Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1907.07
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MANAGEMENT OF HEALTH RECORDS FILE ROOM AND SCANNING

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook provides basic procedures for managing the health record File Room and Scanning activities within a Health Information Management (HIM) Department.

2. SUMMARY OF CONTENTS: This new VHA Handbook establishes guidance for managing the health record File Room and Scanning function(s).

3. RELATED DIRECTIVES: VHA Handbook 1907.01, Health Information Management and Health Records, and Records Control Schedule (RCS) 10-1.

4. RESPONSIBLE OFFICE: The Office of the Assistant Deputy Under Secretary for Health for Informatics and Analytics (10P2C) is responsible for the contents of the Handbook. Questions may be referred to 217-649-3691.

5. RESCISSIONS: None.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last day of May 2021.

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1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides procedures for managing the scope and operations of the health record File Room and Scanning activities. **AUTHORITY:** 38 U.S.C. 305, 5723(d), 5727(9); 44 U.S.C. 3102(1).

2. BACKGROUND

File Room and Scanning activities include functions relative to providing complete, accurate, clinically pertinent and readily accessible patient health records to support the care provided to the patient. Scanning involves activities to digitize documents and data utilizing imaging or pictorial technology available in the patient health record. This Handbook outlines the standardized processes and procedures regarding creation, maintenance, management, processing, and expected quality monitors.

3. SCOPE

The File Room and Scanning section(s) at a facility provide(s) customer service to the users of the health record by retrieving and delivering health records that meet all applicable Federal laws, rules and regulations as well as The Joint Commission standards for provision of health records. The File Room and/or Scanning section(s) are staffed with, and supervised by, qualified, trained personnel. File Room and Scanning staff members are considered experienced once they have had the opportunity to review all available training aids, guides, handbooks, and complete hands-on training to develop a thorough understanding of File Room and Scanning activities. The time frame may vary by facility but at a minimum developing qualified staff will require 6 months of supervised training and experience.

4. RESPONSIBILITIES

a. **VA Medical Facility Director.** The VA medical facility Director, or designee, is responsible for establishing policies and processes that are in place ensuring:

(1) All duties associated with health record filing and scanning are done in a timely manner and in accordance with existing VA and National Archives and Records Administration statutes, regulations, and policies.

(2) Health record File Room and Scanning activities are under the supervision of a qualified professional who is well-versed in all aspects of health record File Room management and Scanning activities, preferably the Chief, Health Information Management (HIM), or designee.

b. **Chief, Health Information Management.** The Chief, HIM or designated File Room/Scanning Supervisor is responsible for the following File Room and Scanning activities when included in the HIM Section:

(1) Developing and monitoring processes to assure all File Room and Scanning activities are completed in an accurate and timely manner.

(2) Overseeing VistA Imaging document scanning.

(3) Ensuring that record tracking software is utilized to its full potential if paper records are in use.

(4) Developing standard operating procedures or other reference documents outlining the responsibilities for both the File Room and Scanning staff members, making them available to all involved in these processes, and monitoring compliance.

(5) Complying with mandated records management requirements, including timely and accurate record retirements.

(6) Ensuring that a system is in place to identify and prioritize expedited requests for both active and retired/archived health records.

(7) Ensuring that all requests for new scanning titles are approved by the Medical Records Committee (MRC) or equivalent.

(8) Ensuring that all staff members with scanning responsibilities are properly trained to accurately capture documents into Computerized Patient Record System (CPRS), using VistA Imaging Capture and VistA Imaging Display Technology, DocManager and Fee Basis Claims System (FBCS).

(9) Identifying, requesting, or reporting the need for new scanning equipment or reporting all computer related problems.

(10) Suggesting recommendations for streamlined documentation processes, such as using electronic record processes vs. paper processes.

(11) Assuring that quality assurance (QA) monitors are in place for the File Room and Scanning functions as detailed in this Handbook.

(12) Deleting incorrect document images and attaching to correct progress note.

(13) Establishing, monitoring, and concurring on all related policies/procedures for the document scanning and File Room management efforts of the facility.

(14) Changing titles of rescinded advance directives to watermark the image, pursuant to the requirements of VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives, or successor policy.

(15) Keeping File Room and Scanning staff members informed of the latest updates to VA and VHA policies, rules, and regulations involving File Room and Scanning; providing staff members awareness and access to updated or new resources, and validating staff participation in all applicable training.

