

<b>REQUEST FOR RECORDS DISPOSITION AUTHORITY</b>			JOB NUMBER <i>NI-513-09-1</i>	
To: NATIONAL ARCHIVES & RECORDS ADMINISTRATION 8601 ADELPHI ROAD COLLEGE PARK, MD 20740-6001			Date received <i>9/23/09</i>	
1 FROM (Agency or establishment) Department of Health and Human Services			NOTIFICATION TO AGENCY  In accordance with the provisions of 44 U.S.C. 3303a, the disposition request, including amendments, is approved except for items that may be marked "disposition not approved" or "withdrawn" in column 10	
2 MAJOR SUBDIVISION Indian Health Service (IHS)				
3 MINOR SUBDIVISION				
4 NAME OF PERSON WITH WHOM TO CONFER Kelvin Vandever, IHS Records Officer		5 TELEPHONE NUMBER 301-443-8029	DATE <i>9/15/2009</i>	ARCHIVIST OF THE UNITED STATES <i>WITHDRAWN</i>
6 AGENCY CERTIFICATION I hereby certify that I am authorized to act for this agency in matters pertaining to the disposition of its records and that the records proposed for disposal on the attached <u>2</u> page(s) are not needed now for the business for this agency or will not be needed after the retention periods specified, and that written concurrence from the General Accounting Office, under the provisions of Title 8 of the GAO Manual for Guidance of Federal Agencies,  <input checked="" type="checkbox"/> is not required <input type="checkbox"/> is attached, or <input type="checkbox"/> has been requested				
DATE 09/21/2009		SIGNATURE OF AGENCY REPRESENTATIVE <i>Yvonne K. Wilson</i> S // Yvonne K. Wilson		TITLE HHS Records Officer
7 ITEM NO	8 DESCRIPTION OF ITEM AND PROPOSED DISPOSITION	9 GRS OR SUPERSEDED JOB CITATION	10 ACTION TAKEN (NARA USE ONLY)	
	Electronic Records Schedule Indian Health Service Resource and Patient Management System (RPMS)  See attached			

## Electronic Patient Health Record

The Indian Health Service (IHS) uses the Resource and Patient Management System (RPMS) to capture patient health information that supports the delivery of health care. The electronic health record contains the same types of information as the hardcopy medical records. Electronic health records can consist of narrative treatment summary, records of hospitalization, laboratory tests, x-ray images and interpretations, electrocardiograph (EKG), and other clinical and administrative records pertaining to IHS patients. The records document the diagnosis, definitive medical, surgical, psychiatric, and dental care or treatment services complied by various health care professionals (in and outside of IHS) who participated in the care of a patient during one or more courses of treatment. Administrative records used to determine eligibility for medical services, hand written correspondence, and similar records are also captured as part of the electronic health record.

The record consists of scanned images from paper-based medical records, computer-generated data and/or data generated by medical equipment. The information becomes a part of the electronic health record utilizing these methodologies. Portions of the electronic health record are created from paper-source documents by imaging/scanning technology. Other patient information is collected and entered directly into the computer system either manually or through electronic means.

The Privacy Act System of Records Notice for IHS is 09-17-0001, IHS Medical, Health and Billing Records Systems.

This schedule does not supersede the paper patient health record, NARA Authority # N1-513-92-4, but rather is intended to supplement the existing schedule.

The word processing and electronic mail instructions will not be included in this schedule because patient health information is entered into the RPMS electronic health record and the IHS Rules of Behavior for appropriate use of information systems and technology resources does not authorized e-mail communication of patient health information.

### I. Input

#### 1. Paper Source Documents.

- a. Hard copy version of information manually input into Resource and Patient Management System (RPMS).

**Disposition:** Destroy after verification of accurate entry of information into RPMS.

- b. Hard copy version of information scanned onto optical disk or other magnetic media.

