Minimizing Hybrid Records: Tips for Reducing Paper Documentation as New Systems Come Online

by Teresa M. Hall, RHIT, MHA, CPC, CAC

It can be tempting for providers to reach for paper, especially when things get hectic. Planning and support help keep the hybrid record from getting more hybrid than it has to be.

Providers who are comfortable with the paper chart system can have a very difficult time letting go of it. Locating information in the electronic health record (EHR) and learning how to use new tools for displaying clinical data can be a challenge. It takes time to learn and master, which providers likely have very little of. It is understandable that physicians faced with a backlog of patients and feeling uncomfortable with the new system would find it easier to fall back to paper to get visits completed as quickly as possible.

Hybrid records—part paper, part electronic—are a reality for many organizations transitioning to digital clinical systems. The best that facilities can hope for is to manage this dual state as efficiently and effectively as possible until the transition is complete. When physicians switch back and forth between paper forms and electronic systems, the result is a hybrid record that is even more hybrid than it needs to be.

The entire organization plays a part in finding a solution. It requires full support and commitment from leadership, systems selection and implementation that addresses clinical workflows and needs, and sufficient training and support, both upfront and ongoing.

The Challenges of Dual Record Systems

Clinics and hospitals in the Billings, MT, Indian Health Services (IHS) area have been up and running with EHRs since late 2005. Most of the facilities are almost paperless, because they also have implemented imaging and scanning systems. IHS facilities in the Billings area are comprised of acute care facilities, critical access hospitals, and federally qualified healthcare centers.

During the organization's transition from paper to electronic, providers have been given the choice to switch back and forth from using the EHR to completing their visits on paper, mostly due to the amount of patients they are seeing in the office or clinic that day.

The impact this has on the HIM department is overwhelming. When providers switch between paper and electronic documentation, HIM staff must complete and compile the legal health record from the different sources generated that day.

Keeping track of the legal health record and the designated record set can become very complex in a hybrid environment. IHS continually documents the EHR on a matrix to keep track of what data reside in the EHR. The matrix is updated as well to reflect what is still on paper, again keeping track on the matrix of the legal record on paper.

In addition, the mix of documentation complicates release of information. When staff respond to a request, they find it difficult to pull all of the requested information in a printed format that captures all of the visit information adequately. The time it now takes to perform ROI duties has almost doubled because of having to review the paper chart as well as the electronic chart for the requested information.

Boost Staffing, Suspend Productivity Measures

This is why it is so very important for organizational leadership to fully support physicians when they go live with the EHR by staffing the clinic or office with additional providers that can help keep up with the volume of patients.

Leadership can contract with a locum tenens agency to bring extra staff on board for a short period of time until the permanent provider staff feel comfortable using the EHR and can complete the entire visit in the EHR with ease.

IHS requires its providers to meet visit productivity requirements based on industry standards. This is not uncommon to most facilities. Such requirements can put a lot of pressure on physicians just starting to learn to use the EHR, so leadership must let providers know that during the transition from paper to the EHR visit productivity standards will not be measured until all the providers feel they have a good handle on using the EHR efficiently and accurately. IHS providers were seeing one to two patients per hour when they first started using the EHR, and after about six months they were again seeing three to four patients an hour.

Providers may be resistant to the EHR or a mandate from leadership because they are afraid they will be spending less time with the patient because of the added responsibilities that come with an EHR. They may see the EHR as a distraction to them, a mechanism that requires their attention to be taken off the patient.

Practice sessions with the new system can help. With staff acting as patients, physicians can use demo records in the EHR to work out the bugs while treating the patient. Providers will then be able to practice how they will interact with the patient as well as the EHR.

Providers can practice how they illustrate to patients their progress with graphs of the patient's lab values, blood pressures, or weight gains and losses over time. There are many tools like this in the EHR environment available to the provider to elicit patient involvement in their care.

