State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
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TO: Hospital CEO's

FROM: Marilyn Dahl, Deputy Commissioner MD
Health Care Quality and Oversight

SUBJECT: Medical Records Storage and Retention by Hospitals

The Department of Health and Senior Services (Department) has been asked by the New Jersey Hospital Association, a number of health care facilities, and other interested parties for assistance in understanding their responsibilities for establishing and maintaining medical records. The New Jersey law on the retention of medical records by health care facilities predates by many years the modern computer era. Moreover, this is a complex area of information technology that is evolving rapidly. As a result, the Department recognizes there is a significant challenge in determining how health care facilities may best comply with existing state law and applicable federal regulations, while utilizing existing information technology.

The Department believes that electronic medical records offer tremendous promise, not only in increased efficiency, but also in improved quality of patient care. The Department is pleased that the federal government has made developing a national infrastructure for a uniform approach to electronic medical records a priority, but we realize the country is some years away from reaching this goal.

During this transition period, the Department's primary concerns are that facilities comply with the existing state law and federal requirements, and to ensure that medical records, regardless of the medium they are created and stored in, are complete, protected from alteration, and can be made readily available. The purpose of this guidance is to provide the requested assistance. Facilities are cautioned, however, to consult with their own counsel in developing their policies and procedures in this area.

A. General Requirements

- Medical records must be retained for a period of ten years after the patient has been discharged., or until age 23, whichever is greater.[1]
- Each facility is obligated to comply with the criteria for the content of medical records, as specified in the licensing requirements, which may be found in the New Jersey Administrative Code and by following the links on the Department website at http://www.state.nj.us/health to the applicable licensure manual.
- Hospitals that provide care to ambulatory patients shall follow the medical records requirements contained in the Manual of Standards for Licensure of Ambulatory Care Facilities.[2]
- The entire medical record is readily accessible when needed for use in patient care and treatment and/or in response to a request from the patient or the Department. There must be a reliable, fail-safe mechanism to track the location of all components of the medical record in order to compile a record that is complete, accurate, available in a timely fashion and systematically organized.
- It has come to the Department's attention that some facilities rely upon the Division of Archives and Records Management (DARM) of the Department of State publication entitled, "Records Retention Schedule: New Jersey Health Care Facilities." This schedule governs the retention and destruction of public records, as approved by the State Records Committee, in accordance with N.J.A.C. 15:3-2.1 et seq. Health care facilities licensed by the Department of Health and Senior Services are not subject to the statutes and regulations pertaining to the storage and retention of public records. Therefore, to the extent that facilities rely upon the above-captioned DARM publication or regulations governing computer security systems issued by the Department of State as operational guidance, they do so solely at their own discretion, on a voluntary basis.
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B. Conversion of Paper Records to Electronic Format After Discharge, "Closed Records"

- Facilities may convert paper medical records into electronic format via scanning methodology.
- Once the electronic document has been created, the paper record may be destroyed.
- The facility must ensure that the records scanning system is secure and reliable.

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[1] *See*, N.J.S.A. 26:8-5.

[2] *See*, N.J.A.C. 8:43A-13.1-13.6.

- The facility must ensure that the records retention system is capable of generating clear hardcopy printouts upon request by the Department or another authorized party. The printouts must be retrievable in a timely fashion, complete, accurate and systematically organized in a manner that facilitates review of the record.

C. Creation of Electronic Medical Records Before Discharge, "Active Records"

- Facilities may create original electronic medical records.
- The facility must ensure that the electronic records retention system is secure and reliable.
- If a facility has some paper-based and some electronic components of an active record, the facility must have written policies and procedures to ensure compliance with the general requirement described above for ready accessibility, completeness, accuracy, and systematic organization.
- Electronic records shall have the same functionality as paper records, including clear identification of subsequent alterations of previously recorded data.
    - The integrity of each electronic record must be preserved with appropriate software programs to ensure that such records cannot be altered after information has been entered without appropriate identification that an alteration has occurred and how it was authorized.

For questions concerning this matter, please contact Mr. John Calabria, Director, Certificate of Need and Acute Care Licensure Program, at (609) 292-8773.

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