**Disposition:** Destroy after verification of accurate scan onto optical disk or other magnetic media.

2. Interim Electronic Source Information.

Electronic version of source information obtained from other electronic databases, optical disk, or other magnetic media not considered as part of the consolidated patient health record. May include information generated electronically by medical equipment.

**Disposition:** Destroy/Delete after migration of information to another electronic medium. Destruction of interim version of information is not to occur until it has been determined that the migrated information represents an exact duplicate of the previous version of the migrated information.

**II. Electronic Final Version of the Patient Health Record**

3. Final, consolidated, electronic version of a Patient Health Record. Includes information migrated from interim electronic information systems, electronic medical equipment, or information entered directly into the RPMS information system. May be stored on optical disks or other magnetic media.

**Disposition:** Cut off files after notification of inactivity (e.g., death of patient, termination by patient of use of IHS medical facilities, or any other evidence of last episode of patient care). Destroy/Delete 75 years after cutoff.

**III. Output**

4. Output in Electronic Form.

May include electronic display versions of patient orders, operation reports, health summaries, etc., and other documents associated with patient health records.

**Disposition:** Destroy/Delete when no longer needed for administrative or clinical operations.

5. Output in Paper or other Hard Copy Form.

May include output consisting of printed hard copy of patient health records.

**Disposition:** Destroy when no longer needed for administrative or clinical operations.

**IV. Documentation**

6. Data systems specifications, file specifications, codebooks, record layouts, user guides, output specifications, and final report (regardless of medium) relating to a master file, database or other electronic records.

**Disposition:** Destroy or delete upon authorization deletion of the related electronic records or upon the destruction of the output of the system if the output is needed to protect legal rights, whichever is later. **GRS 20-11a(1)**

## Electronic Patient Health Records

**Purpose:** This record appraisal and accompanying Standard Form 115 (SF-115), Request for Records Disposition Authority, provide retention and disposition requirements for the Indian Health Service (IHS) electronic patient health records, including records which have been optically scanned. In addition, the appraisal and SF-115 provide disposal requirements for paper records that have been scanned onto magnetic media or optical disks, hence after referred to as storage media.

The retention and disposition standards for electronic patient health records are established in accordance with the National Archives and Records Administration (NARA) regulations. The electronic version of the patient health records cannot be destroyed until the Archivist of the United States, NARA, approves the SF-115 for the records. Electronic patient health records are subject to the regulations, requirements, provisions, etc. governing the retention and disposition of Federal government records.

**Background:** The Government Paperwork Elimination Act (GPEA), implemented in Fiscal Year 2004, encourages Federal agencies to develop the capability of managing records electronically for their full authorized retention period. In accordance with the GPEA, agencies must also give persons and entities that are required to maintain, submit, or disclose information to the Federal government the option of doing so electronically when practicable as a substitute for paper, and to use electronic authentication (electronic signature) methods to verify the identity of the sender and the integrity of the electronic record content.

In providing an optimal level of health care services to the Nation's Native American and Alaska Natives and their beneficiaries, IHS medical facilities create patient health records, both paper and electronic, to document medical care provided by IHS health care professionals. The paper patient health record is authorized for retention and disposition pursuant to NARA authority N1-513-92-4. This authority provides for the records to be retained in IHS health care facility from 3 to 7 years after the last episode of care. Records may be retired to the Federal Records Center after 3 or more years of inactivity. Records are destroyed 75 years after the last episode of care.

**Analysis:** The retention and disposition requirements contained in this appraisal and counterpart SF-115 apply to all IHS medical facilities. All IHS medical facilities utilize some form of electronic recordkeeping technology to store patient health record information. To dispose of patient's electronic health records, IHS needs to obtain the approval from NARA. Health records maintained in hardcopy will continue to be disposed in accordance with the disposal and authority approved by the NARA.

Like paper health records, electronic patient health records document the health care of IHS patients and serve as a legal record. The electronic patient health record system represents a conversion from the traditional processing of patient information to a system based upon computer technology to process patient information.

