Dealing with Paper Post–Document Imaging

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The electronic health record (EHR) has been a work in progress for decades. According to a 2007 American Hospital Association information technology survey, 68 percent of hospitals have a partially or fully implemented EHR.[1]

Today's health information environment is made up of a multitude of media, and the road to an EHR is cluttered with them: paper, film, digital data, and more. Document imaging has served as a significant tool in merging paper into the EHR.

A document imaging system can serve as an interface to link paper documents to the EHR or other systems, or it can serve as a supplement to the EHR, acting as an electronic archival system for paper documentation. For some organizations document imaging is the first step toward a paperless environment, while for others it serves as an interim step.

When it comes to document imaging, one underlying question always remains: What happens to the paper after scanning is complete? The answer depends on many factors associated with paper's lifecycle after the facility's implementation of a document imaging system.

How Long Should Paper Be Kept?

There is no definitive answer to how long organizations should keep paper after scanning it to a document imaging system. Each individual facility must determine how long to store paper based on its individual circumstances. Retentions times could range from 0 to 6 months.

For example, a facility's available space will affect retention time. If the facility lacks space, retention will most likely be short. Management, risk management, and legal counsel should also weigh in on the appropriate retention time for paper documents.

The percentage of documents that are COLD-fed is another consideration in determining paper retention times. If a facility has 70 percent of its documents COLD-fed into the system, it may not find purpose or value in retaining the remaining 30 percent, and it may thus decide to immediately destroy all paper copies once scanning is complete.

Another significant influence is the quality analysis stage of document imaging, also referred to as quality control or validation. The majority of organizations perform some kind of quality control to ensure that records are accurately scanned.

Every organization should determine how much it will spend on quality control according to budget and level of risk.[2] Does the organization want 100 percent, 97 percent, or 90 percent accuracy in its document imaging system? If a facility has a 65 percent accuracy rate, it is justified in keeping paper for a longer time frame, and it may have to commit resources to employee training and other programs to increase its accuracy rates.

Regardless of situation or reasoning, organizations should remember that the longer the paper is kept, the more it can become a crutch and hinder progress.

What Processes Are Needed?

Every facility should have a policy and procedure that clearly defines when the paper is to be scanned (e.g., upon completion of the inpatient record) and when it is destroyed (e.g., within 30 days of scanning). The destruction of all protected health information (PHI) should also have a schedule in place so appropriate measures can be taken.

Keep in mind that it is just as important that policies are enforced and followed. An organization that writes a destruction policy and then does not follow it puts itself at huge risk.

If paper is going to be stored after scanning, it should be clearly marked with the scan date. This can be done in several ways. It can be done by date stamping the back of each document or date stamping the cover page (usually not scanned) of each batch or each box. Some facilities will put a day's worth of scanning into boxes specifying the date of completion. Once the date has clearly been marked, the papers should be stored according to facility policy and destroyed according to its respective destruction schedule.

The method of destruction may follow the same method as the facility's main destruction schedule, or it may be kept as its own separate project since its retention and destruction schedule is much shorter than that of the facility's business health records. Since the information is protected, destruction must be compliant with all laws and regulations (e.g., shredding, incineration). A destruction certificate is not necessary, since all documentation has been scanned and is available in the system. The hard copies are now duplicates.

Who Authorizes Destruction?

An effective policy and procedure, approved by appropriate governing bodies, should designate ownership so that authority of retention and destruction of the scanned paper is never in question. Authority will most likely lie with the director or manager of the HIM department and may be further designated to the document imaging manager or supervisor.

Even though this is not the retention and destruction maintenance of the organization's business health records (which belongs with the custodian of records), it is still the retention and destruction of PHI and must be handled as such.

What If Litigation Occurs before Paper Is Destroyed?

In order to serve as business records, health records must be maintained in a manner that complies with applicable regulations, accreditation standards, professional practice standards, and legal standards. Therefore, an organization must identify the content required for its legal health record as well as the standards for maintaining the integrity of that content.[3] It is imperative that the legal health record of an organization be defined, especially once health information starts to reside electronically or in a hybrid environment.

If litigation occurs before the paper is destroyed, the organization's legal health record policy will clarify the legal record. If the policy states that the record is electronic and resides within the document imaging system, EHR, or other system, then the paper copy should not matter.

However, in the event of litigation, HIM professionals should always consult with their risk manager and legal counsel before destroying any existing paper that may be related to litigation. Each case will have varying circumstances, and integrity of the information is paramount.

Organizations must ask themselves many questions when implementing a document imaging system. HIM professionals can help answer them to ensure that the organization meets the confidentiality and security principles of PHI.

Notes

1. American Hospital Association. "Continued Progress: Hospital Use of Information Technology." February 2007. Available online at www.aha.org/aha/content/2007/pdf/070227-continuedprogress.pdf.
2. Burrington-Brown, Jill. "In Search of Document Imaging Best Practices." *Journal of AHIMA* 79, no. 9 (Sept. 2008): 60–61.
3. AHIMA EHR Practice Council. "Developing a Legal Health Record Policy." *Journal of AHIMA* 78, no. 9 (Oct. 2007): 93–97.

Further Reading

Burrington-Brown, Jill. "In Search of Document Imaging Best Practices." *Journal of AHIMA* 79, no. 9 (Sept. 2008): 60–61.

Liette, Elizabeth, Chris Meyers, and Keith Olenik. "Is Document Imaging the Right Choice for Your Organization?" *Journal of AHIMA* 79, no. 11 (Nov.–Dec. 2008): 58–60.

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