Tips for Smoother Transitions from Paper

- Bring in extra help while providers learn to use the EHR; relax productivity requirements during this time.
- Offer practice sessions with staff acting as patients. Providers can practice how they will interact with the patient as well as the EHR.
- Provide plenty of upfront and ongoing training.
- Offer a friendly reminder of how things used to be in the paper world—lots of forms, many trips to the HIM department. That can ease some tension and change outlooks on mastering the new system.
- Agree on a firm date for when all providers will be using the new system.

Remember the Old Days

A friendly reminder of how it used to be is always fruitful and can ease some of the tension providers are experiencing in the transition. It can change their outlook on the new system they are asked to take on and master.

It may help physicians to remember the voluminous paperwork they were responsible for completing in the paper world—the many superbills or charge sheets they had to complete in selecting the evaluation and management code level, for example, and the selection of ICD-9, CPT, and HCPCS codes. Within the EHR, selecting these codes has become much less cumbersome. Providers can set up pick lists of supplies, evaluation and management codes, CPT procedural codes, and ICD diagnostic codes specific to each of their services or privileges and specific to each of their patient populations.

It also may help providers to remember the many visits they made to the HIM department to complete their delinquent medical records. They may have already forgotten the many times they had to fill out lab requisition slips and the times they had to dictate a report, critique the transcribed report, and sign the report—all of which could require several trips to the HIM department. In the IHS facilities that have implemented imaging and scanning, physicians may now use the EHR to review paperwork from other providers involved in the care of their patient.

It does take time for providers to learn how to find and use these new pick lists, but when they do they provide the diagnostic, procedural, and supply code information that results in a quality coded visit. Access to more complete and up-to-date

information clearly benefits patient care.

Electronic systems also offer a back-office benefit, with quicker turnaround of coded visits and billed claim forms that result in accurate reimbursement back to the facility. These combined efforts by providers and coders result in a more accurate picture of why the patient was seen, what procedures or services were rendered, and what supplies were used to carry out the treatment.

Realizing these benefits requires that the organization commit to upfront and ongoing provider training and education. Both physicians and leadership must be committed to not turning back, meeting milestones for when all providers will be using the EHR, and choosing a firm date for when the organization will become paperless.

EHRs will be a reality in time, and the hybrid record is the transitional phase many of us will face for some years. A successful transition takes commitment and support at all levels of the organizations. With good effort, we can make the transition as "minimally hybrid" as possible.

Understanding Individual Provider Styles

To get the full return on their EHR systems, organizations must commit to adopting them thoroughly and consistently. However, understanding individual physician workflow needs and preferences—and adapting standardized templates and training accordingly—can make the transition smoother and more effective.

Providers have their own workflows, and each documents the patient's history of present illness, review of systems, past, family, social history, physical exam, and medical decisions a little differently. Some providers prefer to use the SOAP format—subjective, objective, assessment, plan—while others prefer to use the CPT evaluation and management format.

Providers also have different styles in how they elicit information from patients, and these may not lend themselves to a standardized format at all. Providers treating a chronic disease patient or a relatively simple acute condition may not document in any standard format. Others seeking time savings may refer the reader back to previous visits or seek to copy information forward from past notes.

Setting up templates in the EHR based on the provider's style of gathering information could save the provider a lot of time and guesswork when filling in the blanks of a new template format. The organization may still use standardized templates but personalize the format to each provider's style.

It may also help providers to have the chief complaint, vital signs, and any notes written by the triage nurse forwarded into the provider's visit notes for that day. This helps all record reviewers see the entire picture of what happened during the visit.

A provider's typing skills or dictation ability also determine how he or she will adapt to the new EHR. Providers will choose to dictate or use check-box templates if they do not have the skills to type. Providers who do feel comfortable typing often prefer to enter their notes in text form; they may not want to take the time to check boxes in a template or pick up a dictation phone line. These providers prefer to create their notes now, and they consider them as the work of a highly trained professional. They may consider other methods insufficient or unnecessary in comparison.

Providers also review past history of treatments, procedures, or consultations differently. Some are comfortable viewing all historical data electronically. Some request the old paper chart because it is easier for them to locate the information. In these instances, organizations must step up their training and support, possibly providing staff who can assist providers in real-time during the transition.

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