

DoD Space Planning Criteria for Health Facilities

Medical Administration

2.5.1. PURPOSE AND SCOPE:

This section provides guidance for the planning of Patient Administration in a medical facility. Patient Administration includes TRICARE offices, admissions & dispositions, inpatient and outpatient records sections, and transcriptions.

2.5.2. DEFINITIONS:

Administrative Personnel: Administrative personnel are all personnel who do not counsel, diagnosis, examine or treat patients, but who do work that is essential for the accomplishment of the missions of a medical treatment facility. This does include military (assigned and borrowed), contract and civilian personnel. It does not include volunteers.

Admission and Disposition Clerk: A medical records technician, who interviews patients being admitted to the hospital or Medical Center and who creates the inpatient record and all documents necessary for the admission.

Birth Clerk: The birth clerk is responsible for birth related records such as birth certificates and counseling/applications for social security numbers.

Cashier: The cashier is the person responsible for receiving, holding and disbursing cash to and from hospital or Medical Center patients as a result of diagnostic care or treatment.

Decedent Affairs Clerk: The decedent affairs clerk is the person responsible for the administrative details (survivor counseling, paperwork and notifications) incidental to the death of a patient.

Extended Ambulatory Records (EAR): Extended Ambulatory Records are the records used to document ambulatory or “same day” surgery and observation status. These records are treated in the same manner as an inpatient record and they are kept on file for the same period of time as an inpatient record. They are stored within the inpatient records room, or a similar secure area.

Inpatient Records: Inpatient records exist in hospitals and in clinics (where they keep records of active duty members admitted to civilian medical treatment facilities). They provide a record of diagnosis and treatment. The creation and maintenance of inpatient records is governed by Service regulation and Retention Schedules. The coding of the diagnoses and procedures is largely governed by the International Classification of Diseases. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is designed for the classification of morbidity and mortality information for statistical purposes, for the indexing of hospital records by disease and operation, and for the data storage retrieval. The clinical modification of the ICD-9 was developed by the National Center for Health Statistics for use in the United States. While each of the three services have their own patient record forms and separate training for patient administration technicians, who work with records, the recording within records of diseases and procedures is done in accordance with the ICD-9-CM. (See <http://www.icd-9-cm.org>).

MEDICARE Eligible: A patient who is 65 years of age or older and is qualified for federal reimbursement for healthcare.

Outpatient Records: Outpatient records provide a record of diagnostic and treatment encounters of ambulatory patients in the clinic or a hospital or in a freestanding clinic. Outpatient records are maintained (filed) separately from inpatient records and may be kept in a hospital, Medical Center or a freestanding clinic.

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Third Party Collection: Third party collection is that effort to obtain payment for health care services from other than the patient. The first two parties to a health care encounter are the patient and the provider or the organization, which the provider represents. The third party (not existing in all cases) is a payer other than the patient. Third Party payers may be insurance companies, employers or, in some case, governmental agencies.

TRICARE: A Tri-Service managed care program that provides all health care for DoD beneficiaries within a DoD geographical region. It integrates Medical Treatment Facilities (MTF) direct care and TRICARE civilian provider resources by forming partnerships with military medical personnel and civilian contractors. There is typically both a military TRICARE section and a TRICARE Service Center (TSC) run by civilian contractors in every MTF. Planners must review the regional TRICARE contract to determine if specific amount of minimum space for the contractor is stated for the TSC. Note: TSC space is not necessarily in the same area as Medical Administration. Military TRICARE sections are separate and distinct from TSC's.

2.5.3. POLICIES:

Patient Records. Patient records in DoD facilities will be created, managed and stored in a manner, which maintains patient privacy. Outpatient records will be stored in a single area or may be stored in multiple areas but they are located in dedicated rooms and kept from other records such as inpatient records. Extended Ambulatory Records will be kept as inpatient records and will be separate from outpatient records, even if created and stored in a freestanding clinic.

2.5.4. PROGRAM DATA REQUIRED

Projected number of non-MEDICARE eligible outpatient records?
 Projected number of MEDICARE eligible outpatient records?
 Number of decedent affairs clerks?
 Holding period for inpatient records?
 Number of FTE, Admission and Disposition Clerks?
 Projected number of admissions annually?
 Number and positions of personnel in TRICARE Service Center (TSC)?
 Number and positions of personnel in military TRICARE section?
 Number of physicians on the staff of the hospital or Medical Center?
 Number of Liaison personnel from Services other than the Service of the MTF?
 Number of patient record clerks, FTEs, working in outpatient records?
 Number of patient record clerks, FTE, working in inpatient records?
 Are ambulatory surgery services provided?
 Projected number of Extended ambulatory records?
 Will high-density file storage systems be used for records storage?
 List the administrative personnel to ensure a total personnel count.

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2.5.5. SPACE CRITERIA (for Hospitals and Medical Centers and for free-standing clinics which maintain EAR's)

2.5.5.1. Patient Administration Office

Coordinate the terms below, since each service may have service specific terminology for various medical administration functions.

