CLASSIFICATION NO. 538
Established: 10/08
Revised: 1/19, 3/24
FLSA: Non-Exempt
EEO: 6

HEALTH RECORDS SPECIALIST, SENIOR

CLASS CHARACTERISTICS

Under general supervision, to perform a variety of complex administrative duties associated with the organization, maintenance and integrity of a health records system requiring both standard and additional level of legal protection; to ensure the availability of records and the organization of patient information; to protect and release information in accordance with applicable laws, rules and regulations governing confidentiality of health records including those applicable to subpoenas and treatment for substance use disorders; to assist in developing, revising and implementing health records policies and procedures; and to do other work as required.

DISTINGUISHING CHARACTERISTICS

The Health Records Specialist classification series is used within the Health Centers Division of Health, Housing & Human Services (H3S) which provides health services to residents of Clackamas County.

The Health Records Specialist, Senior is considered a subject matter expert on health information management (HIM) and is responsible for training and quality assurance of health records activities. Incumbents are also responsible for processing subpoenas and court orders and responding to requests for health information with an additional level of protection requirements under State and Federal laws, rules and regulations. The incumbent processes and maintains accurate and legal health records which provide real-time availability of quality information for professional health care providers to deliver services and protect the financial and legal interests of the provider, facility, and patient.

The Health Records Specialist, Senior differs from the Health Records Specialist which responds to requests for health information with standard level of legal protection requirements and does not process subpoenas and court orders. Additionally, the Health Records Specialist is not responsible for the review and quality assurance of program-wide health information activities.

TYPICAL TASKS

Duties may include but are not limited to the following:

1. Receives, tracks and processes external requests for a variety of health information with standard or additional level of protections including subpoenas; verifies and reviews subpoenas and health information requests and authorization forms for validity, completeness and compliance with State and Federal law and confidentiality guidelines; determines and compiles appropriate health records and documents to release based on review and interpretation of applicable and evolving laws, rules, regulations and County policy; consults with supervisor on complex information requests; calculates charges for

health record copies; mails, emails and/or faxes records, and documents actions appropriately in the record; requests records from and provides records to outside providers; confers with clinicians, administrative and support staff, supervisors, patients, public agencies, attorneys and outside health care providers regarding subpoenas, court orders and other requests for health information.

2. Prepares, scans, indexes, abstracts, and processes health records containing protected health information through electronic and other health record systems for immediate access by medical providers, clinicians, dental providers, and clinic office support staff; processes internal requests for health, behavior health, and dental records, and dental referrals searches for missing records; forwards health records to appropriate location.

3. Provides assistance and information to staff, patients, and third parties such as other clinics, insurance companies, government agencies, and law firms via phone and email; acts as a point of escalation for complex inquiries and requests.

4. Serves as a subject matter expert in health information operations; answers questions about confidentiality, documentation standards, procedures, and release of health information; provides initial and ongoing training to Health Records staff on health information and records management; assists in educating clinicians and other internal staff regarding health records issues, and appropriate use of unit and sub unit codes and corresponding documentation requirements; provides guidance to internal staff regarding procedures and conduct if subpoenaed; resolves issues in locating information.

5. Acts as Records Custodian for Health Centers, Behavior Health, and Public Health Divisions to respond to subpoenas and court orders for health records of patients/clients served; signs affidavits to certify the authenticity, completeness, and validity of requested records; appears in court to testify; testifies to the authenticity, completeness, and validity of the creation of patient/client records and the processes regarding release of records.

6. Acts as gatekeeper for Driving while Under the Influence of Intoxicants (DUII) Treatment Completion Certificates; adheres to administrative rules to ensure documentation is complete and billing is paid in full, which provides proof client completed a treatment program ordered by the court; coordinates clinician authentication; discloses certificates to Department of Motor Vehicles (DMV) and client; maintains log of completed DUII certificates; reorders certificates from DMV.

7. Reviews health records for completeness; searches for missing records; follows up with clinicians and others to obtain missing documentation, information or required signatures; performs data entry of health information into supporting databases according to timelines; extracts and compiles medical care and other data from health records for various inquiries and reporting requirements navigates among several specialized, complex systems; merges duplicate registrations.

8. Reviews the work and operational processes of the Heath Information Management team to ensure compliance with federal, state, and local laws and regulations; monitors updates to federal and state confidentiality laws, HIPAA, and department policies and recommends changes.

9. Assists in developing, revising and implementing procedures to improve quality, content and security of health records; assists in maintaining health records procedure manuals; makes recommendations for procedural changes as needed; audits charts and internal processes.
10. Leads and/or coordinates the work of paraprofessional or support staff as directed by management; assigns and reviews work; provides input for performance evaluations; identifies training needs for work unit.

REQUIRED KNOWLEDGE AND SKILLS

Working knowledge of: Electronic Health Records systems; principles and practices of health records management including documentation practices, auditing techniques and filing systems; medical terminology including basic anatomy and physiology; current, relevant Federal, State and local laws, rules and regulations applicable to health record confidentiality, release of information and security including those specific to subpoenas, court orders and treatment for substance use disorders; concepts and techniques for prioritizing and organizing work; office practices and procedures; basic English, spelling, grammar and punctuation; basic math.

Skill to: Independently, accurately and effectively perform assigned tasks and duties following established procedures and policies with adherence to timelines; correctly research and interpret and apply laws, rules, and regulations governing health records, release of information, confidentiality and security; organize and maintain an accurate health records filing system; perform detailed record research, maintenance, retrieval and filing utilizing multiple software programs; compute charges due according to billing schedule; communicate effectively, both orally and in writing; operate office equipment including personal computers, printers and fax machines; use variety of software programs including spreadsheets and specialized databases; maintain cooperative working relationships with County staff, health professionals, patients, attorneys, other agencies and the public.

MINIMUM QUALIFICATIONS

Minimum qualifications are used as a guide for establishing the minimum experience, education, licensure, and/or certifications required for employment in the classification. The following minimum qualifications are established for this classification. Additional minimum qualifications and special conditions may apply to a specific position within this classification and will be stated on the job announcement.

Experience: A minimum of four (4) years of related experience that would provide the required knowledge and skills to perform the responsibilities of this position.

Licenses/Certifications:
The following licensure/certifications are required at the time of hire.

- Registered Health Information Technician (RHIT) or Registered Health Information Administrator (RHIA) from the American Health Information Management Association (AHIMA).

PRE-EMPLOYMENT REQUIREMENTS

Must successfully pass a criminal history check which may include national or state fingerprint records check.

Driving may be necessary for County business. For position(s) with occasional/incidental driving, incumbents must possess a valid driver's license. Accommodation requests for an acceptable alternative method of transportation will be reviewed on an individual basis in compliance with State and Federal legislation. For position(s) with regular driving, incumbent(s) must also possess and maintain an acceptable driving record throughout the course of employment.

POST-EMPLOYMENT REQUIREMENTS

May require possession of or ability to obtain Notary Public Certification within six (6) months of hire.