

## RETIRING THE PAPER CHART DURING IMPLEMENTATION

The most frequently asked group of questions by practices implementing EMR are: "What do we do with our old paper charts, once we go electronic?" "Do we scan the whole chart in? Do we just scan in certain parts? Do we keep the paper chart or shred it?" "What have other practices done?"

### ***What have other practices done?***

Practices who have won the Health Information System Society's Ambulatory Davies Award of Excellence in implementation are asked to share lessons learned during implementation. What went well? What didn't go well? These practices consistently site scanning in the entire chart as a drain on resources in both time and money with very little usable result. A preferred procedure for culling useful data from the paper chart and transferring it into the electronic chart is a combined method of hand-entering data and selective scanning of relevant documents done in a time frame consistent with how often patients are typically seen.

### ***Why not just scan in the whole chart? Why isn't that practical?***

When a care team member scans the page of the chart, the resulting file created is a picture. A person must manually enter the file name for each picture [ie: bobjones\_page1.jpeg] taken of each page of the chart or group the pictures/pages together into one file [ie: bobjones\_history.jpeg]. If a user in the future would like to search for a page of the chart, they must flip through the pictures to find the page they want similar to flipping through a photo album. They cannot search the page/pictures by name or visit date unless someone manually labeled the page picture as such. Some documents are valuable to retain, label and add to the electronic chart; the way these documents are named could affect the time and effort involved when trying to locate a particular portion of the chart.

### ***How does the combined method work?***

The practice needs to first do an assessment on practice chart characteristics to decide what data will be transferred, how it will be transferred (typed or scanned), who will do the transfer and when. Does each chart have a face sheet with a summary of data such as active medical problems, allergies, a current medication list, family history, etc. that can be typed in? Are there essential reports care team members often refer to at visits such as the last electrocardiogram, consultant report, hospital discharge summary, health proxies, etc. that need to be scanned in? What about reports unique to some patients? Who will mark those and when? Who has the expertise to do the transfer into the EMR? Does it have to be a nurse or can it be a college or graduate student? Are there available people resources to scan documents into the EMR? How

many active patients does the practice have and how do they define active? Does different data have to be put in for acute visits or follow-up visits as opposed to routine visits? When will the practice enter all visits and data into the EMR? All of these questions influence the aforementioned what, how, who and when concerns.

### ***Timing***

The practice needs to declare an official start date of when all encounters and new data will be entered into the EMR. Larger practices may have resources to systematically retire charts in alphabetical order prior to the official start date assuming someone has marked those reports unique to the patient to be scanned in. If chart data is transferred into an EMR too far in advance of the official go-live date the practice must have a method for revisiting any paper charts that have subsequent information added to them. The practice also needs to have a clear visual cue on the paper chart once it is retired to deter its use. One practice tied a ribbon around a retired chart (and anyone who cut a ribbon was fired).

In smaller practices with fewer people resources, charts can be retired over a period of time typical of how an active patient is defined. For example, in a pediatric practice retiring a chart may be done over the course of a year and in an internal medicine office this may be done over three to five years. A day or two before a patient is seen for a routine visit, all summary data is typed in and those paper reports the practice deemed essential are scanned. When a patient is seen for their visit both the data in the EMR and the paper chart can be available. The doctor can confirm the data entered and mark the chart for any additional reports unique to the patient that may need to be scanned in. For an acute visit, perhaps only medicines, active medical problems and allergies need be entered prior to the encounter.

### ***The Retired Paper Chart***

In the hybrid method, the paper chart must still be retained for the time as mandated by law.

And as ALWAYS a back up plan for electronic data must be in place and TESTED BEFORE entering any data into your practice's new electronic system.