FUNCTION	AUTHORIZED		PLANNING RANGE/COMMENTS
	m ²	nsf	
Chief of Patient Administration	11.15	120	If FTE projected
NCOIC/LCPO/LPO Patient Administration	11.15	120	If FTE projected
Medical Records Clerks	5.57	60	Minimum. Provide one per FTE of medical records technician personnel projected.
Storage Room	5.57	60	One per Patient Admin Section.
Office Automation Room	11.15	120	One per Patient Admin. Section.
Hospital Treasurer	11.15	120	If FTE projected
Hospital Cashier	5.57	60	Secure room with a payments window
Patient Counseling Room	11.15	120	One per Patient Admin. Office
Birth Clerk(s)	11.15	120	One private office for each FTE projected.
Decedent Affairs Clerk(s)	11.15	120	Per decedent affairs clerk FTE projected
Benefits Counselor(s)	11.15	120	One private office for each FTE projected.
Patients' Effects Storage	11.15	120	Secure room for patient luggage
Medical Board/Disability Board or Physical Evaluation	5.57	60	Provide 60 nsf per FTE projected.
Service Liaison Offices	5.57	60	Provide 60 nsf for each (Army, Navy Air Force, and Marine Corps) Service representative attached to the hospital.
Third Party Collection	5.57	60	Per Third Party Collection clerk FTE projected
Air Evac.	5.57	60	One per Patient Admin Section.
Coding Section for all Records	11.15	120	Minimum area for MTF with inpatient services. Add an additional 60 nsf per coding clerk above two.
Medical Statistics and Quality Assurance Section	11.15	120	Minimum area for MTF with inpatient services. Add an additional 60 nsf per clerk above two.

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FUNCTION	AUTHORIZED		PLANNING RANGE/COMMENTS
	m ²	nsf	
Patient / Family Waiting Supports several functions of the medical administrative sections/offices. Most patient using these areas will be seen by A&D clerks, Air Evac. Clerks, and Special Action/Correspondence clerks. Sizes listed are for each independent function. These are three independent sections/offices that may be co-located. Co-location of these functions could reduce the overall size.	9.29	100	For freestanding clinic, which maintains EARs. Maximum.
	18.58	200	For hospitals with up to 100 average daily inpatients.
	37.16	400	For hospitals with more than 100 average daily inpatients.
Toilets		varies	See Section 6.1

2.5.5.2. TRICARE Service Center (in freestanding Clinics, Hospitals, and Medical Centers) Planner must review the regional TRICARE contract to determine if specific minimum space requirements exists (minimum amount of space that the government is required to provide the contractor).

FUNCTION	AUTHORIZED		PLANNING RANGE/COMMENTS
	m ²	nsf	
TSC Director	11.15	120	One if TSC Director FTE projected.
Secretary's Office	11.15	120	One if FTE projected.
Workstation cubicle	5.57	60	Minimum. 60 nsf per FTE projected.
Storage Room (Forms, Literature)	5.57	60	One per TSC Office.
Office Automation Room	11.15	120	One per TSC Office. May be shared with Military TRICARE.
TSC Waiting Area	5.57	60	Minimum, plus 30 nsf for each two (2) TSC Service Consultant FTE in excess of four (4)
TSC Receptionist	7.43	80	Combine with waiting area.

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2.5.5.3. Military TRICARE (in freestanding Clinics, Hospitals, and Medical Centers)

FUNCTION	AUTHORIZED		PLANNING RANGE/COMMENTS
	m ²	nsf	
TRICARE Chief's Office	11.15	120	One if TRICARE Chief FTE projected
NCOIC/LCPO/LPO's Office	11.15	120	One if FTE projected.
Secretary's Office	11.15	120	One if FTE projected.
Workstation cubicle	5.57	60	Minimum. 60 nsf per FTE projected.
Storage Room (Forms, Literature)	5.57	60	One per TRICARE Office.
Office Automation Room	11.15	120	One per TRICARE Office. May be shared with TRICARE Service Center.
TRICARE Consultant(s) Office	11.15	120	Per TRICARE Service Consultant FTE projected (Examples - Benefits Advisors, Nurse Managers, Utilization Mgmt.)
TRICARE Waiting Area	5.57	60	Minimum, plus 30 nsf for each two (2) TRICARE Service Consultant FTE in excess of four (4)
TRICARE Receptionist	7.43	80	Combine with waiting area.

