abstracted are to be placed in this category.

1.1.5.10 **Diagnostics Neuromuscular Skeletal:** Diagnostic reports/documents/images received after the existing paper record has been abstracted are to be placed in this category.

1.1.5.11 **Diagnostics Other:** Diagnostic reports/documents/images received after the existing paper record has been abstracted are to be placed in this category.

1.1.5.12 **Echocardiograms:** Category removed from service June 1, 2009

1.1.5.13 **Stress Testing:** Category removed from service June 1, 2009

1.1.5.14 **Invasive Cardiology:** Category removed from service June 1, 2009

1.1.5.15 **Home Health/Hospice:** All home health records, regardless of business or clinical information are to be placed in this category. This includes documents from the existing paper record and documents received after the paper record has been abstracted.

1.1.5.16 **Consents:** June 1, 2009 forward – All consents are to be placed in this category. This includes documents from the existing paper record and documents received after the paper record has been abstracted. Exception: Consent to photograph and all HIPAA documentation will be placed in Application Extender.

1.1.5.17 **Directives:** June 1, 2009 forward – All directives are to be placed in this category. This includes documents from the existing paper record and documents received after the paper record has been abstracted.

1.1.5.18 **Missed Appointments:** The lavender “No Show” form should not be used when documenting in the EHR. Use the No Show Template within the EHR prompted from the visit type. The Alerts tab can also be utilized to document the date, reason, clinic, provider and instructions from provider.

1.1.5.19 **Pain Management:**

1.1.5.20 **Operative Reports:** Refer to the Document Identification Classification Grid for a detailed listing of documents that fall under this classification.
This includes documents from the existing paper record and documents received after the paper record has been abstracted.

1.1.5.21 **Discharge Summary**: Documents from the existing paper record includes instructions, summaries, or notes regarding discharge.

1.1.5.22 **Psychiatry**: Refer to the Document Identification Classification Grid for a detailed listing of documents that fall under this classification. This includes documents from the existing paper record and documents received after the paper record has been abstracted.

1.1.5.23 **Patient Business Record AX Separator Sheet**: This is a sheet to be placed over the business related records.

1.1.6 Preparation of business related documents to be sent for scanning that will be entered into “Application-Extender”. Remove the following documents from the paper patient chart. Select the newly created encounter and go to your master home template. Under “Visit Type” select “Chart Update”.

**Responsible Party**: Clinical Staff, Front Desk Staff, New Patient Registration, HIM Abstractors

1.1.6.1 Insurance card
1.1.6.2 Other Pertinent insurance forms
1.1.6.3 Completed HIPAA “Acknowledgment of Notice of Privacy Practices” form
1.1.6.4 Completed HIPAA “Personal Representative” form
1.1.6.5 Other completed pertinent HIPAA forms
1.1.6.6 Completed “Consent to Photography” form
1.1.6.7 Copy of social security card of minors
1.1.6.8 Waivers and ABN’s
1.1.6.9 Patient Payment Plans, Sliding Scale Qualification Forms
1.1.6.10 **Note**: Drivers licenses are not permitted to be scanned into Application-Extender or into the EHR per the Office of General Counsel.
1.1.6.11 Print “Patient Business Record AX separator sheet”, place in front of all documents, place a clip over all documents and lay on the inside of the paper record on the left hand side.

1.1.7 After the stickers have been placed on the chart, the chart will be returned to the clinical area. The chart is now ready for the physician/provider to use at the scheduled patient appointment.

**Responsible Party**: Providers, Clinical Staff

UNT SYSTEM POLICY TEMPLATE
1.1.8 Once the initial encounter with the patient has been completed, the provider will determine if any additional information is required for abstraction into the NextGen EHR. The physician/provider may reference the paper chart during the encounter, but is to document the encounter in the EHR. If there is no additional information to be abstracted or flagged for scanning, the provider will place his/her initials on the “Patient has EMR” sticker on the front of the paper chart next to “Full EMR (Physician Initials)”. After the clinical area has reviewed the chart for complete initials next to each category, the chart will be forward to Records and Information Management “RIM” to complete the scanning process. The provider will not be able to make further entries into the paper chart.

Responsible Party: Providers, Clinical Staff

1.1.9 In the event that the physician/provider determines that additional information is required for abstraction, the provider will mark the documents with a highlighter and draw a highlighted line on the sticker affixed to the front of the paper chart. This will indicate that more information from the paper chart is required to be abstracted. The clinical area will review the highlighted documents and determines whether any information marked is to be abstracted by the clinical abstractor. If so, the clinical employee will enter the information as outlined in 1.1.1 of this policy. If this information to be abstracted relates to documents outlined in 1.1.3 of this policy, the clinical area will forward the record to the HIM Abstraction Staff to complete the abstraction process. The provider will not be able to make entries into the paper chart after this encounter.

Responsible Party: Providers, Clinical Staff, HIM Abstractors

1.1.10 Once the chart has been received by RIM for abstraction, the RIM staff will complete the following:

1.1.10.1 Scan: RIM personnel will scan all properly separated documents received.

1.1.10.2 Bar code: RIM personnel will return all abstracted documents to the chart prior to sending the paper chart to the records center. Current documents (loose paper) sent for scanning will be destroyed by shredding once saved in the EHR.

References and Cross-references.
Thinning of Medical Records Policy; Document Identification Grid for ICS

Forms and Tools. (optional)

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