(16) Overseeing all File Room and Scanning activities to ensure they are completed according to established time standards. ***NOTE:*** *In the rare circumstance when this is impossible for good cause, a delay notification will be provided to the person requesting the health record or assistance with the scanned document.*

(17) Managing day-to-day File Room and Scanning operations.

(18) Monitoring daily reports for pending health record requests for paper health records and documents waiting scanning for section productivity.

(19) Establishing a priority system for completion of health record requests and document scanning, including expedited requests, to ensure all requests are completed within required timeframes.

5. SCANNING REQUIREMENTS

a. Completing required training for document scanning;

b. Scanning documents in a timely manner with quality and integrity;

c. Ensuring all scanned documents are indexed correctly and attached to the appropriate patient, progress note title.

d. Performing and documenting concurrent and retrospective quality checks of all scanned documents as outlined in the Quality Monitor section 20 of this policy;.

e. Reporting any problems or errors to their immediate supervisor and/or designee, and informing Office of Information & Technology and HIM as appropriate. Examples of these include, but are not limited to, issues with software functionality, or errors identified with scanned images; and

f. Adhering to any new changes in policies, procedures or training methods related to document scanning, VistA imaging, VA policies and FBCS.

6. RESCISSION OF ADVANCE DIRECTIVES

a. Advance Directive progress notes are displayed via postings in CPRS as specified in VHA Handbook 1004.02.

b. Alerting Chief, HIM or designee of the need to rescind Advance Directives in CPRS in order for it to be marked “Rescinded” in VistA Imaging or other approved imaging system.

7. FILE ROOM AND SCANNING STAFF AND STRUCTURE

a. It is recommended that File Room management and Scanning oversight operations be centralized under a single supervisor who provides services to the main facility, on-site clinics and any medical facility associated Community Based Outpatient

Clinics (CBOCs). The ability to safeguard the Veteran's privacy must be considered when designing the File Room and Scanning sections.

b. The File Room and Scanning staff members must possess knowledge of federal privacy laws.

c. File Room and Scanning staff members must have a knowledge of information technology equipment used in the File Room or Scanning sections to efficiently import documents and assemble the selected documents for scanning.

d. File Room and Scanning staff members must possess the ability to navigate efficiently and effectively through the paper and electronic health record, VistA Record Tracking software, and VistA Imaging software to accurately index scanned information.

e. File Room and Scanning staff members must possess knowledge of the health record tracking system and the facility's storage system to determine if paper records exist, the location of the paper records, and the process to request or recall the records if not at the facility, such as those at a federal storage facility.

8. FILE ROOM RECORD PROCESSES

All health records in any medium are processed in accordance with the requirements outlined in VHA Handbook 1907.01, Health Information Management and Health Records, or subsequent policy issue.

a. Each health record request is prioritized to determine urgency utilizing a facility established priority system.

b. Upon receipt of a health record request, a File Room staff member reviews the request and determines the location of the health record utilizing the VistA Records Tracking System and/or Locator Cards.

(1) If the facility has paper records, the File Room staff member must retrieve the paper health record. The File Room staff member will charge out the correct paper volume(s) in the VistA Records Tracking System to assure proper recording of the location of record.

(2) File Room staff members must ensure that the health record is secure during the delivery to the requestor.

c. If required, archived health records are requested from storage facilities. Record retrieval for those records stored at the VA Record Center and Vault may be requested online utilizing the Electronic Records Retrieval System. If stored at any other storage facility, those records will be requested for return from the storage facility, using the process identified between facility and other storage facility. Storage and reference services are available to any VA on a fee-for-service-basis. Additional information can be found at http://www.rcv.va.gov/.

d. If there are requests for records where the subject of the request is not registered or found in the Master Veteran Index and no information is available, the request must be referred to the supervisor or designee.

9. SHADOW RECORDS

Shadow records are defined as duplicate health records that are kept for the convenience of a department or health care provider. The elimination of shadow records should be considered based on utilization of the electronic health record by the facility. Shadow records must not contain original documentation of the patient's care. Original documentation must be kept in the official health record.

10. CLOSING THE FILE ROOM

Many VA medical facilities have closed their File Rooms or are in the process of converting their File Rooms from paper to all electronic. With this process, there are steps to be taken to assure an organized conversion to ensure availability of health records. The following steps should be taken to close the File Room:

a. Set a "Closing Date".

b. Stage the process in the following order:

(1) Conduct research for the project.

(2) Decide on and announce the closure date to management and clinical staff members.

(3) Organize a team.

(4) Review documentation needs.

(5) Determine appropriate paper records storage, i.e. Federal Records Center or Records Storage Vendor.