2.5.5.4 Inpatient Records (in hospitals and Medical Center and clinics with ambulatory surgery service)

FUNCTION	AUTHORIZED		PLANNING RANGE/COMMENTS
	m ²	nsf	
Inpatient Records Files Room	18.58	200	Minimum. See formula below in para. 2.5.5.7
Ambulatory Surgery Records		varies	100 nsf minimum. Ambulatory surgery records are called "Extended Ambulatory Records" but are treated the same as inpatient records and stored with inpatient records in a hospital or medical center. In a freestanding clinic with ambulatory surgery service, these record are managed and stored the same as inpatient records. See formula in para. 2.5.5.7. for inpatient records
Records Work Area and Air Evacuation Work Area	18.58	200	One per records room. Includes copy machine.
Admission and Discharge (A&D) Booths	5.57	60	One "privacy booth" per A&D Clerk FTE projected.
Patient Records Clerk(s)		varies	60 nsf / patient records clerk FTE projected
Transcription Room		varies	60 nsf per transcription clerk FTE projected
Physicians' Work Room	11.15	120	Minimum, plus 60 nsf for each increment of 50 physicians in excess of 25.

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2.5.5.5. Outpatient Records (in any Medical Treatment Facility).

FUNCTION	AUTHORIZED		PLANNING RANGE/COMMENTS
	m ²	nsf	
Records Window	5.57	60	One per outpatient records area for the dispensing/collection of records. Area may be distributed inside and outside of the records area window. This space can be decentralized to the Primary Care Clinic.
NCOIC/LCPO/LPO Outpatient Records	11.15	120	If FTE projected. This space can be decentralized to the Primary Care Clinic.
Medical Records Clerks		varies	40 nsf per clerk during peak staffing shift. Comment - This accounts for large facilities that run several shifts in this area. This space can be decentralized to the Primary Care Clinic.
Personnel Reliability Program (PRP) Office	11.15	120	One per PRP FTE. This space can be decentralized to the Primary Care Clinic.
Outpatient Records Storage Area		varies	See formula in para. 2.5.5.7. This space can be decentralized to the Primary Care Clinic.

2.5.5.6. Central Appointments Office. (In any Medical Treatment Facility with a Central Appointment staff).

FUNCTION	AUTHORIZED		PLANNING RANGE/COMMENTS
	m ²	nsf	
Chief of Central Appointments	11.15	120	If FTE projected
Central Appointment Clerk Workstations		varies	60 nsf per clerk during peak staffing shift. Comment - This accounts for large facilities that run more than one appointment shift.
Central Appointments Lounge	9.29	100	Only for areas with 8 or more clerks. 100 nsf minimum. Add 10 nsf for each five clerks over 10.

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2.5.5.7. Formulas.

Formulas for Patient Records Storage Areas:

Formulas for Inpatient Records and Extended Ambulatory Records Storage Areas:

Inpatient/EAR Records: $NSF = (\text{annual admissions}) \times (\text{maximum year records are retained factor}) \times (\text{inches of records per admission}) \times (0.055 NSF)$

Note: Because measurement of these records is based on an actual measurement of records on hand, there is not a requirement to calculate MEDICARE eligible records separately.

STEPS:

1. Project the number of admissions and ambulatory surgery procedures in medical facility annually.
2. Determine the number of years this facility will retain active records and apply the appropriate factor:
 - factor = 3, if not required to maintain records for two years.
 - factor = 6, if required to maintain records for five years.

NOTE: As a rule medical centers retain records for five years and other hospitals retain records for two years.
3. Calculate the inches of record per admission, often a fraction of an inch. Count the number of inpatient records in a typical sample of 50 inches of records (4 foot - 2 inches) of records. This is a measure of the thickness of the records. The fifty inches of records would be 50 inches if staked on top of each other. Divide 50 inches by the number of records in the stack 50 inches high - i.e. you will arrive at average thickness of a record (inches per record).
4. 0.055 is a conversion factor (square foot per inch), which converts inches of records into square feet of floor space needed to store the records in shelving that is 3 feet wide and 6 shelf units high and includes the aisle space to file and retrieve records.
5. Insert the appropriate numbers and factors in the formula and calculate the required net square feet (nsf).

Note: Inactive records are sent to the National Treatment Records Center.

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Formula for Outpatient Records Storage Areas:

Outpatient Records Room: NSF = (projected number of records) / (linear feet conversion factor) X (0.06 square feet per linear feet, shelf factor)

NOTE: This formula must be calculated separately for MEDICARE eligible patients and for non-MEDICARE eligible patients using a different linear feet conversion factor and different projected numbers of records.

STEPS:

1. From the beneficiary population to be served, project the number of non-MEDICARE eligible patient records that require file space.
2. Use a linear feet conversion factor of 16 records per linear foot for non-MEDICARE patients.
3. Insert the appropriate numbers and calculate the formulas.
4. If the MTF is providing care to MEDICARE eligible patients, then also calculate additional space using the same formula as follows.
5. From the beneficiary population to be served, project the number of MEDICARE eligible patient records that require file space.
6. Use a linear feet conversion factor of 8 records per linear foot.
7. Insert the appropriate numbers and calculate the formulas.
8. Combine the NSF of space required for MEDICARE and non-MEDICARE eligible patients to obtain the total outpatient files storage area required.

Note Concerning all records storage areas: If a high density file storage system (space saver) is planned, the net square footage may be reduced by 44.8%.