The electronic patient health record contains the same type of information as the hardcopy health records. Electronic records can consist of narrative treatment summary, records of

hospitalization, laboratory tests, x-ray images and interpretations, electrocardiograph (EKG), and other clinical and administrative records pertaining to IHS patients. The records document the diagnosis, definitive medical, surgical, psychiatric, and dental care or treatment services complied by various health care professionals (in and outside of IHS) who participated in the care of a patient during one or more courses of treatment. Administrative records used to determine eligibility for medical services, handwritten correspondence, and similar records are also captured as part of the electronic patient health records.

The record consists of scanned images from paper based medical records, computer generated data and/or data generated by medical equipment. IHS information becomes a part of the electronic health record utilizing these methodologies. Portions of the electronic health record are created from paper source documents by imaging/scanning technology. Other patient information is collected and entered directly into the computer system either manually or through electronic means.

The process of scanning documents translates paper documents into legible, accurate and complete copies that can be incorporated, viewed, stored, and retrieved as a part of the electronic health record. An optical scanner is used to convert paper documents into a digital format that is stored on the appropriate storage media.

Each IHS medical facility has established standard operation procedures to back-up all electronic patient information. The storage media are stored in an area separate from the remote workstations. These procedures are used to safeguard against the loss of information due to equipment malfunctions, human error, etc.

Digital imaging and optical storage systems were selected primarily because of the large number of records that can be processed and stored electronically. Optical images are viewed by using computer workstations. Paper copies can be generated by authorized personnel on a need-to-know basis via a laser printer.

The life expectancy of storage media must be sufficient to retain the information for the retention requirement for the records, thus ensuring that the records will be retained to meet any legal requirements and that the integrity of the information will not be compromised. While the life expectancy of the disks is long and will meet current retention requirements, the life expectancy of the device to read the disk is not. Standard file formats will be used, and files will be migrated to new technology periodically

To safeguard against the loss of information, regular backups are produced and historical backups maintained. These backups are stored in an area separate from the location where the original storage media are maintained.

Quality control measures are in place to ensure quality, accuracy, and integrity of the scanned information. Audits ensure that scanned documents are legible and assigned to the correct patient. Computer monitors are used to view the scanned document and to ensure that all paper documents are accurately converted to optical disk images.

Safeguards are in place to ensure information security. Access to the records is restricted to users on a need-to-know basis. Safeguards are in place to ensure that the scanned paper documents as well as the electronic records are protected against unauthorized disclosure. Computer security procedures are followed in accordance with IHS information security protocols.

Source documents are no longer necessary once these checks are complete and it is deemed that the scanned image(s) meet quality standards. These source documents can be disposed of after verification they have been fully and accurately converted to optical disk images. Destruction method for disposal of paper source documents is shredding.

As an integral part of the electronic patient health record system, an index is maintained to provide easy access to electronic documents. All electronic information is indexed by patients' names, social security number, and/or other appropriate identifiers (e.g. Master Person Index (MPI). The Privacy Act System of Records (PASOR) Notice for IHS is 09-17-0001, Medical, Health and Billing Records Systems. This PASOR notice covers electronic patient health records. The notice will state that the records will be maintained and disposed of in accordance with the record disposition authority approved by the Archivist of the United States.

Auxiliary medical records produced as a result of specific medical procedures or tests, e.g. x-ray, EEG, are to be disposed of in accordance with their disposition authority.

**Recommendation:** Final versions of storage media and electronic records are to be destroyed/deleted 75 years after the last episode of patient care, which is commensurate with NARA authority N1-513-92-4 for the IHS patient health records. Interim versions of storage media and electronic records may be destroyed after the information has been migrated to another storage media. However, destruction of the interim versions of storage media is not to occur until it has been determined that the migrated information represents an exact duplicate of the previous version of information. This requirement will ensure that the information is retained 75 years after the last episode of patient care. Paper source documents are to be destroyed after they have been accurately scanned onto optical disks.