(6) Review IT needs.

(7) Determine processes for entry of necessary information into VistA Records Tracking System or other approved electronic system.

(8) Hold weekly meeting and provide communications on File Room closure status.

c. Establish a team with representatives from HIM, Health Informatics, Nursing, Clinical Staff, Information Technology, and VistA Imaging.

d. Review template needs by identifying where paper records are being generated. Plan for education and dates for implementation of new templates.

e. Review HIM personnel needs.

f. Consider record retirement needs, including retirement of inactive records prior to closing.

g. Obtain location or vendor for storage of active paper records.

h. Pull and box active records for shipment.

i. Write a plan including processes for retrieval of records when needed, including recall of records or scanning.

NOTE: *Closure of the File Room does not eliminate the facility's responsibility to provide paper records when required to treat the Veteran or for other agency purposes, such as processing Freedom of Information Act requests.*

11. PERMANENT TRANSFER OF PAPER RECORDS

Paper records are no longer transferred from one VA facility to another VA facility unless a health care provider requests the transfer.

12. EXTERNAL SOURCE DOCUMENTS

a. External Non-VA health records (exception: Non-VA Purchased Care records) will be reviewed by a practitioner to determine what documents are to be retained based on the impact to present and/or continuing care. The appropriate VA medical facility may require the practitioner complete and sign the nationally developed form approved for local use, "Request to Scan Non-VA Documents", available at http://vaww.vhahim.va.gov/index.php?option=com_edocman&view=document&id=930&catid=162&Itemid=713 *(**NOTE:** This is an internal VA Web site that is not available to the public)*, and attach the documents they wished scanned. Alternatively, a summary progress note written by a practitioner after a review of the Non-VA source documents may be used in lieu of filing and/or scanning any Non-VA source documents. In regards to Non-VA Purchased Care, if signed documents cannot be obtained, the guidance pertaining to a summary progress note should be followed in lieu of scanning the unsigned documentation. A facility may develop a local policy that specifies which documents may be scanned into VistA Imaging without practitioner review.

b. If utilized by the VA facility, the Request to Scan Non-VA Documents form must be scanned as the first sheet (coversheet) of the scanned file of the Non-VA documents. It must include an index, so the when image opens, a list of what is contained as part of the electronic file is viewable.

c. Scanned source documents may be destroyed if the source document is indexed and imaged as an exact replica of the original document, quality control processes are in place, and there is assurance that the imaged document is stored, accessible, and retained according to VA and NARA records retention requirements.

d. The documents must be scanned with a minimum resolution of 300 x 300 dots per inch (dpi).

13. LOCATOR CARDS

Locator Card system may be maintained electronically in a secure drive. They should be reviewed to assist in determining the disposition of the inactive or perpetualized health records, to help identify the location that records have been transferred to other VA facilities. Locator Cards must not be destroyed unless an exact electronic replica is included in the facility Master Veteran Index. Locator Cards are maintained for all patients registered or treated since the facility's inception. These cards include the following information: patient's full name and any other names they may have used; date of birth; Address; Social Security Number; dates of admission and discharge or date of visit or encounter; disposition of patient's records.

14. ADVANCE DIRECTIVES

a. VHA handbook 1004.02, Advanced Care Planning and Management of Advance Directives, establishes requirements and procedures for documenting, managing, and rescinding advance directives. An Advance Directive is a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that the individual becomes unable to make those decisions.

b. Where there is no electronic health record, a copy of the advance directive must be filed in the paper health record either behind a tab specifically designated "Advance Directive" or, at a minimum, as the first document in the current or open health record. Each facility must develop a mechanism to ensure that the Advance Directive is maintained in both the paper outpatient record and the paper inpatient record to accommodate patient movement from one setting to another or from one VA facility to another.

c. An advance directive progress note will be created to be displayed in Postings to CPRS.

d. Advance directive documentation must be linked to the Advance Directive note.

e. When an advance directive is rescinded, the note title in Text Integration Utility (TIU) must be changed from "Advance Directive" to "Rescinded Advance Directive." After the TIU process is complete, all images associated with the rescinded advance directive will be watermarked "Rescinded" and a confirmation email will be sent to the subscribers of G.MAG SERVER mail group with the status of the watermarking.

f. The image associated with the advance directive will be watermarked "Rescinded" and made available to VistA Imaging Clinical Display users.

g. The TIU note title and the associated images must be correct. If the TIU note title is not correct and associated images are watermarked, a new advance directive must be entered for the patient.

h. When a note title is electronically modified to rescind an advance directive, the title is changed from the previous title to the new title; a change history of the title name

is not maintained. Local facility policy must state who has the authority to change a patient note title and under what circumstances these options are utilized. The change title option must be used.

