Managing Existing Patient Records in the Transition to EHRs in Physician Practices

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Arguably, the greatest challenge for a medical practice implementing an electronic health record (EHR) system is change. Setting up new software and hardware is typically easier than disrupting and reconfiguring the practice's processes and determining how to handle its existing paper records.

Practices face many decisions in choosing which paper records to bring forward into the new system. They must also manage the integrity of data during the conversion to the new system and create workflows and policies for those legacy records that will remain in paper.

Determining Which Paper Records to Convert

As physician offices start down the path to implementing an EHR system, many questions will arise regarding what to do with existing patient medical records.

These questions range from what and how much patient data or information should be brought forward to the EHR to methods of transferring that data (i.e., scanning and/or data entry). Further questions can include what to do with the old patient records, how long they should be available to clinicians after the new system is implemented, and how long they should be kept in storage before being destroyed.

These questions require careful evaluation to safeguard the quality of patient information, avoid the inefficiencies of working with two systems (paper and electronic), and ensure clinicians have a complete record of each patient treatment.

The decisions practices make regarding the handling of existing patient records will be affected by a variety of factors, including:

- The scope and type of medical specialties in the practice or clinic
- The type of services offered (e.g., clinic, urgent, or emergency care)
- The cost and availability of staffing, space, and other resources necessary to transfer information into the EHR or retrieve old records that may be needed
- State laws, where applicable

There are significant costs associated with converting existing records to a new EHR system, which must be balanced against the need to have adequate information necessary for ongoing patient care.

Failure to strike the proper balance between these two needs can negatively impact physicians' ability to fully and successfully utilize the new system. EHR implementation success, clinician workflow, and quality of care can suffer if doctors must routinely access both old paper records and the new system to get the information needed for patient care.

Managing Information in Transition

In addition to determining which historical patient information will be brought forward into the new system, practices must also manage their information throughout the overall transition to the electronic system. Managing information well will both affect and be affected by the following aspects of the implementation.

Achieving User Buy-In

A main challenge during the EHR transition is user buy-in and trust in the reliability of the system. Users must be assured that the data and information displayed on an electronic source are complete, accurate, and reliable. Continuous monitoring and evaluation as data migrate from paper to electronic is an essential task in promoting trust and confidence.

Success requires the buy-in of all care providers, including advanced practice nurses and physician assistants. There are many ways to positively manage the change, including incentives, rewards, recognition, and continuous communication. It is also important to wean users off the paper record and support them in solely relying on the electronic methods. There should be a defined schedule for when the paper will no longer be available.

Effective Decision Making

As with any new addition to a medical office, there is much planning that must take place and many decisions to be made during an EHR implementation. One of these core decisions involves the consideration of the "clinical drivers" that will impact the EHR conversion.

Clinical drivers will vary by specialty and individual practice needs. For example, an internist's information needs will differ from those of a urologist or oncologist. Determining each driver is important for overall success.

Defining the content of the practice's legal health record will help determine the information that must be converted. Defining the content will raise questions such as:

- Will the legal health record be defined to include the existing paper record and the electronic record?
- Will there remain a "hybrid record," where some historical documents will remain in paper form and need to be accessed outside the EHR?
- Will the project be staffed internally, outsourced to the vendor, or both?
- What resources are available and necessary for converting the required information and records? What changes will there be to the workflow process?

Processes during the Transition

Ensuring proper data management in the transition to an EHR will require changes to many processes. These include:

- **Prepping for patient visits.** The appointment schedule is the logical source to direct the health information manager or appropriate personnel to the back-scanning needs for upcoming appointments.
- **Printing.** Printing clinical abstracts for physicians to have on hand may ease the transition process. However, guidelines must make clear the purpose and permissions so that providers do not resist when printouts are eventually discontinued.
- **Capturing external data.** It is essential that external data be captured electronically by scanning, importing, or interfacing. This will also aid in familiarizing physicians and promoting a comfort level that the electronic chart is indeed their "record of record."
- **Planning for downtime.** Few medical practices can afford downtime. During the paper-to-electronic migration process, however, it is inevitable. A process must be mapped out in advance to continue work processes, capture pertinent patient information, and provide physicians with patient historical information that meets medical needs in the event the system is unavailable. There must also be a process defined for inputting all data captured during the downtime once the system is back online.
- **Retention periods of old data.** A good rule of thumb is that paper records are made available for the initial post-conversion appointments to allow physicians to tag any historical information for scanning. After the appointment, the practice must establish and follow a process for retiring the paper charts to storage.

