Is Document Imaging the Right Choice for Your Organization?

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Document imaging is a valuable bridge to an electronic health record (EHR). It can be used as an archival system for the legal medical record or to supplement EHR systems with paper documents. In this situation the medical record is located in at least two electronic systems. Information created electronically is maintained in the source EHR application, while information created on paper is scanned into the document imaging system to allow for online access and storage. This is one example of a hybrid record.

When paper-based information is retained on paper and electronically created information is retained in the EHR application, the retrieval and storage of information is extremely complicated and cumbersome. Reviewing the patient's complete medical record requires knowing where to look for all of the components. Organizations in this situation are good candidates for a document imaging system to improve medical record storage and retrieval. As they would for any IT solution, however, they must assess the technology's abilities against their own needs, and they likely must project a positive cost-benefit analysis.

What Document Imaging Can-and Cannot-Do

Assessing document imaging requires that the organization share clear expectations of what such systems offer.

What It Is	**What It Is Not**
The imaging system is a bridge to the paperless electronic health record.	The imaging system is not an electronic health record system that captures discrete data elements.
What It Will Do	**What It Will Not Do**
Provide timely, simultaneous access by multiple caregivers to a patient's medical record that will improve patient safety, enhance quality of patient care, and improve the flow of information.	It will not provide the user the ability to search through the system on discrete data elements or provide decision support (e.g., alerts and reminders).
Provide timely, simultaneous access by administrative and other healthcare operations to a patient's medical record, increasing staff productivity and efficiencies in work processes throughout the organization.	It will not provide immediate, real-time access to all documents (imaging or importing of most document will have an established turnaround; e.g., two to 24 hours).
Ensure higher integrity of the medical record by improving the timeliness of filing into the record, providing electronic workflow that routes charts for	It will not eliminate paper. It eliminates the long-term storage of the paper, but if the record is produced using paper, it will continue to be

dictation and reports for signatures, and allows charts to be completed remotely.	produced in this way until electronic health record systems are implemented.
Support compliance efforts with HIPAA, the Joint Commission, and other regulatory bodies and agencies affecting reimbursement.	
Support data integrity and business continuity plans by incorporating handwritten documents that are created during downtime for clinical information systems and supporting emergency downtime or disaster preparedness.	
Reduce file management and storage requirements across the organization freeing up space currently used for record storage in clinical areas that could be used for revenue-generating services.	

One System, Multiple Functions

Some organizations decide that having the legal medical record in one archival system helps secure the permanent record and ensure that the complete record is available for disclosure. These organizations interface data created in the electronic record systems into the document imaging system (e.g., laboratory data is interfaced into the document imaging system).

Some organizations have gone the extra mile of creating documents in the EHR that can be produced for disclosure, and they interface them to a document imaging system (e.g., assessments, flow sheets, and progress notes). These organization do not have to retrieve information from multiple systems to produce the medical record, as the information created electronically and on paper is stored in the document imaging system.

Other organizations look at document imaging as a supplement to the EHR. Documents are scanned into the system and integrated into the EHR, or they are scanned directly into the EHR. The end user has one view into the patient's medical record and access to paper-based documents through the EHR. This type of situation is only possible if the EHR allows for the inclusion of paper-based documentation. The EHR must also be able to index the documents.

Regardless of the document imaging model an organization chooses, it must consider the legal issues associated with producing the medical record when requested. If the medical record exists in multiple systems, HIM professionals must ensure that all of them will comply with appropriate retention requirements. They must also consider a model's ability to produce all information defined to be part of the medical record in a consistent and timely manner.

Assessing Document Imaging

Organizations considering a document imaging system should assess their current and expected future paper volumes and consider their EHR implementation strategy. They must also gain common expectations of what document imaging can and cannot do. The table on the left offers a summary.

Organizations must justify the expense of document imaging systems, which can be difficult, as they frequently compete with funds earmarked for clinical patient care systems. One benefit of a document imaging system is its ability to improve efficiencies through workflow and remote access. Multisite organizations may centralize certain functions such as chart completion, release of information, coding, or chart scanning. The ability to centralize or distribute work can increase efficiencies by making better use of staff as volumes change or staffing varies due to vacancies or absences. Organizations can consider the following benefits when completing a cost-benefit analysis:

- **Improved access** to patient data and information. Caregivers have immediate access to critical medical record information without waiting for paper records to be delivered. Patient data are available online and can be accessed remotely, including physician offices. Fewer paper records in circulation means a reduction in lost records.
- **Remote coding.** Scanning records at discharge for either permanent or temporary storage can provide access to the record to off-site coders, either staff or contract services. Enabling staff coders to work from home can improve morale and free up space in the facility. Contract coders can easily be brought on board to help reduce backlogs or cover for vacancies or vacations. Coding can be centralized for multiple-facility organizations.
- **Revenue cycle.** Efficiencies of the online medical record can improve DNFB and AR days.
- **Release of information.** The medical record can be printed on demand. Production of the medical record may include output to CDs, PDFs, and other formats.
- **Chart completion** and electronic signature. Physicians can sign deficient records online, reducing record delinquencies and the staff needed to retrieve and process incomplete medical records.
- **Medical record processing.** Many functions, such as assembly, filing, and manual retrieval, can be eliminated.

Resources

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