15. DOCUMENT SCANNING PROCEDURES

a. After meeting required competencies, the facility may determine that Scanning staff may be authorized to create administrative progress notes for scanning purposes.

b. Images must be linked to the correct progress note for a specific visit date. Progress notes will be created using appropriate verbiage and/or templates as approved by the Health Record Committee, or equivalent, that is specific to the scanned document. If a progress note has been created to link an image, the note must be electronically authenticated by the individual who will be creating and scanning the document.

c. Each facility must develop a mechanism to ensure documents are not discarded without being scanned first, for example, by date stamping the document after scanning to indicate that the document(s) has been scanned. Only the first page of a multi-page document set regarding one patient is stamped.

d. Staff members responsible for document scanning will ensure, prior to scanning, that VHA-originated scanned images of paper documents include the patient identifiers (full name, last four digits of the SSN, and date of birth (DOB)). Digital image capture should meet the same criteria of patient identifier as scanned documents. However, some paper and digital images received from sources outside VHA, such as private hospitals or physician offices, do not contain all of the identifying data required of VHA-originated documents. In the case of electronically received Non-VA images, the cover page must include, at a minimum, the patient's name and last four digits of their social security number before importing into VistA Imaging. Each subsequent page should contain enough identifying traits to clearly identify the patient. In the case of a large quantity of non-VA paper documents received (as determined by local policy) the full name, last four digits of the SSN, and DOB can be written on the first and last page of the documents in lieu of adding the last 4 and DOB to the patient name on every page when scanning as a complete packet.

e. When scanning duplex documents, blank pages may only be scanned after an "intentionally blank" or "Blank" stamp has been embossed on the document.

(1) Scanners can be set up to not scan blank pages in the scanner software. The VistA Imaging Coordinator at the facility will determine if this is possible from the scanner manual.

(2) If documents such as Same Day surgery packets, with one-sided and two-sided documents, are to be scanned as a packet, then the blank pages are stamped "BLANK" and scanned as a duplex. Use of one-sided documents is encouraged. It speeds up

the scanning process and the ability to see documentation timely, and it negates the possibility of accidently scanning only one side of a two-sided document.

f. Data integrity and accurate indexing for documents must be captured using VistA Imaging Capture in a consistent manner, and the integrity of the document must be maintained as in the paper health record.

g. Documents scanned into VistA Imaging Capture must utilize consistent index terms to allow for proper sorting and searching of scanned documents by clinicians and administrative staff.

h. Administrative documents/images must be captured by attaching the scanned image to the patient instead of a progress note and indexed with appropriate administrative indices. Administrative documents/images will be captured by using the Administrative Association in VistA Imaging Capture.

16. GUIDELINES ON IMAGE DELETION

a. Errors involving scanned documents must be reported to the Chief, HIM, Privacy Act Officer, or designee. The Chief, HIM, or designee will review the record and reported error and take appropriate action.

b. Errors by scanning staff members must be tracked for quality assurance purposes to ensure the quality of scanning by the staff.

c. The VA facility must have a process to assure that image deletion requests are documented, including the specific image and/or progress note to be deleted. If the image has annotations, follow the process outlined in the Annotation Guidance Fact Sheet.

d. Staff members correcting the error must print the image prior to deleting it from the present location.

17. DESTRUCTION

a. Source documents may be destroyed only if the source document is indexed and imaged as an exact replica of the original document, quality control processes are in place, and there is assurance that the imaged document is stored, accessible and retained according to VA and NARA records retention requirements.

b. Source documents are original documents with wet or electronic signatures, such as consent forms or patient advance directives and copies of authenticated documents, such as Non-VA treatment records.

18. SCANNING AND FILE ROOM CONTINGENCY PLANS DURING COMPUTER DOWNTIME

Preparations must be made in advance of scheduled computer downtime for scanning of health records from the inpatient wards. Scanning timeframes will be based upon the time document is received in the File Room. Contingency plans must specify procedures for short- and long-term downtimes. File Room contingency plans are prepared for management of paper-based records during computer downtimes. Advance plans should anticipate the need to keep a manual log of records taken outside of the File Room; how requests may be taken when the computers are unavailable, i.e., by telephone, in person; and records delivery to support patient care. Paper records provided in response to requests during downtime should be loaded into the Record Tracking System when the downtime is concluded.