Data Quality and Integrity throughout the Transition

The healthcare industry is made up of diverse professions that look at the issue of data quality from different perspectives. All agree that quality data are critical for patient care and safety, reimbursement, accreditation, and research.

However, there has been little discussion about who is responsible for ensuring data quality in the electronic environment.

Historically, the data quality role has fallen largely on health information management (HIM) professionals as the custodians of the paper record. In a physician practice setting this role may be assumed by a designated individual or shared among support staff members.

In the electronic environment, everyone from administrative and support staff responsible for specialty applications to direct caregivers who document in patient records will be tasked with ensuring data quality. It is a break in tradition that each individual in the array of caregivers who treat, touch, evaluate, and assess a patient has a role in creating and maintaining quality data in the patient's record.

Various quality assessment methods such as total quality management and continuous quality improvement have helped healthcare professionals focus on process and workflow. Focus on quality with attention to record completeness, timeliness, and authenticity are important factors for data integrity, validity, and reliability.

Data Quality Program

A successful transition to an EHR requires data strategies and an effective data quality program that incorporates documentation improvement and/or data integrity processes. A well-developed program will help monitor and manage data throughout a conversion to reduce error, risk, and potential harm. For this reason, it is important for the practice to determine what functionality a given EHR system offers for gathering, accessing, and transferring quality data.

Practices must decide what data to clean up, how far back to go, and how long the transition will take. The information should be tracked and reviewed regularly for accuracy so that bad data are not entered or pass through interfaces into the EHR. The overall plan and implementation for entering information needs to be clearly defined to ensure the integrity and validity of the information.

Policies and Procedures

Establishing policies and procedures to help manage and maintain data and information needs through the transition will help ensure data integrity and validity. Policy should be clearly defined and readily accessible to all staff. At a minimum, practices should document the following policies and procedures:

- **Access to information**-who can view, enter, and scan into the health record
- **Addendums, amendments, and corrections**- who can make changes and when changes may be made
- **Printing**-who can print, when is printing permitted, what is to be done with the printed version after use
- **Audit processes**-how often audits will be conducted, results reported, and errors corrected
- **Scanning**- the overall process, the process for outside records (e.g., scanning only those pertinent to care), and what to do with the paper after scanning
- **Retention and destruction**-how long the electronic record will be kept
- **Record completion**-how timely entry by all users will be ensured

Training

Proper training for all users, including the leadership team, is a crucial step for any implementation. Training provides the guidance and education staff needed to properly follow all policies and procedures. Unfortunately, it is a task that is usually understaffed and underscheduled. A well-designed training program will:

- Streamline communications
- Establish individual and organizational expectations
- Enforce accountability of actions
- Change user attitudes and behaviors during the transition from paper to electronic

Finally, the practice must determine the logistics associated with eventually phasing out the use of paper records, considering the effects on workflow and record retention requirements.

Converting Data from Current Health IT Systems and EHRs

Some physician offices that choose to participate in the federal "meaningful use" incentive program will no doubt find it necessary to de-install and replace an existing EHR system with one that meets the program's certification requirements.

Operating a practice with data in two different EHR systems presents the same, if not worse, workflow issues and conditions as operating with both paper records and an EHR. It is therefore usually necessary to convert most, if not all, clinical information and data from the system that is to be decommissioned.

A critical step in transitioning to a new system starts in the product selection phase. A careful analysis must be performed to ensure that all important data can be accurately and completely converted from the current system to the new one.

Selecting a new system that is based on the Health Level Seven EHR System Functional Model will also help facilitate data conversion; it is important to ensure that the selected EHR supports this standard.

Finally, it is essential that the implementation process includes a data validation procedure. Those who are familiar with the data should carefully examine it for accuracy and completeness prior to go-live and use in patient care.

Once it is determined that the data conversion is successful and the new system is operating as planned, the practice can continue with a decommissioning process of the old system in which data are removed from old hardware and otherwise destroyed.

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