19. DOCUMENT SCANNING TRAINING

a. Document Scanning training is conducted for at least 1 week prior to allowing the employee to scan documents without direct supervision.

b. Once the employee has reviewed the facility scanning policy, the supervisor, Chief, HIM, and/or designee, will train the employee on the computer functions of CPRS and VistA Imaging Capture & Display.

c. The supervisor, Chief, HIM, and/or designee, will then go thru the processes of scanning a document with the employee and then allow the employee to scan documents with direct supervision.

d. When the designated training time is completed, the employee should be given the opportunity to scan documents without direct supervision. The Chief, HIM, and/or designee, will then monitor and review every document scanned by the employee until the employee has scanned a minimum of 100 consecutive documents error free for both administrative and clinical documentation.

20. CONDUCTING QUALITY ASSURANCE MONITORS

a. VHA Handbook 1907.01, Health Information Management and Health Records, addresses scanning quality control processes for readability and indexing. During the scanning process, the person scanning must verify that the document is being scanned appropriately.

b. Documents are to be scanned and reviewed for quality by the person scanning. During the first quality check, the image will be checked for the overall quality and visibility of the document. The person scanning will be responsible for reviewing each image, to make sure that the demographic information is correct on every page, the image is positioned as correctly as possible, and that all pages of documents have been captured in VistA Imaging, which may include blank pages when applicable. The second quality check of the scanned document must be verified by logging into VistA Imaging Display. The responsible person scanning the document will perform both

processes. These checks will be performed by the person responsible for scanning the document and will be performed on 100 percent of the documents scanned.

c. Areas reviewed for accuracy should include the following:

(1) Scanned to correct patient;

(2) Correct title/X-ray exam/Admin indexing used;

(3) Linked to correct consult when appropriate;

(4) Correct additional signers identified when appropriate;

(5) Required identifying information on all pages scanned;

(6) Progress Note entered correctly (containing required information);

(7) Indexed per procedure;

(8) Image legible; and

(9) Image oriented in CPRS.

d. For quality monitoring purposes, the following should be noted:

(1) The date the document was scanned, the department it was scanned in, and the staff that scanned;

(2) The document can be retrieved through the client display portion of VistA Imaging; and

(3) The abstract of the scanned image/document is pulled up, right click on it, and select the option “Image Information.”

e. A Quality Assurance Monitor must be performed to assess the quality of documents scanned. In order to determine which patients are selected for the monitor, the Chief, HIM, and/or designee, picks a random sample of scanned documents. Errors and image deletions must always be included in the Quality Image Assurance Monitors. The facility should have a method to track image deletion requests as well as the number of images deleted.

f. Pertinent results of monitors must be discussed with the individual who performed the scanning. When consistent problems are identified on any of the reviews, focused reviews will be conducted that look at a higher volume of scanned documents. The errors must be investigated to determine the cause, scope, and seriousness and an action plan must be implemented.

g. The Scanning Supervisor or designee must conduct quality checks for all scanning staff quarterly at a minimum and as determined by the facility. The QA

Review functionality in VistA Imaging Display will be utilized to identify cases to be reviewed for each scanning staff member.

21. GUIDELINES FOR REPORTING QUALITY ASSURANCE MONITOR RESULTS

Results of quality assurance monitors may be reported to a facility oversight committee. Action plans for any monitors not meeting established thresholds must be prepared and completed with ongoing monitoring to assure compliance with thresholds.

22. DOCUMENT SCANNING STAFFING

HIM Scanning personnel needs must be assessed by determining the amount of paper (documents) to be scanned and/or by transitioning File Room FTEEs to Scanning FTEEs. A recommended measure for computing FTEE is the average amount of paper documents scanned per hour per FTEE.

23. DOCUMENT SCANNING JOB SERIES AND PERFORMANCE DESCRIPTION (PD)

a. The positions of staff working in the File Room are classified to the Mail and File Series, GS-305. The appropriate appointment for positions in this series is when file duties are predominantly File Clerk and includes Document Scanning. These positions have been classified in this series to be at the GS- 4 level for the highest level. See the following: GS 305-4. OPM File Clerk Decision Memorandum.

b. Although this occupation has traditionally consisted of the manually performed operations associated with the maintenance of paper files, the GS-305 series standard recognizes the advent of automated filing systems and the associated changes that have occurred in the methods applied to storing records. The standard notes that these changes have not affected the basic nature of the work, i.e., the use of an automated system involves a rearrangement of, but no change in, basic filing processes. Therefore, filing work performed within an automated system is encompassed by the GS-305 series.

24. DOCUMENT SCANNING PRODUCTIVITY

HIM Health Information Management (HIM) Managers and Scanning Supervisors utilize the tools available through VistA Imaging to monitor productivity. Processes included in scanning/document imaging are: prepping, scanning, indexing and analyzing. The minimum expected scanning productivity standards for fully trained professional scanning staff members performing the scanner scope of work requirements are specified as follows:

a. **Scope of Work–Minimum Standard Per Day Note.** The minimum standards are based on a 7.5 hour workday and do not include leave, educational hours, or non-scanning activities performed by the scanning technician. Appropriate lower standards may be set for technicians in developmental positions. An individual scan is to scan/import appropriate documents into VistA Imaging.

b. **Scanning All 3 Types Below.** 13 Individual scans per hour or > 59 Individual scans a day (69 pages per hour).

c. **VA Administrative.** 24 Individual scans per hour or > 108 Individual scans a day (106 pages per hour).

d. **VA Clinical.** 16 Individual scans per hour or > 72 Individual scans a day (80 pages per hour).

e. **Non-VA (Not FEE).** 11 Individual scans per hour or > 50 Individual scans a day (79 pages per hour).

NOTES: *Productivity standards were developed based on input from Field Subject matter experts as well as an analysis of the national HIM survey results of 100 percent of all VA health care facilities on scanner productivity. Higher standards may be set as determined to be appropriate by the HIM Manager or Scanning Supervisor based on facility specific variables.*

The Non-VA (Not Fee) standard is set at a lower than the VA standards as these documents are less familiar to the scanning staff and may require additional time to identify rather than familiar documents from the local facility.

Facility productivity and accuracy standards must be negotiated with your local union representatives.

25. REFERENCES

a. NIST Special Publication 800-53, Recommended Security Controls for Federal Information Systems.

b. NIST 800-66, An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

c. NIST 800-88, Guidelines for Media Sanitization.

d. Title 5 U.S.C. 552a, The Privacy Act of 1974.

e. Title 44 U.S.C.33, Disposal of Records.

f. Title 5 CFR 2635, Standards of Ethical Conduct for Employees of the Executive Branch.

g. Title 21 CFR 1306, Prescriptions.

h. Public Law 104-191, Health Insurance Portability and Accountability Act of 1996.

i. VA Directive and Handbook 5021, Employee/Management Relations.

j. VA Directive 6609, Mailing of Sensitive Personal Information.

k. Assistant Secretary for Information and Technology Memo, May 4, 2004, “Limits on the Use of Certain E-mail Features and Configurations.”

l. RCS 10-1, Records Control Schedule.

m. VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives.

n. VHA Handbook 1004.04, State-Authorized Portable Orders.

o. VHA Handbook 1004.05, iMedConsent™.

p. VHA Handbook 1605.1, Privacy and Release of Information.

q. VHA Handbook 1907.01, Health Information Management and Health Records.

OCCUPATIONAL HEALTH RECORD-KEEPING SYSTEM (OHRS)

a. The Employee Medical File (EMF), which is under the responsibility of Occupation Health , is covered under multiple Federal regulations, including: Privacy Act (PA); Health Insurance Portability and Accountability Act (HIPAA); Genetic Information Nondiscrimination Act (GINA); Americans with Disability Act (ADAA); Family Medical Leave Act (FMLA); Occupational Safety Health Administration; National Personnel Records Center (NPRC); Office of Personnel Management (OPM) GOVT10 and 08VA05. OHRS is an electronic record that separates employee health information from Veteran health information. CPRS does not meet the regulatory requirements of the above regulations.

b. When an employee leaves Federal service, his or her former agency must put any long-term occupational health records in the EMF for storage at the NPRC. If there is information in CPRS, it must be printed out and put into the EMF. Doing this when the employee separates, which could be decades after health information is entered into CPRS would make it impossible to determine what must be printed out because one will not be able to determine what an occupational health record is related to employment at the VA. Responsibility for printing those documents lies with Occupational Health with the knowledge to determine what a long-term medical encounter is considered. This would include physicians, nurse practitioners, physician assistants, and registered nurses.

c. There is no other option for order entry at this point in time, so orders must be placed in CPRS and results are recorded there. These cannot be separated from Veteran records and do not meet the above laws.

d. It is highly recommended because of the requirement above that staff members print out any clinical notes, tests, medications etc. and place them in the EMF.